CHAPTER 1

Using competitive pricing to set beneficiary premiums in Medicare

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Chapter summary

Last year, the Commission began exploring the statutory and structural differences between the traditional fee-for-service (FFS) Medicare program, Medicare Advantage (MA), and accountable care organizations (ACOs). Medicare has different payment rules for the three payment systems that can create payment inequities and inefficiencies for beneficiaries and taxpayers. One issue that the Commission studied was how beneficiary premiums and the federal contribution for FFS and MA coverage would vary in different parts of the country under different premium designs. Because beneficiaries in ACOs are part of FFS Medicare, only two of Medicare's payment systems—FFS and MA—are relevant to the study of premiums.

With respect to premium design, Medicare could seek to encourage beneficiaries to choose the most efficient option for receiving Medicare benefits while maintaining equity for beneficiaries across markets. The incentives that encourage beneficiaries to choose more efficient models would be aligned with the incentives that encourage providers and MA plans to provide care in a more efficient manner.

This chapter provides additional information on the three illustrative designs that the Commission constructed last year to examine their potential to encourage beneficiaries to use the more efficient system (FFS or MA) in their area. These designs are:

In this chapter

- a nationally set base premium that buys FFS Medicare in every market;
- a nationally set base premium that buys either FFS Medicare or a reference MA plan—whichever costs less—in each market; and
- locally set base premiums that buy either FFS Medicare or a reference MA plan—whichever costs less—in each market.

Under each design, beneficiaries can enroll in either FFS or MA, but what premium they pay to do so differs. In addition, the federal contribution is financially neutral across payment systems—that is, equal for FFS and MA in each market. We used the MA plan with the median bid as the reference plan, but that is a design choice. The determination of beneficiary premiums is important because it is a key element of proposals to adopt a premium support model in Part A and Part B of Medicare. (Medicare already uses a premium support model for its Part D drug benefit.)

Under the second and third designs, beneficiaries who want to use the more costly payment system would pay a higher premium. How much higher that premium would be depends on the difference between average FFS costs and the cost of the reference MA plan in the geographic market area. About 45 percent of beneficiaries live in areas where the difference in costs between FFS and the median MA plan is less than $50 per month, but 34 percent live in areas where the difference is more than $100 per month. Under these designs, most beneficiaries who would see premiums increase by $100 or more are FFS enrollees who live in large metropolitan areas with relatively high FFS spending and elect to remain in FFS. Also, MA enrollees in a number of smaller markets with relatively high MA benchmarks and spending would also see similar increases if they elect to remain in MA. Under the illustrative designs, policymakers could choose to mitigate the increase in beneficiary premiums in a number of ways, such as limiting how much premiums could vary across delivery systems or phasing in any increase over time.

The statutory and structural differences between MA and FFS (and ACOs, although they are not discussed separately from FFS in this chapter), including elements beyond premium design, raise important issues of equity and implementation that will need to be resolved to maximize the value of the Medicare program to its beneficiaries and taxpayers. Medicare needs to determine whether and how to set payment rules that reward the more efficient system of care in a market, how to encourage beneficiaries to receive care through that system, and how to provide the information they need to make informed decisions. ■

Introduction

Under the current Medicare program, there are three payment systems: traditional fee-for-service (FFS), Medicare Advantage (MA), and accountable care organizations (ACOs). Traditional FFS pays providers for individual services (or in some cases for a set of services, such as an inpatient hospital stay), according to the payment rates established by the program. By contrast, under MA, Medicare pays private plans a risk-adjusted per person (or capitated) payment rate to provide the Part A and Part B benefit package to plan enrollees. Medicare introduced ACOs in 2012. Under the ACO system, a group of providers is accountable for the spending and quality of care for a group of beneficiaries attributed to them. The goal of the ACO program is to give groups of FFS providers incentives to reduce Medicare spending and improve quality, similar to the incentives for MA plans. However, only some ACOs currently bear two-sided risk; most share only savings, not losses.

In the traditional FFS Medicare and ACO systems, beneficiaries essentially have no restrictions on choice of provider. In the MA system, the MA plan can restrict provider choice to a specified network of providers; beneficiaries receiving care from providers outside the network pay more. In this respect, MA plans are more like commercial plans commonly available to the population not eligible for Medicare.

Under current law, Medicare's payment rules, quality improvement measures, and incentives are different and inconsistent across the three payment systems. Various approaches to making those rules more consistent have been considered. In its June 2014 report, the Commission focused on setting a common spending benchmark for MA plans and ACOs based on local FFS spending. That report's focus on equal benchmarks as a key element of synchronizing Medicare policy across payment systems represented a refinement of the principle of financial neutrality between FFS and MA.

In its June 2015 report, the Commission found that which payment system had the lowest program spending varied from market to market. The report also explored changing the method for calculating beneficiary premiums, including examples in which the lower of local FFS spending or MA plan bids would determine the reference point for the federal contribution and beneficiary premium. In these examples, individuals who want to receive Medicare benefits through the more expensive system would pay a higher premium, which is a key element of proposals to use a premium support model in Part A and Part B of Medicare. (Medicare already uses a premium support model for its Part D drug benefit.) Finally, we examined the need to make sure that the reporting of patient diagnoses is more consistent across the three systems (Medicare Payment Advisory Commission 2015a).

If the payment rules and incentives for the FFS, MA, and ACO systems were synchronized and geared toward making each more competitive, beneficiaries and the Medicare program would both benefit. First, beneficiaries could choose a system and providers that match their preferences. Second, competition among the systems could expose inefficiencies and drive market share away from the less efficient systems. For example, in markets where per capita FFS spending is high, MA plans could best FFS by offering additional benefits at a lower cost. Similarly, if FFS had lower costs than MA plans in some markets, FFS could take market share from higher cost MA plans (or the plans could exit the market). By having all systems compete, beneficiaries in each market can choose which system provides them the best value. However, some beneficiaries would likely have to pay more than they do now for their existing coverage.

The Commission has for many years supported giving Medicare beneficiaries a choice between traditional FFS and private plans under MA. The original goal for private plans in Medicare was to provide a mechanism for introducing innovation into the program while constraining Medicare spending. Private plans have greater flexibility to develop innovative approaches to care and can more readily use care management tools and techniques than traditional FFS. This flexibility enables private plans to reduce spending and improve the quality of health care services. In turn, Medicare beneficiaries' ability to choose between traditional FFS and MA plans could lower program spending if Medicare payments to plans were reduced to capture some of those gains. However, as the Medicare program adopted the goal of making MA plans available to all beneficiaries—even in markets where plans are not able to effectively compete with FFS based on cost—plan payments were increased above FFS levels, not reduced. Higher payments resulted in higher MA enrollment and higher costs to the program.

MA benchmarks are now transitioning to levels that are closer to FFS, as required by the Patient Protection and Affordable Care Act of 2010, and plans have reduced

Other factors besides premiums that affect beneficiary choice

The illustrative examples in this chapter show how beneficiary premiums will vary depending on the choice that a beneficiary makes between fee-for-service (FFS) Medicare and among Medicare Advantage (MA) plans. However, the premium amount is not the sole factor that a beneficiary would consider in making a choice. Additional financial considerations include the expected level of cost sharing for services, the presence of a cap on out-of-pocket spending, and the value a beneficiary expects to derive from any additional benefits a plan might offer. Other considerations include factors such as the extensiveness of the network of providers available through a plan, whether one's current providers are in a plan's network, and ease of access to a plan's providers. Sometimes such factors affect the cost of a plan; for example, a preferred provider organization is likely to be more expensive in a given market than an HMO with a narrow network.

The factors to consider can also vary among categories of Medicare beneficiaries. For example, a person with disabilities who has fashioned his or her own "network" of providers in FFS may be reluctant to enroll in a plan that does not have contracts with all of the person's providers. The decision-making process can also be especially challenging for beneficiaries with mental or cognitive impairments.

Plan quality is also an important factor, and in the current MA system, differences in quality are reflected in higher payments to plans through the quality bonus program, which can translate into more generous benefits for enrollees. The extra benefits become a financial incentive to enroll in higher quality plans. Thus, from the point of view of a beneficiary choosing among plans, there are both financial and nonfinancial aspects to differences in quality among plans. In addition, all plans are expected to meet a minimum level of quality performance based on their star ratings; plans that do not can be terminated from the program. Having appropriate quality standards is especially important to ensure that the lowest bidding plans that are most attractive to low-income beneficiaries do not have lower bids because of lower quality.

Beneficiaries need certain tools or resources to be able to make informed decisions about their health care choices, but the tools that are now available are lacking

(continued next page)

their bids relative to FFS. But on average, taxpayers and beneficiaries continue to subsidize the MA program through higher taxes and higher Part B premiums. In its March 2016 report to the Congress, the Commission estimated that MA plans currently cost the Medicare program, on average, about 102 percent of FFS program costs. (Substantial variation exists in the relative costliness of MA and FFS across local markets. Payments to MA plans are also higher than that figure suggests because plans report more diagnoses for their enrollees, on average, compared with FFS enrollees.)

In this chapter, we continue to examine the challenges of using various premium designs to give beneficiaries an incentive to use the more efficient delivery system. We see this approach as one step toward synchronizing Medicare's payment rules across the three different systems. On the issue of beneficiary premiums, we have updated figures on the three examples that we outlined in our June 2015 report and provide additional information about markets where FFS or MA enrollees would face large premium increases. Given the potential magnitude of the increases in many areas, we also discuss ways that policymakers could mitigate their impact on beneficiaries.

Alternative methods of determining beneficiary premiums

Under the current system, beneficiaries choose between FFS and MA plans to receive Medicare benefits. The two systems can look very different in terms of premiums, benefit design, and choice of providers. The Commission maintains that the Medicare program should pay the same on behalf of beneficiaries, on average, regardless of which choice the beneficiaries make, to encourage beneficiaries to choose the system that they perceive as affording them

Other factors besides premiums that affect beneficiary choice (cont.)

in some respects. Currently, beneficiaries are able to compare MA plans using the Plan Finder tools at www.medicare.gov and can consult with State Health Insurance Assistance Programs (SHIPs). In an earlier report, the Commission examined ways in which the Plan Finder could be improved (Medicare Payment Advisory Commission 2015b), and, in connection with informing beneficiaries about low-income assistance programs, the Commission recommended that the Secretary increase SHIP funding for outreach to low-income Medicare beneficiaries (Medicare Payment Advisory Commission 2008).

In the illustrative examples discussed in this chapter, plan differences are expressed as premium differences that can be clearly communicated to beneficiaries. In the current MA environment, plans offer extra benefits when they have low bids in relation to current benchmarks. A premium support model could accommodate the offering of additional benefits in the interest of promoting innovation and offering greater choice to beneficiaries. Using the funds that, in our examples, are used to provide cash rebates to beneficiaries, plans could instead finance extra benefits. Plans could also offer extra benefits as riders that beneficiaries would purchase. If plans were allowed to offer extra benefits, then, to facilitate comparisons among plans, there could be standardized sets of benefit packages or there could be an actuarial standard whereby beneficiaries can more readily compare the value of the extra benefits in one plan versus another.

A difficult issue is how to compare quality between the FFS sector in an area and MA plans—a topic the Commission addressed in its March 2010 report to the Congress (Medicare Payment Advisory Commission 2010) and again in the June 2014 report to the Congress (Medicare Payment Advisory Commission 2014). Beneficiaries would have to be able to compare the quality of FFS with the quality of MA plans, but we are not yet at the point where such comparisons can be made. Once such comparisons can be made, a quality bonus program could be incorporated in a premium support model by giving beneficiaries a financial incentive to choose a higher quality plan in the form of reduced premiums for the higher quality plans. Such an approach allows the incentive to apply to either MA plans or FFS, depending on which option has higher quality. ■

the highest value in terms of cost and quality. The program should not subsidize one choice more than another.

To examine how different approaches to calculating beneficiary premiums could influence a beneficiary's choice between FFS and MA, we considered different ways to determine beneficiary premiums using FFS spending and MA plan bids for 2016.[1] In our analysis, we defined a market area, calculated each market's FFS spending, and recalculated each market's MA plan bids from service-area bids. For simplicity, all FFS spending and MA plan bids in our analysis were expressed as per beneficiary per month amounts and standardized for a beneficiary of average health status. Moreover, we excluded the quality bonus payments that MA plans can now receive. Quality is a complex issue and is only one of the factors that beneficiaries weigh when comparing FFS and MA (see text box on factors that affect beneficiary choice).

Definition of market areas

For our analysis, we wanted to define market areas that best matched insurance markets served by private plans. Using market areas that are too small can result in many areas with a small number of FFS beneficiaries, and there can be instances of adjacent areas with very different levels of FFS spending. However, if a market area is too large, the cost of serving beneficiaries can vary widely within the area. Accordingly, we adopted a definition of market areas that is larger than the county definition currently used in the MA program.[2]

- In urban areas, we use collections of counties located in the same state and the same core-based statistical area (CBSA), which is a collective term for both metropolitan areas (50,000 or more in population) and micropolitan areas (10,000 to 49,999 in population). Each area consists of one or more counties and includes the counties containing the core urban areas

TABLE 1–1 **Distribution of market areas by average monthly FFS spending per beneficiary, 2016**

Average monthly FFS spending per beneficiary	Number of market areas	Share of beneficiaries
$563–$600	6	0.5%
$600–$700	242	13.3
$700–$800	639	44.8
$800–$900	276	32.9
$900–$1,234	68	8.5
Overall average ($784)	1,231	100

Note: FFS (fee-for-service). FFS spending for 2016 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments. FFS spending is per beneficiary per month and standardized for a beneficiary of average health status. Market areas consist of core-based statistical areas and health service areas in the 50 states and the District of Columbia.

Source: MedPAC analysis of Medicare Advantage (MA) plan bids for 2016 and MA enrollment data for January 2016.

and any adjacent counties that have a high degree of social and economic integration with the urban core.

- Among counties outside CBSAs, we use health service areas (HSAs) as defined by the National Center for Health Statistics. HSAs consist of collections of counties where most of the short-term hospital care received by beneficiaries living in those counties occurs in hospitals in the same collection of counties.

The data used in our analysis included 1,231 market areas in the 50 states and the District of Columbia.

Average FFS spending per beneficiary in market areas

To calculate a beneficiary premium for FFS Medicare in a given market area, we determined the equivalent of an FFS "bid" based on the area's FFS spending. To calculate FFS spending that is comparable with MA plan bids for 2016, we used the projected average monthly FFS spending per beneficiary for 2016 and excluded hospice, direct graduate medical education, and indirect medical education payments.[3] We standardized the calculation for a beneficiary of average health status. We calculated market-area average spending by using county-level FFS spending and weighting those figures by the area's number of FFS beneficiaries as of January 2016.

Table 1-1 shows the distribution of market areas by average monthly FFS spending per beneficiary for 2016, ranging from $563 to $1,234. About 15 percent of beneficiaries lived in areas with FFS spending below $700 a month; about 45 percent in areas with spending between $700 and $800 a month; and about 40 percent of beneficiaries in areas with FFS spending above $800. Across the market areas in our analysis, the average monthly FFS spending was $784.

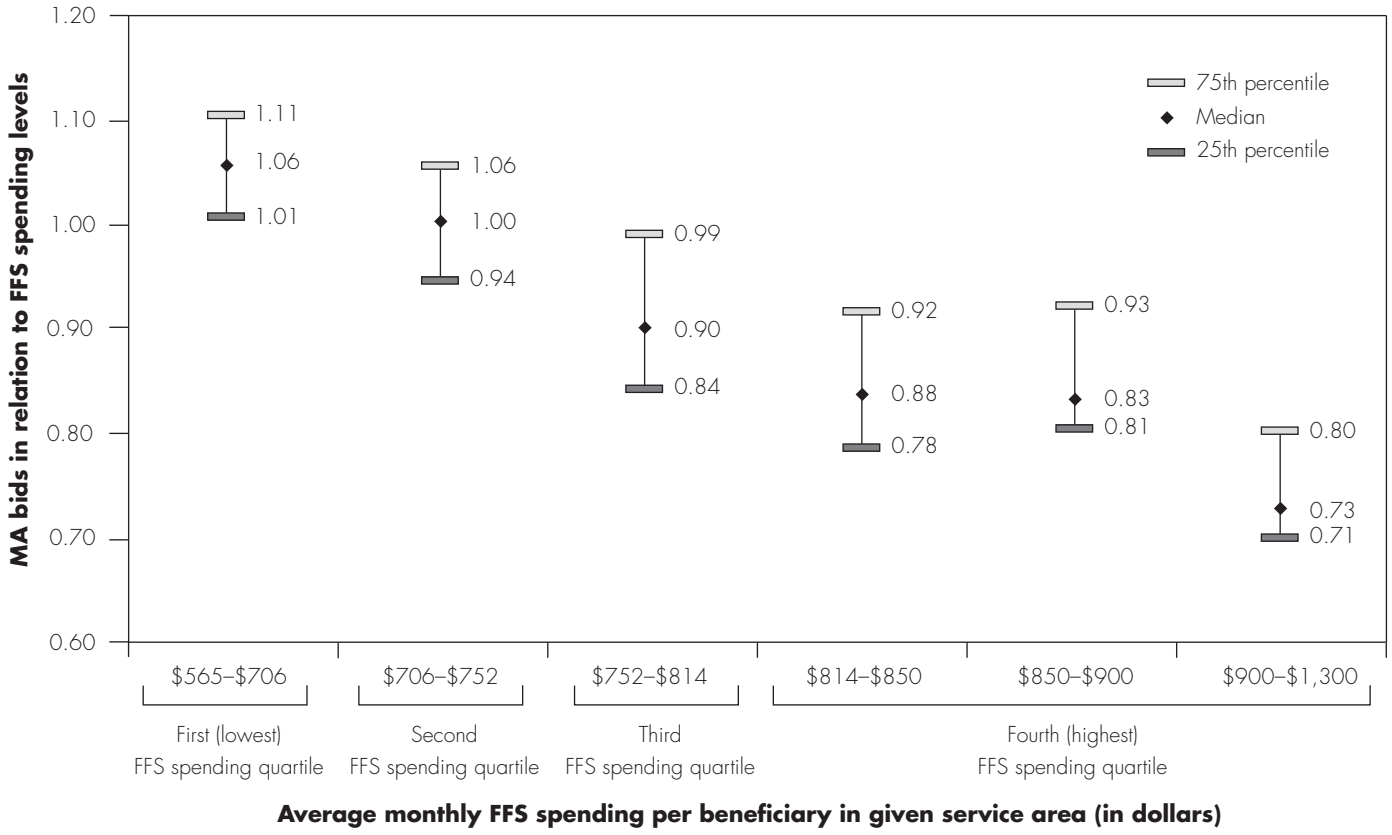
These spending figures are based on the cost-sharing structure of the current FFS benefit, which differs from MA in certain respects. For example, MA plans have an annual cap on beneficiary out-of-pocket spending while the FFS benefit does not. We used the existing FFS benefit design for this analysis, but the Commission has previously recommended making several changes to it, such as adding an annual cap on beneficiary out-of-pocket spending (Medicare Payment Advisory Commission 2012).

Adjustments to MA plan bids for market areas

Under current law, MA plans are required to cover all Medicare Part A and Part B benefits except hospice.[4] For each county, CMS sets the MA benchmark. This local MA benchmark represents a bidding target and is set using statutory formulas and adjusted for the plan's quality ranking. Under current law, MA benchmarks are increased relative to local FFS spending in low-spending areas and decreased in high-spending areas, so there is less variation in MA benchmarks than in FFS spending across areas. Furthermore, current MA plan

FIGURE 1–1

Medicare Advantage bids in relation to FFS spending levels, 2016



Note: FFS (fee-for-service), MA (Medicare Advantage). The figure excludes employer group plans, special needs plans, and plans in the territories.

Source: MedPAC analysis of MA bid and FFS expenditure data from CMS.

bids are highly correlated with MA benchmarks, and as a result, there is less variation in MA plan bids than in FFS spending across areas (see Figure 1-1, which shows how plan bids and FFS spending compare across the four spending quartiles that are currently used to calculate MA benchmarks).

Given the local MA benchmark, each MA plan selects counties that make up its service area and submits a bid for the service area.[5] The plan's bid reflects its costs to provide the Part A and Part B benefit package for a beneficiary of average health status and includes plan administrative cost and profit.[6] In our analysis, MA plan bids are monthly amounts for the Part A and Part B benefit portion only and are standardized for a beneficiary of average health status. Because the current MA plan bids are for plan-defined service areas, we made the following assumptions in our analysis to convert plan bids at the service-area level to plan bids at the market-area level:

- We assumed that plan bids were constant over the entire plan-defined service areas, where service areas can be larger or smaller than market areas.
- We assumed that if a plan was offered to at least half of the market area's Medicare beneficiaries, the plan would serve the entire market area with its current bid. If the plan was not offered to at least half of the area's beneficiaries, we assumed that the plan would not bid to serve that market area.
- We excluded bids for plans with little or no projected enrollment in the market area—which we defined as fewer than 100 projected enrollees—because those bids would not necessarily reflect costs for those areas.

TABLE 1–2 **Distribution of market areas by number of eligible MA plan bids in market area, 2016**

Number of eligible plan bids in market area	Number of market areas	Share of beneficiaries	Average FFS spending per beneficiary	Average MA penetration rate (in percent)
Zero*	208	2.4%	$799	8.2%
1 to 2	278	6.2	759	17.3
3 to 5	372	14.8	753	21.0
6 to 10	211	20.0	760	30.1
11 to 20	126	30.7	774	34.4
More than 20	36	26.0	834	42.0

Note: MA (Medicare Advantage), FFS (fee-for-service). FFS spending for 2016 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments. FFS spending and MA plan bids are per beneficiary per month and standardized for a beneficiary of average health status. Market areas consist of core-based statistical areas and health service areas in the 50 states and the District of Columbia. The numbers of Medicare beneficiaries and MA enrollees are as of January 2016.

*Market areas have no eligible plan bids if either (1) no MA plans are available in those areas or (2) we excluded all of the available MA plans based on the criteria we used for our analysis. The average penetration rate of 8.2 percent in these areas reflects enrollment in MA plans that we excluded from our analysis, such as employer group plans and special needs plans.

Source: MedPAC analysis of MA plan bids for 2016 and MA enrollment data for January 2016.

- We excluded plans that were not open to all of a service area's beneficiaries, such as employer group plans and special needs plans.

The number of MA plan bids that met those criteria varied across market areas in our analysis (Table 1-2). About 2 percent of beneficiaries lived in a market area without an eligible MA plan, and another 6 percent had only one or two MA plans available to them. However, more than 90 percent of beneficiaries had at least 3 MA plans available in their market areas, and more than 25 percent had more than 20 MA plans available.

Illustrative examples for calculating beneficiary premiums

Under current law, there is no premium for Part A for beneficiaries entitled to Medicare who receive Social Security or Railroad Retirement Board benefits or are entitled to Medicare because they have end-stage renal disease.[7] All beneficiaries who elect Part B pay a monthly base premium for that coverage, set at about 25 percent of Part B national average benefit costs per beneficiary; conversely, the government's subsidy equals 75 percent of the Part B costs. The base Part B premium is set nationally and does not vary across areas.[8]

Beneficiaries in the traditional FFS program pay the same Part B premium in any area of the country. In contrast, MA enrollees' premiums (Part B and MA plan premiums) vary, depending on how plan bids compare with the local MA benchmark. If plan bids are higher than the benchmark, then MA enrollees pay the Part B premium and the difference between the bid and the benchmark as an additional premium. If plan bids are lower than the benchmark, then beneficiaries pay the Part B premium and receive the difference between the bid and the benchmark in extra benefits and reduced premiums, including in a few cases a reduced Part B premium. (Most MA plans tend to offer extra benefits rather than premium reductions.)

Applying the current-law method for calculating the base Part B premium to our data—25 percent of Part B spending per beneficiary—results in a base premium of $106 per month. (That figure equals 0.25 × $424, where $424 equals the Part B share of average FFS spending of $784.) This amount represents about 13.5 percent of average combined Part A and Part B FFS spending per beneficiary—and an implied government subsidy rate of 86.5 percent of combined Part A and Part B spending.[9] Our calculated base premium of $106 per month is lower than the actual Part B premium for 2016 of $121.80 per month, but this difference is to be expected given the adjustments we made in calculating FFS spending in our data.[10]

We examined other ways to calculate beneficiary premiums. For illustrative purposes, we considered three

TABLE 1–3 **Three illustrative examples for calculating beneficiary premiums**

Illustrative example	Base premium	What base premium pays for
Example 1 Beneficiary pays *national* base premium for FFS in every market	13.5% of national FFS	FFS Medicare in every market
Example 2 Beneficiary pays *national* base premium for lower of local FFS or reference MA bid in each market	13.5% of national FFS	FFS Medicare or reference MA plan, whichever costs less
Example 3 Beneficiary pays *local* base premium for lower of local FFS or reference MA bid in each market	13.5% of either local FFS or reference MA bid, whichever costs less	FFS Medicare or reference MA plan, whichever costs less

Note: FFS (fee-for-service), MA (Medicare Advantage). In our three examples, we assume that the base premium is set to 13.5 percent of the Medicare Part A and Part B benefit cost, which represents 25 percent of the overall Part B share of the benefit cost. The government subsidy is then 86.5 percent of the benefit cost.

approaches that differed in the base premium charged and in the Medicare option that the beneficiary can buy for the base premium (Table 1-3). Under all three examples, beneficiaries may choose an option other than the one the base premium pays for. In that case, individual beneficiaries' total premium equals the base premium plus the difference between the option they choose and the option the base premium pays for. Two of the following designs have a base premium set as a share of national average FFS spending and one has a base premium set as a share of either local average FFS spending or the bid for the reference MA plan, whichever is lower:

- ***Example 1—***The base premium is set at 13.5 percent of the *national* average FFS spending. Beneficiaries would pay this amount for FFS Medicare in every market. Under this approach, the premium for beneficiaries choosing an MA plan in their market area equals the base premium plus the difference between the plan bid and their market area's average FFS spending.
- ***Example 2—***The base premium is set at 13.5 percent of the *national* average FFS spending. Beneficiaries would pay this amount for either FFS Medicare or the reference MA plan—whichever costs less—in each market. (We used the MA plan with the median bid as the reference plan, but that is a design choice.) Under this approach, if FFS spending is lower than the MA bid, the base premium pays for FFS Medicare. But if FFS is higher than MA, the base premium pays for MA, meaning that the Medicare option the base premium pays for would vary across market areas, depending on how FFS spending compares with MA.
- ***Example 3—***The base premium is set at 13.5 percent of either the *local* average FFS spending or the bid for the reference MA plan—whichever costs less. Beneficiaries would pay this amount for the less expensive option in each market.[11] (As above, we used the MA plan with the median bid as the reference plan.) Under this approach, in markets where either the local FFS spending or the bid for the reference MA plan is lower than the national average FFS spending, the base premium would be lower than the nationally set base premium. In markets where both local FFS spending and the bid for the reference MA plan are higher than the national average FFS spending, the opposite would be true, and the base premium would be higher than the nationally set base premium.

These examples differ from current law in several respects. MA plans now bid against benchmarks that are not set competitively but instead are set administratively through statutory provisions specifying benchmark levels. Plans that bid below the benchmark receive a portion of the difference as a rebate that they can use to provide extra benefits. Under these examples, the administratively set benchmarks would be eliminated, and the competition between FFS spending and MA plan bids would determine the reference point for the federal contribution and beneficiary premium. The current system of rebates and

An alternative approach: Greater use of competitive pricing within the MA program

One of the objectives of a premium support model is to achieve savings for the Medicare program. Premium support achieves savings by promoting competition—between the fee-for-service (FFS) sector and Medicare Advantage (MA) plans, and among MA plans—and by using incentives that are aligned across beneficiaries, providers, and plans to promote efficiency. Under our three illustrative examples, beneficiary incentives are clearly expressed as differential premiums that beneficiaries face based on the choices they make. The differential premiums reflect the differences in program costs among the available choices. As one of the choices under this approach, FFS is essentially a bidding plan that competes with MA plans.

Some proposals that seek to achieve savings for the Medicare program aim to do so through greater competition that is limited to the MA sector. The proposals rely on the concept that a system in which benchmarks are determined through plan competition, rather than set administratively, achieves more appropriate prices in MA and can better generate program savings. Such a proposal was put forth by the Bipartisan Policy Center (BPC) in 2013 (Bipartisan Policy Center 2013), and a similar approach appeared in President Obama's 2017 budget proposal. Both proposals would use competition among MA plans to determine an area benchmark for MA plans (set at the average bid or at a specific percentile level) and would use that benchmark as the basis for MA payment in areas where program savings are achieved relative to current law. Each proposal (initially, in the case of the BPC) calls for plans to bid on a package that is an enhancement of the Medicare basic Part A and Part B package, in recognition of the current level of extra benefits available through MA plans. In the BPC proposal, the additional benefits are a standardized set of benefits; in the President's budget proposal, the actuarial value of the additional benefits would be 5 percent of the area benchmark—which is standardized in the sense that it facilitates plan comparisons when beneficiaries are evaluating the value of one plan compared with another.

In both proposals, the government contribution toward the plan costs would be at the competitively set benchmark level. Plans that bid below the benchmark would provide, as they currently do, extra benefits to beneficiaries (in the President's proposal, equal to the full difference between the bid and benchmark), or (in the BPC proposal) plans would return the full difference to beneficiaries in the form of a cash rebate. In both proposals, if savings are not expected in a given area under the new benchmark approach, the area benchmark would continue to be the administratively set benchmark as determined under current law—which is one aspect of the proposals that is intended to ensure savings if the alternative benchmark is used. In either proposal, the alternative, competitively set benchmark would be lower than current benchmarks.

Currently, 96 percent of nonemployer, non–special needs plans are bidding at a level below the statutory benchmark. As illustrated in Table 1-4, p. 14, there can be a wide range of bids in a market. With a benchmark set at the weighted average of MA bids, or at a set

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extra benefits would also be eliminated, and plans (or FFS, in the second and third examples) that cost less than the benchmark would instead use any savings to reduce beneficiaries' premiums.[12] These examples would thus move Medicare from a model in which MA plans compete (with FFS and with each other) largely by offering extra benefits to a model in which MA plans and FFS compete more on price, as reflected in the beneficiary premium.

In addition, these examples all include FFS costs as one of the options that determine beneficiary premiums. In that sense, expected FFS costs serve as a "bid" analogous to those submitted by MA plans. We include both FFS and MA plans in the calculation of premiums to promote equity so that the relative costs of all forms of Medicare coverage are taken into account. Furthermore, the presence of the FFS program in these examples, particularly the second and third examples, could serve as a reference

An alternative approach: Greater use of competitive pricing within the MA program (cont.)

percentile of bids, some MA bids would be below the newly determined benchmark and others would be above it. Thus, by design, in any market in which the alternative benchmark is used, we would expect to see program savings under static assumptions of current bid and MA enrollment levels. However, the large majority of current MA enrollees are in plans that do not charge an additional premium beyond the Part B premium, and many enrollees are in plans with generous extra benefits. Thus, in an environment where some plans will be charging a plan premium, we would expect movement of beneficiaries among MA plans and shifts between MA and FFS.

These proposals would not affect FFS costs or premiums, unlike the illustrative examples presented in this chapter, and they also depart from the principle of financial neutrality between FFS and MA that the Commission has supported. However, this system would reduce payments to plans in areas where the benchmarking option based on MA bids applied (because it would be expected to create savings compared with the current benchmarking approach) and could result in lower supplemental benefits for MA enrollees—for example, in areas such as Miami where current extra benefits have a much higher value than the level of extra benefits contemplated in either proposal. In some markets, the value of the extra benefits in the benchmarking option based on MA bids could be close to, or even be greater than, the current level of extra benefits offered in MA. Because the benchmarking option based on MA bids is most likely to take effect in areas that are already paying plans less than FFS Medicare, it could lead to some loss of MA enrollment in the very places where the MA program is producing savings for Medicare. In the Miami market, for example, average per capita spending is $1,102 in 2016, while the median MA bid is $744. Under the existing MA payment system, a plan that submits a bid of $800 would receive a rebate that it could use to offer extra benefits; under an alternate payment system where the MA benchmark is based on the median bid, that plan would now have to charge an additional premium. As a result, some plans could be less desirable for beneficiaries than FFS Medicare since there would be no extra cost associated with choosing the FFS option.

In short, the benchmarking system based on MA bids would save program spending in some markets, given that we assume no changes in bidding and enrollment patterns. It would reduce spending by reducing payments to plans and reducing payments to fund supplemental benefits for MA enrollees. In Miami, for example, plans would look less attractive than they do now, and some plan members might disenroll to enter FFS Medicare, which is far more costly in terms of program expenditures. Therefore, in the long run, savings from benchmarking based on MA bids are not assured. Given this possibility, one strategy to prevent migration from MA to FFS would be to impose an additional premium in FFS in the markets where MA is less costly and the benchmarking system based on MA bids takes effect. Even though FFS would not be treated as a bidding plan in these markets, as in the illustrative examples discussed in this chapter, a policy decision is whether there should be an additional charge for beneficiaries choosing FFS in these markets to make FFS a relatively less attractive option. ■

point in negotiations between plans and providers and help to keep payment rates close to FFS levels. However, the inclusion of FFS is a design choice. Some proposals would expand the use of competitive pricing, but only within the MA program (see text box on an alternative approach).

To illustrate what premiums would look like in dollar terms under these examples, we applied them to three market areas—Portland, OR; Columbus, OH; and Miami, FL. As shown in Table 1-4 (p. 14), the three areas have different levels of per beneficiary FFS spending, ranging from Portland's $652 to Miami's $1,102; Columbus's $744 is about 5 percent below the national average of $784. Each area has many MA plans and high MA penetration (i.e., at least 42 percent of Medicare beneficiaries in each area are in MA plans). In all three examples, we used the median MA plan bid as the reference MA plan bid, which is also a design choice. (For example, the reference

TABLE 1–4 **Per beneficiary FFS spending and plan bids in selected market areas, 2016**

	Market area		
	Portland, OR	**Columbus, OH**	**Miami, FL**
Number of Medicare beneficiaries (in thousands)	292	294	429
Average monthly FFS spending	**$652**	**$744**	**$1,102**
Number of MA plan bids	23	26	25
MA penetration rate	58%	42%	64%
Range of MA plan bids			
Lowest bid	$571	$605	$630
25th percentile bid	701	699	671
Median bid	**712**	**704**	**744**
75th percentile bid	744	786	780
Highest bid	819	926	922
Number of counties in area	5	10	1

Note: FFS (fee-for-service), MA (Medicare Advantage). FFS spending for 2016 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments. FFS spending and MA plan bids are per beneficiary per month and standardized for a beneficiary of average health status. Market areas consist of core-based statistical areas and health service areas in the 50 states and the District of Columbia. The numbers of Medicare beneficiaries and MA enrollees are as of January 2016.

Source: MedPAC analysis of MA plan bids for 2016 and MA enrollment data for January 2016.

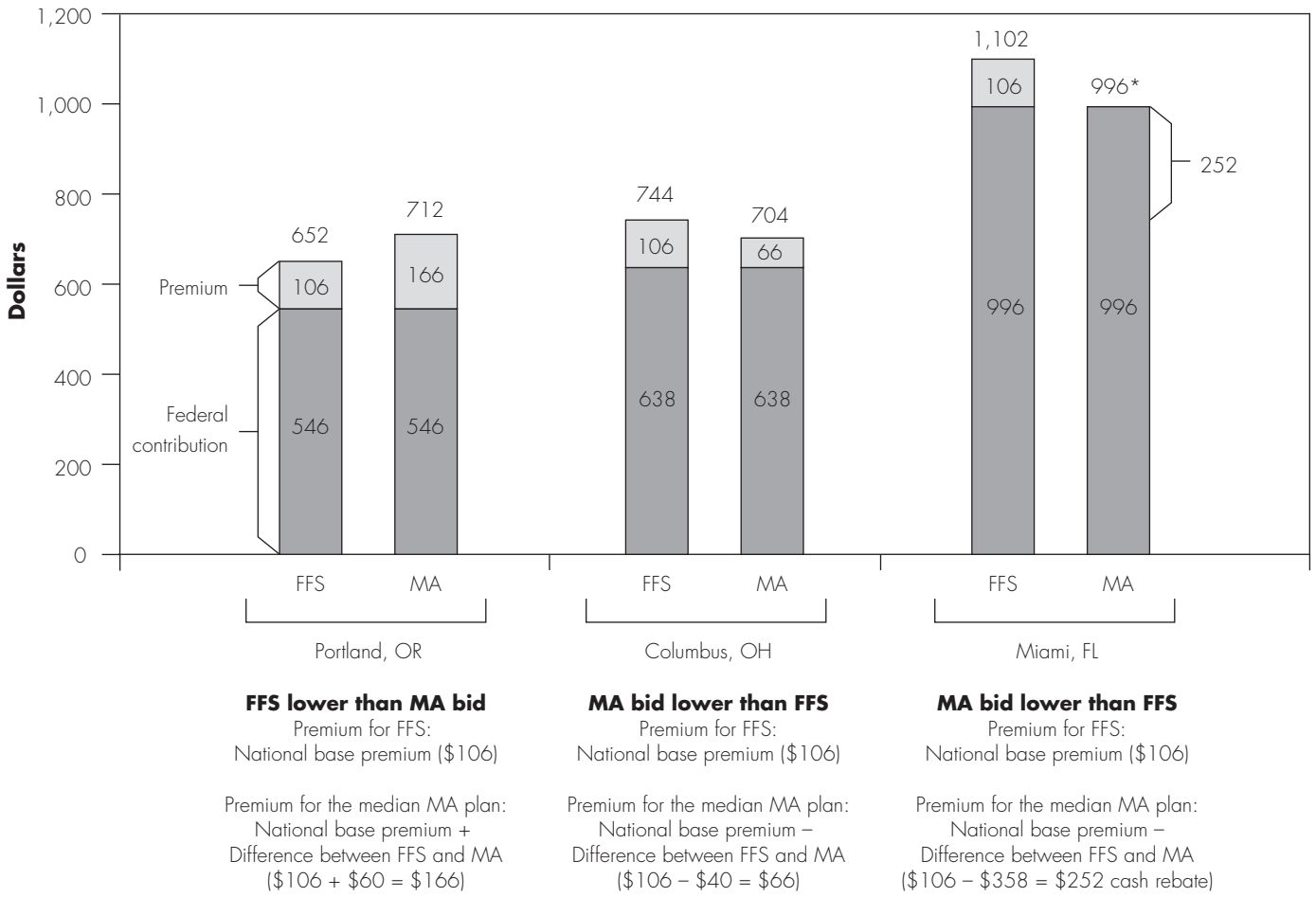
bid could be the lowest bid, the second lowest bid, a weighted average bid, etc.) The median plan bid in these three markets varies less than the FFS spending in those markets, in part because the current-law MA benchmarks in 2016 for those markets also vary less than the average FFS spending.

Using the data from these three markets, Figure 1-2 illustrates the first example for calculating beneficiary premiums. The base premium in all three market areas is $106, or 13.5 percent of the national average FFS spending ($784). In Portland, the reference MA bid is higher than local average FFS spending, and the difference between MA and FFS spending equals $60 ($712 minus $652). Therefore, if the beneficiary chooses MA, the premium for the median plan equals the base premium ($106) plus the difference ($60), or $166. (Premiums for MA plans whose bids are lower than $712 would be less than $166; premiums for MA plans whose bids are higher than $712 would be more than $166.) In contrast, in Columbus and Miami, the median MA plan bid is lower than local average FFS spending by $40 and $358, respectively. Therefore, the premium in Columbus for the median MA plan, which equals the base premium plus the difference, is $66 ($106 minus $40) and in Miami is –$252 ($106 minus $358). For simplicity, a negative premium can be thought of as a reduction of the entire premium plus a cash payment. In this example, we assumed that the beneficiary receives the entire difference between FFS and MA. However, how to share this difference between the beneficiary and the program is a policy decision. For example, under current rules, if MA plans bid below the benchmark, the program retains a share of the difference and the balance is commonly returned to the beneficiary in the form of extra benefits.

In the second example, the base premium of $106 no longer pays for FFS Medicare in every market (Figure 1-3, p. 16). Instead, it pays for either FFS or MA—whichever costs less—in each market. Therefore, in Portland, where FFS is lower than MA, the base premium pays for FFS, whereas in Columbus and Miami, where MA is lower than FFS, the base premium pays for MA. The difference between FFS and MA is added to the beneficiary premium of the higher cost option in each market. In other words, while the beneficiary pays the base premium of $106 for FFS in Portland and for MA in Columbus and Miami,

FIGURE 1–2

Example 1: Illustration of beneficiary paying nationally set base premium for FFS in every market



Note: FFS (fee-for-service), MA (Medicare Advantage). FFS spending for 2016 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments. FFS spending and MA plan bids are per beneficiary per month and standardized for a beneficiary of average health status. Market areas consist of core-based statistical areas and health service areas in the 50 states and the District of Columbia. The numbers of Medicare beneficiaries and MA enrollees are as of January 2016. MA figures are for the plan with the median bid.
*In Miami, the MA plan would receive $744 and the beneficiary would receive a cash rebate of $252.

Source: MedPAC analysis of MA plan bids for 2016 and MA enrollment data for January 2016.

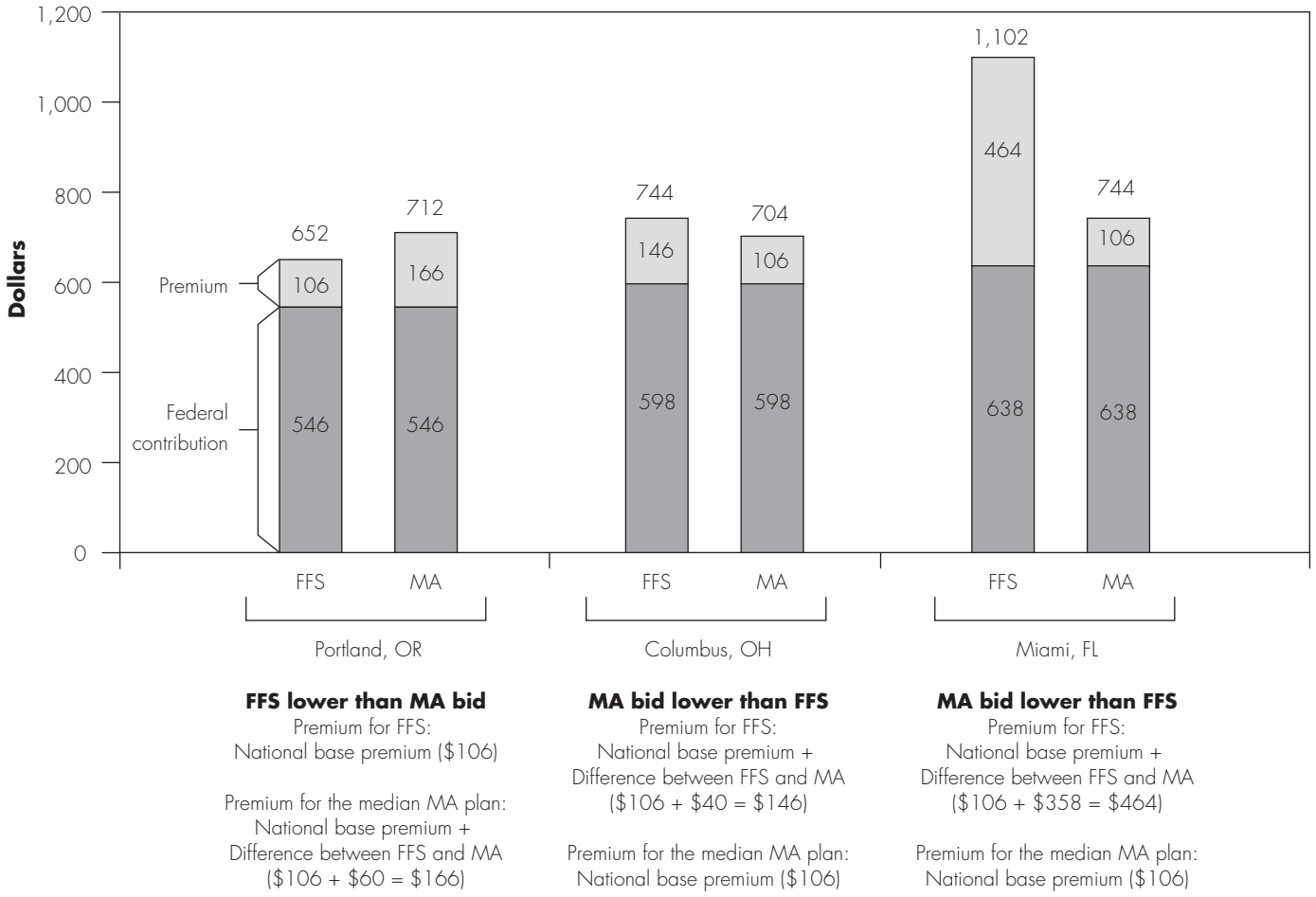
beneficiaries pay a higher premium if they choose MA in Portland and FFS in Columbus and Miami.

Finally, under the third example, the base premium is set to 13.5 percent of either local FFS spending or the bid for the reference MA plan, whichever is lower: $88 in Portland, $95 in Columbus, and $100 in Miami (Figure 1-4, p. 17). These changes in the base premium, compared with those under the second example, reflect the beneficiary sharing in the geographic variation in the cost of the less expensive option across market areas. As in the second example, the base premium pays for either FFS or MA—whichever costs less—in each area. In other words, beneficiaries pay the base premium for FFS in Portland and for MA in Columbus and Miami, but they pay a higher premium if they choose MA in Portland or FFS in Columbus and Miami.

The first and second examples for calculating beneficiary premiums highlight how the difference in the average monthly cost of the Medicare benefit under FFS and MA within each market area can be shared between the program and the beneficiary. Differences in the median MA bid relative to FFS in each market are summarized in

FIGURE 1–3

Example 2: Illustration of beneficiary paying nationally set base premium for either FFS or MA, whichever costs less, in each market



Note: FFS (fee-for-service), MA (Medicare Advantage). FFS spending for 2016 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments. FFS spending and MA plan bids are per beneficiary per month and standardized for a beneficiary of average health status. Market areas consist of core-based statistical areas and health service areas in the 50 states and the District of Columbia. The numbers of Medicare beneficiaries and MA enrollees are as of January 2016. MA figures are for the plan with the median bid.

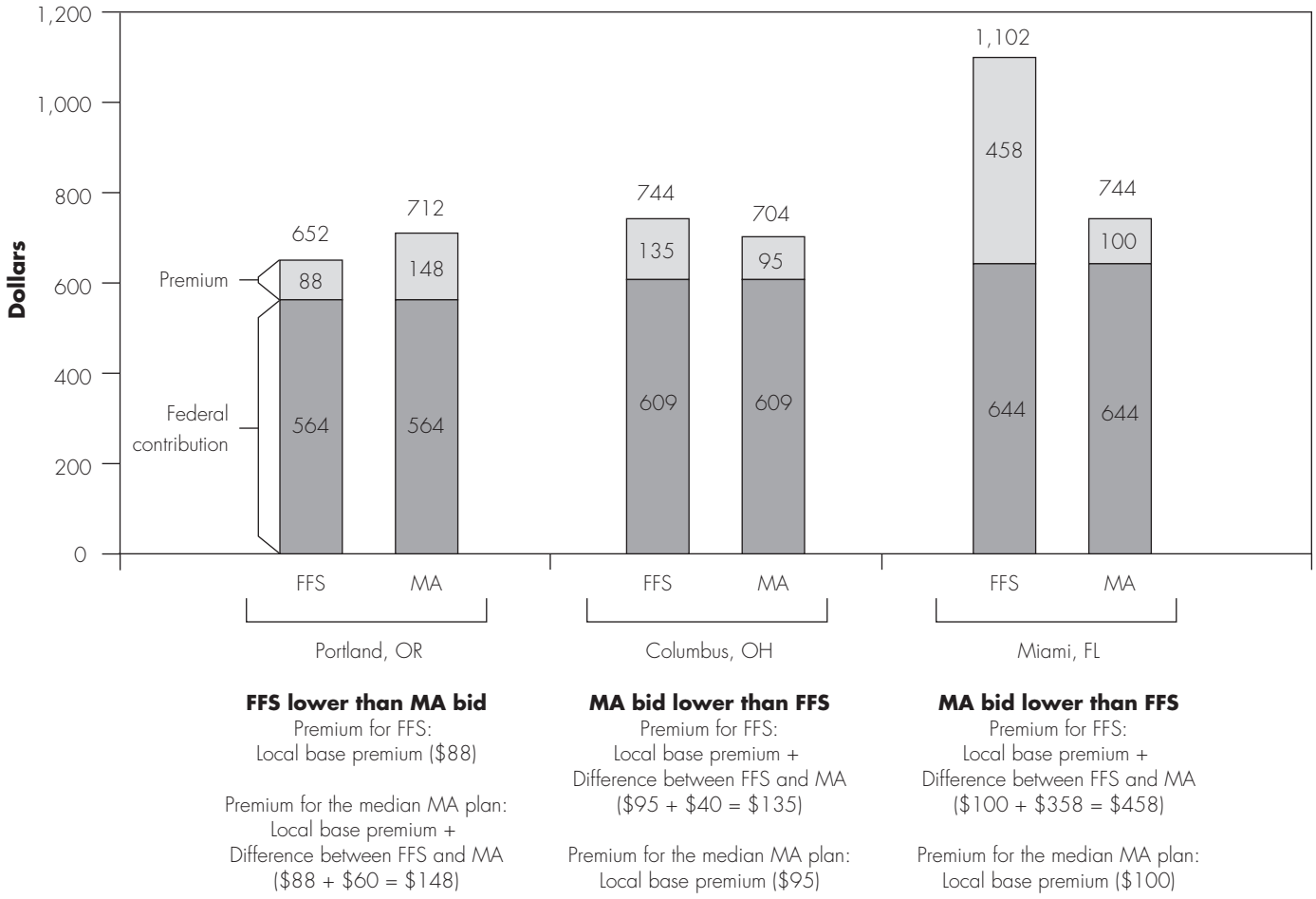
Source: MedPAC analysis of MA plan bids for 2016 and MA enrollment data for January 2016.

Table 1-5 (p. 18): $60 in Portland; –$40 in Columbus; and –$358 in Miami. Under the first example, the beneficiary who chooses MA pays the entire difference if MA costs more than FFS, and gets the entire difference if MA costs less than FFS. In contrast, in the second and third examples, the beneficiary who chooses the higher cost option pays the entire difference regardless of which option—either FFS or MA—is higher cost.

In all three illustrative examples, the difference between the average FFS spending and the median MA bid is a key variable in calculating beneficiary premiums. Especially in the second and third examples, this difference is the additional premium that beneficiaries would pay if they were to choose the higher cost option between FFS and the reference MA plan. Figure 1-5 (p. 19) summarizes the distribution of the differences between FFS and MA for all market areas. About 45 percent of beneficiaries are in market areas where the difference is less than $50. About 3 percent of beneficiaries are in market areas where the median MA bid is higher than FFS spending by $100 or more. In contrast, about 31 percent of beneficiaries are in market areas where FFS spending is higher than the median MA bid by $100 or more. Figure 1-5 also shows

FIGURE 1–4

Example 3: Illustration of beneficiary paying locally set base premium for either FFS or MA, whichever costs less, in each market



Note: FFS (fee-for-service), MA (Medicare Advantage). FFS spending for 2016 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments. FFS spending and MA plan bids are per beneficiary per month and standardized for a beneficiary of average health status. Market areas consist of core-based statistical areas and health service areas in the 50 states and the District of Columbia. The numbers of Medicare beneficiaries and MA enrollees are as of January 2016. MA figures are for the plan with the median bid.

Source: MedPAC analysis of MA plan bids for 2016 and MA enrollment data for January 2016.

that, even among market areas where FFS is higher by a large amount, Miami remains an outlier, with a difference of $358. In all other markets, the difference between FFS and MA is less than $300.

Markets that would see large changes in premiums

In addition to the overall distribution shown above, we highlight some of the market areas where the difference between FFS spending and the median MA bid is $100 or more in either direction, under our static assumptions about plan bidding and beneficiary behavior. These areas are ones where enrollees in the MA plan with the median bid would have to pay a significantly higher premium to remain in their plan, or FFS enrollees would have to pay a significantly higher premium to remain in FFS.

There are 51 market areas where the median MA bid is higher than FFS spending by $100 or more. About 1.3 million beneficiaries (3 percent of all Medicare beneficiaries) live in these areas, and about 450,000 of them are in MA plans. These areas generally have relatively few beneficiaries, low FFS spending, and MA benchmarks that typically equal 115 percent of FFS

TABLE 1–5 **Summary of illustrative examples for calculating beneficiary premiums**

	Market area		
	Portland, OR	**Columbus, OH**	**Miami, FL**
Median MA plan bid	$712	$704	$744
Average monthly FFS spending	652	744	1,102
Difference between MA and FFS	60	–40	–358
Example 1: Beneficiary pays nationally set base premium for FFS Medicare in every market			
FFS premium	106	106	106
MA premium for median plan	166	66	–252
Federal contribution	546	638	996
Example 2: Beneficiary pays nationally set base premium for either FFS Medicare or reference MA plan, whichever costs less, in each market			
FFS premium	106	146	464
MA premium for median plan	166	106	106
Federal contribution	546	598	638
Example 3: Beneficiary pays locally set base premium for either FFS Medicare or reference MA plan, whichever costs less, in each market			
FFS premium	88	135	458
MA premium for median plan	148	95	100
Federal contribution	564	609	644

Note: MA (Medicare Advantage), FFS (fee-for-service). FFS spending for 2016 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments. FFS spending and MA plan bids are per beneficiary per month and standardized for a beneficiary of average health status. Market areas consist of core-based statistical areas and health service areas in the 50 states and the District of Columbia. The numbers of Medicare beneficiaries and MA enrollees are as of January 2016. In our examples, we use the median MA plan bid as the reference MA plan bid. "Difference" is between the median MA plan bid and average FFS spending. For simplicity, a negative premium can be thought of as a reduction of the entire premium plus a cash payment. These figures are based on current MA bids; with different bidding and enrollment patterns, the differences between the examples may be greater than portrayed here.

Source: MedPAC analysis of MA plan bids for 2016 and MA enrollment data for January 2016.

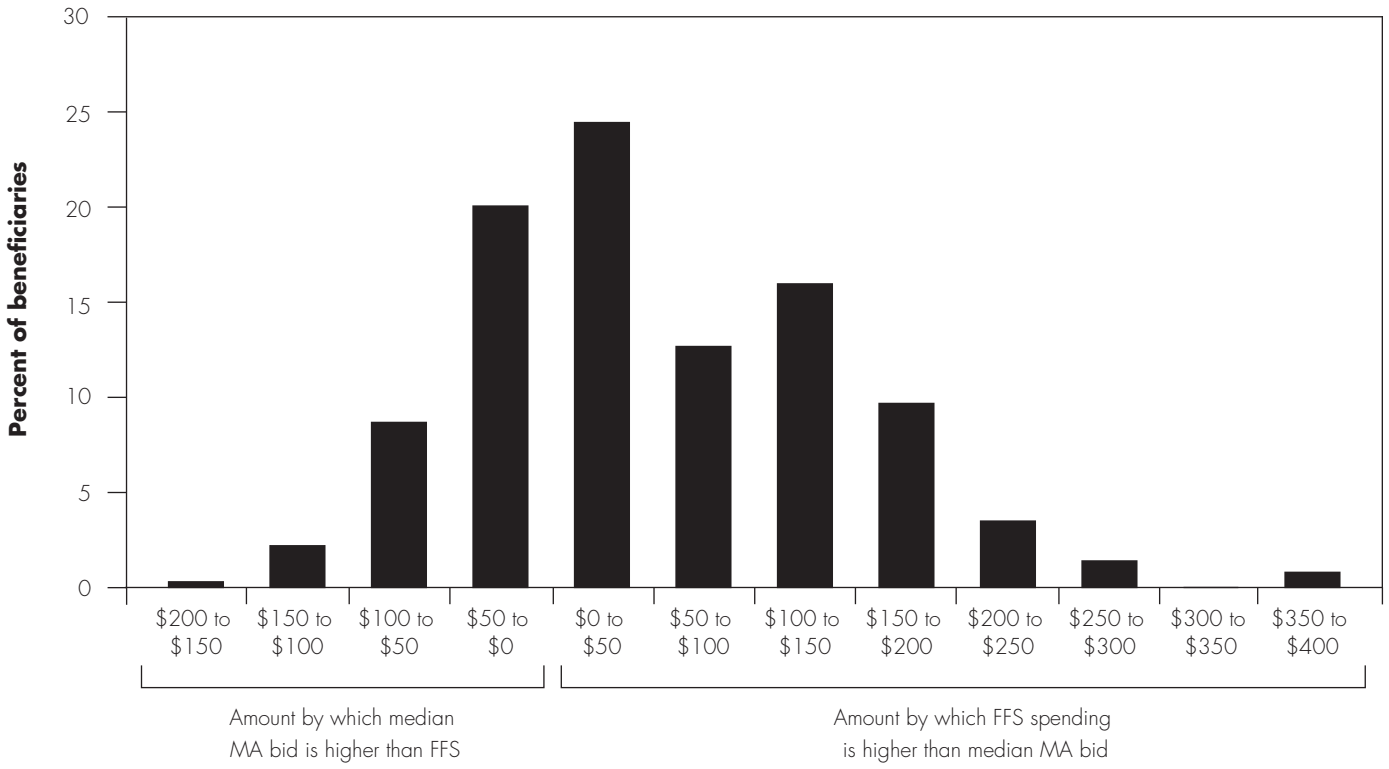
spending under the current MA payment system. Table 1-6 (p. 20) shows the 10 largest areas in this group, based on MA enrollment, which together account for about 75 percent of the group's MA enrollees. The group's largest single market area is Rochester, NY, which has about 130,000 MA enrollees and accounts for almost 30 percent of the total for the group. Only Rochester and Honolulu have more than 50,000 MA enrollees.

Table 1-6 (p. 20) also shows the estimated monthly premium that FFS enrollees and enrollees in the MA plan with the median bid would pay in 2016 under the third example. Since local FFS spending in these market areas is lower than the national average, basing premiums on local FFS costs instead of national FFS costs would reduce premiums for all beneficiaries living in these areas. For 2016, we estimate that basing premiums on local FFS costs would reduce monthly premiums in these market areas by $6 to $30, and would thus partly offset the higher premiums that MA enrollees in those market areas would face.

At the other end of the distribution, there are 123 market areas where FFS spending is higher than the median MA bid by $100 or more. About 16.7 million beneficiaries (31 percent of all Medicare beneficiaries) live in these market areas, and about 10.8 million are in FFS. These markets are generally larger, with relatively high FFS spending, numerous MA plans available, and MA benchmarks that typically equal 95 or 100 percent of FFS spending under the current MA payment system. Table 1-7 (p. 21) shows the 10 largest market areas in this group, based on FFS

FIGURE 1–5

Distribution of beneficiaries based on the difference between average FFS spending and the median MA plan bid, 2016



Note: FFS (fee-for-service), MA (Medicare Advantage). FFS spending for 2016 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments. FFS spending and MA plan bids are per beneficiary per month and standardized for a beneficiary of average health status. Market areas consist of core-based statistical areas and health service areas in the 50 states and the District of Columbia. The number of Medicare beneficiaries is as of January 2016. Out of 1,231 market areas in our dataset, 208 market areas have no eligible plan bids, either because no MA plans are available in those areas or because we excluded all of the available MA plans for our analysis. The market areas with no eligible plan bids have about 1.3 million beneficiaries, or 2 percent of the overall total.

Source: MedPAC analysis of MA plan bids for 2016 and MA enrollment data for January 2016.

enrollment, which together account for about 50 percent of the group's FFS enrollees and include many of the nation's largest metropolitan areas. The 10 largest market areas each have at least 300,000 FFS enrollees.

Table 1-7 (p. 21) also shows the estimated monthly premium that FFS enrollees and enrollees in the MA plan with the median bid would pay in 2016 under the third example. Since the bid for the median MA plan in these market areas is usually lower than national average FFS spending, basing premiums on the lower of local FFS costs or the bid for the median MA plan would typically lower premiums for the MA enrollees in these areas by roughly $5 to $20. This reduction would also partly offset the higher premiums that FFS enrollees in those market areas would face relative to current law.

Options for mitigating or delaying the impact on beneficiaries

Given the size of the increase in premiums that many beneficiaries would face under the examples presented earlier, policymakers may also want to consider measures that would mitigate the impact on beneficiaries. Broadly speaking, policymakers would need to decide how much of the increase in premiums beneficiaries should ultimately face, and how quickly premiums should reach that ultimate level. Policymakers would also need to consider how changes in the calculation of beneficiary premiums would affect low-income Medicare beneficiaries and state Medicaid programs.

As a first question, policymakers would need to decide whether beneficiaries should ultimately face the full

TABLE 1–6

Ten largest market areas (based on MA enrollment) where the median MA plan bid exceeds average FFS spending by $100 or more, 2016

	Medicare beneficiaries (in thousands)			Monthly premium under Example 3		Change from current premium under Example 3	
Market area	**Total**	**FFS**	**MA**	**FFS**	**MA**	**FFS**	**MA**
Rochester, NY	214	82	132	$79	$214	–$27	$61
Honolulu, HI	168	87	81	81	185	–25	65
Lancaster, PA	101	63	37	90	210	–16	84
Erie, PA	55	30	25	90	191	–16	84
Hawaii-Kauai, HI	52	33	19	84	266	–22	72
Lebanon, PA	29	18	11	90	210	–16	84
Braxton-Doddridge-Gilmer-Harrison-Lewis-Upshur, WV	32	22	9	85	224	–21	73
Gratiot-Ionia-Mecosta, MI	27	19	9	100	205	–6	41
Schuyler-Steuben, NY	26	17	8	82	195	–24	68
La Crosse, WI	21	13	8	76	252	–30	55

Note: MA (Medicare Advantage), FFS (fee-for-service). FFS spending for 2016 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments. FFS spending and MA plan bids are per beneficiary per month and standardized for a beneficiary of average health status. Market areas consist of core-based statistical areas and health service areas in the 50 states and the District of Columbia. The numbers of Medicare beneficiaries, FFS enrollees, and MA enrollees are as of January 2016. MA premium figures are for beneficiaries enrolled in the plan with the median bid in each market area; beneficiaries enrolled in other MA plans in those market areas would pay different amounts. The figures for the change from the current premium under Example 3 account for supplemental MA premiums that beneficiaries now pay under current law.

Source: MedPAC analysis of MA plan bids for 2016 and MA enrollment data for January 2016.

increase in premiums that would result from the three illustrative examples discussed earlier in this chapter or only part of the increase. All three examples are designed to encourage beneficiaries to choose the most efficient option in their area for receiving Medicare benefits. Policymakers could decide that a smaller differential in premiums would still be sufficient to encourage beneficiaries to use the most efficient option and could therefore limit the allowable difference between the FFS premium and the premium for the reference MA plan to a specific dollar or percentage amount. Another option would be to grandfather existing Medicare beneficiaries and use the new method of calculating premiums only for future Medicare beneficiaries, although this option could be challenging for CMS to administer.

The new method of calculating premiums could also be implemented over several years to minimize disruptions for beneficiaries and give them time to adjust to the new system. During the transition period, premiums could be a weighted average of the amount calculated under the current method and the amount calculated under the new method, with the weight for the new method rising over time. In addition, policymakers could limit the annual increase in premiums that beneficiaries would face during the transition period to a specific dollar or percentage amount. Under this approach, the transition period would be longer for beneficiaries who live in market areas where premiums would change significantly under the new method.

Policymakers would also need to decide how a new method for calculating premiums would treat low-income Medicare beneficiaries and the states. The distribution for dual-eligible beneficiaries based on the difference between average FFS spending and the median MA bid is similar to the overall distribution shown in Figure 1-5 (p. 19), although our analysis suggests that dual eligibles are somewhat more likely to live in market areas where FFS spending exceeds the median MA bid by $50 to $200. Medicaid currently pays the Part B premium for about 15 percent of Medicare beneficiaries through the Medicare Savings Programs (MSPs), which provide assistance to beneficiaries with income below 135 percent of the federal poverty level. The second and third examples outlined above would require

TABLE 1–7

Ten largest market areas (based on FFS enrollment) where average FFS spending exceeds the median MA plan bid by $100 or more, 2016

	Medicare beneficiaries (in thousands)			Monthly premium under Example 3		Change from current premium under Example 3	
Market area	**Total**	**FFS**	**MA**	**FFS**	**MA**	**FFS**	**MA**
Chicago, IL	1,177	934	243	$244	$97	$138	–$9
New York, NY	1,493	923	570	243	95	137	–11
Los Angeles, CA	1,372	720	652	294	99	188	–7
Northeastern New Jersey	700	581	119	239	98	133	–8
Houston, TX	743	453	289	377	89	271	–17
Nassau-Suffolk, NY	518	424	94	253	98	147	–8
Baltimore, MD	454	410	43	249	112	143	6
Phoenix, AZ	672	392	280	248	89	142	–17
Dallas, TX	535	369	166	282	98	176	–8
Tampa-St. Petersburg, FL	602	307	295	301	85	195	–21

Note: FFS (fee-for-service), MA (Medicare Advantage). FFS spending for 2016 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments. FFS spending and MA plan bids are per beneficiary per month and standardized for a beneficiary of average health status. Market areas consist of core-based statistical areas and health service areas in the 50 states and the District of Columbia. The numbers of Medicare beneficiaries, FFS enrollees, and MA enrollees are as of January 2016. MA premium figures are for beneficiaries enrolled in the plan with the median bid in each market area; beneficiaries enrolled in other MA plans would pay different amounts.

Source: MedPAC analysis of Medicare Advantage plan bids for 2016 and MA enrollment data for January 2016.

beneficiaries to pay higher premiums for the more expensive system for receiving Medicare benefits, which would increase MSP spending and effectively shift responsibility for some Medicare spending to the Medicaid program, or require beneficiaries to pay the difference to enroll in FFS or higher cost MA plans, depending on the area.

Policymakers could limit the impact on states by exempting MSP enrollees from the higher premiums or by placing a limit on the amount that MSPs are required to cover. For example, the Part D low-income subsidy provides assistance with Part D premiums, but covers the full amount for only a subset of lower premium plans. Policymakers could use a similar approach for the MSPs. Alternatively, policymakers could also expand eligibility for the MSPs if they decided that the higher premiums would pose a hardship for beneficiaries who currently do not have incomes low enough to qualify for the MSPs. Policymakers could also limit the impact on states by federalizing some or all of the MSPs (a topic discussed in Chapter 9 of this report).

In addition, certain other categories of beneficiaries may warrant special treatment. Within the FFS population, beneficiaries who have supplemental coverage (medigap or employer-sponsored supplemental coverage) use more services than beneficiaries who do not, which increases average FFS expenditures. This higher utilization is not due to greater health needs. In its June 2012 report to the Congress, the Commission recommended that an additional charge be imposed on supplemental insurance in recognition of the "additional costs to the program that are not fully reflected in their supplemental premiums" (Medicare Payment Advisory Commission 2012). If beneficiaries would be expected to pay a higher premium for FFS in a market area, a distinction could be made between those beneficiaries with supplemental coverage and those without it. The former would face a higher cost in choosing FFS (that is, the amount added to their FFS premiums would be higher than for people with no supplemental coverage).

In the same way that providers can get payment bonuses by participating in alternative payment models (APMs) in FFS such as ACOs, beneficiaries could also be allowed to benefit from involvement in APMs in a premium support model. In this case, the amount added to the FFS premium would be lower for such beneficiaries, although the reduction could be small in some market areas. (In

administering such a policy, there would be issues of how to identify such individuals, what the minimum level of APM involvement would be, etc.)

As part of the transition, policymakers would also need to ensure that beneficiaries understand the tradeoffs of enrolling in FFS or a particular MA plan under the new system. Premiums are an important factor in making that decision, but there are also several other important elements to consider (see the earlier text box (pp. 6–7) on factors that affect beneficiary choice and the limitations discussed below). Policymakers could help inform beneficiaries by providing additional funding to State Health Insurance Assistance Programs and improving the decision-making tools available to beneficiaries.

Finally, the options outlined above are not mutually exclusive. Many of them could be combined.[13]

Limitations of our analysis

Our analysis has important limitations. First, in illustrating only three premium designs, our analysis does not represent a definitive or comprehensive set of design choices. Differences in design choices can have a major impact on beneficiaries and on an area's health care marketplace. Our June 2013 chapter on competitively determined plan contributions provides a broader discussion of key design elements (Medicare Payment Advisory Commission 2013). Furthermore, the examples used to illustrate the relative effects of a particular design may not be realistic as actual policy choices.

Second, our analysis uses plan bids under the current MA program as a proxy for the total cost of providing the Medicare benefits through private plans because they are the best measure we have. However, these bids are the plans' responses to current rules, which are different from all three illustrative examples. Under different rules, MA plans are likely to bid differently. For example, current MA bids are highly correlated with current MA benchmarks, which range from 95 percent to over 125 percent of FFS spending in 2016. Without those administratively set benchmarks, as in our analysis where federal contributions were based on the lower of either FFS spending or the MA bid, plans would likely change their bids. Additionally, plan bids would be different if MA plans defined their own service area, as under current law, compared with the program defining a market area, as under our illustrative examples. Moreover, under different rules for calculating beneficiary premiums and the federal contribution, MA plans would likely make different decisions regarding whether to enter or exit a particular market area and how much to bid.

Third, as we noted earlier, we assumed in our analysis that the current system of rebates and extra benefits for MA plans would be eliminated and that differences in the relative cost of FFS and MA would be reflected in the beneficiary's premium. Extra benefits could be included as part of a new method for calculating beneficiary premiums, but such a change would raise policy issues that are beyond the scope of this chapter.

Finally, our analysis does not discuss how beneficiaries would respond to changes in their premiums. Our examples show that methods for calculating beneficiary premiums could have a major effect on beneficiaries' finances. But a premium is only one of many factors beneficiaries might care about. In making a choice with the highest value to them, some beneficiaries would need to trade off premiums and other aspects of the benefit package as well as their perception of quality and other factors affecting their choices. This process can be difficult and complex. For example, under current law, choosing traditional Medicare offers no restrictions on providers but may require additional choices among Medicare supplemental plans and among Part D plans; choosing an MA plan may simplify the process by offering all Medicare benefits—Part A, Part B, Part D, and supplemental coverage—in a single plan but would necessitate receiving care from a limited network of providers. When choices require considering multiple dimensions simultaneously, beneficiaries' ability to compare and make tradeoffs among a large set of options would likely be limited. Moreover, if the difference in premiums among choices is too great, the choice that the beneficiary would otherwise consider most attractive might be prohibitively expensive and therefore not a realistically viable choice. These issues are additional policy considerations that must be factored into designing beneficiaries' financial incentives.

Conclusion

For many years, the Commission has supported the concept of financial neutrality between FFS Medicare and Medicare Advantage. That concept was first applied at an aggregate level, with the Commission recommending that total payments to MA plans should not exceed what it would cost the government, on average, to serve the

same beneficiaries in the FFS program. Starting with its June 2015 report and continuing with this chapter, the Commission has extended this concept to individual beneficiaries and, in this chapter, has illustrated the effects of having the government's contribution be the same in both FFS and MA.

Since the cost of FFS and MA coverage varies both within and across markets, equalizing the government contribution would require beneficiary premiums to vary, with beneficiaries paying higher premiums for the more costly delivery system. Policymakers could equalize the government contribution in many different ways, and this chapter has used three illustrative examples to explore some of the possible effects.

Average spending for FFS and MA differs significantly in many areas of the country, so equalizing the government contribution would, if implemented fully, result in much higher premiums for some beneficiaries. In one of our illustrative examples, about a third of Medicare beneficiaries live in areas where monthly premiums for some beneficiaries would increase by $100 or more. Most of the beneficiaries facing higher premiums would be FFS enrollees, but MA enrollees in some areas would also be affected. Our illustrative examples also differ in their effect on current beneficiaries; under our first example, most beneficiaries would not face higher premiums for their existing coverage (since the FFS premium would stay the same and most MA enrollees are in plans that are less expensive than FFS), while under our second and third examples, a majority of beneficiaries would face higher premiums for their existing coverage (since the base premium would be tied to the less costly form of coverage, which would lead to higher FFS premiums in many areas).

Given the potential magnitude of the premium increases if any of these illustrative examples were adopted, there would likely need to be some sort of transition period to mitigate the initial impact on beneficiaries. As part of the glide path to the new system, policymakers could place an overall limit on how much premiums for FFS enrollees could increase, phase in the higher premiums over time, or both. The potential impacts on low-income beneficiaries and state Medicaid programs would also be important considerations. ■

Endnotes

1 Under current law, beneficiary premiums for Medicare Part A and Part B are separate. Most beneficiaries pay no premium for Part A based on their employment history, whereas all beneficiaries who elect Part B pay a monthly premium set at about 25 percent of Part B benefit costs per beneficiary. In this chapter, we define beneficiary premiums as a set share of combined Part A and Part B benefit costs, but we do not specify the mechanism through which it would be collected.

2 To mitigate these problems, in 2005 the Commission recommended combining counties into larger payment areas for MA, consisting of metropolitan statistical areas (MSAs) and health service areas outside MSAs (Medicare Payment Advisory Commission 2005).

3 FFS spending data are from CMS's 2016 MA rate calculation data. We only excluded hospice, direct graduate medical education, and indirect medical education to make FFS spending comparable with what MA plans now include in their bids. How these payments would be handled under a new method for calculating beneficiary premiums is a policy choice.

4 With some exceptions, all MA plans must also offer an option that includes the Part D drug benefit, although payments for the Part D benefit are handled separately. For the purposes of this analysis, we used only the Part A and Part B component of the bid.

5 The local MA benchmark for a plan serving only one county is the county benchmark rate. Plans serving multiple counties have a weighted benchmark based on the expected enrollment coming from each county. Regional preferred provider organization plans, another option within MA, bid in relation to regional benchmarks, which are set under a different methodology.

6 We use current MA plan bids for 2016 because they represent the latest data available. As discussed, county benchmarks under the current MA program can differ significantly from county FFS spending, and plan bids tend to be correlated with benchmarks, not FFS spending. Therefore, MA plan bids would likely change if benchmarks and rules changed.

7 For individuals who are not eligible for premium-free Part A and have 30–39 quarters of Medicare-covered employment, the premium is $226 per month in 2016. For individuals who are not eligible for premium-free Part A and have fewer than 30 quarters of Medicare-covered employment, the premium is $411 per month. There are very few individuals in these two categories.

8 Higher income beneficiaries pay higher monthly premiums (as high as $390 a month in 2016) based on their modified adjusted gross income.

9 Part A is primarily financed through dedicated payroll taxes paid by current employers and employees. If we took these payments into account, the ultimate government subsidy would be lower.

10 The difference between the estimated and actual Part B premium amounts is also partly due to the fact that the actual Part B premium includes an additional amount that is meant to bolster the reserves of the Part B trust fund.

11 This example differs slightly from the version that we used in our June 2015 report. In the previous version, the base premium simply equaled 13.4 percent of local average FFS spending. (That figure differs slightly from the 13.5 percent used in this report because it was based on older data.) We modified this example because the previous version would have increased premiums for all beneficiaries living in areas with high FFS spending, even those enrolled in less costly MA plans.

12 There are alternative policy designs that could contemplate offering enhanced benefits in addition to premium reductions, but they are beyond the scope of this current chapter.

13 For example, the Medicare Modernization Act of 2003 required the Secretary to conduct a demonstration project in up to six metropolitan areas that would have adjusted Part B premiums for FFS enrollees based on how average FFS costs in those areas compared with the average MA bid. FFS premiums would have been increased if FFS were more expensive than MA, and reduced if FFS were less expensive than MA. However, any increase in premiums for FFS enrollees would have been phased in over four years and would not have applied to anyone receiving the Part D low-income subsidy, which has broader eligibility rules than the MSPs. The increased premium could also never be more than 5 percent higher than the original Part B premium. The demonstration, originally scheduled to begin in 2010, was never implemented and Congress repealed it in 2010.

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