CHAPTER 3

Using premium support in Medicare

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Chapter summary

Medicare finances Part A and Part B using a combination of government funding and beneficiary premiums. Most beneficiaries are not required to pay a premium for Part A coverage. For Part B coverage, most beneficiaries pay a standard premium regardless of whether they are enrolled in the fee-for-service (FFS) program or a Medicare Advantage (MA) plan. As a result, beneficiary premiums do not reflect any differences in the underlying cost of providing the Medicare benefit package through the FFS program or an MA plan.

Under a premium support model, the amount that the government pays for each beneficiary's Medicare coverage would be changed to a fixed dollar amount that remains the same whether the beneficiary enrolls in the FFS program or a managed care plan. Beneficiaries would pay premiums that equal the difference between the overall cost of providing the Medicare benefit package and the government contribution. As a result, premiums for FFS coverage and managed care plans would vary based on the underlying differences in their overall costs. Plans with lower overall costs would charge lower premiums, while plans with higher overall costs would charge higher premiums. A form of premium support has been used in the Part D program since its inception.

The Commission makes no recommendation on whether premium support should be used. The Commission has long believed that provider and

In this chapter

beneficiary incentives can both play a role in ensuring that care is delivered in an efficient manner and has studied premium support to understand how it could give beneficiaries a financial incentive to enroll in coverage options that can provide the Medicare benefit package more efficiently. Given the Congress's interest in premium support and the Commission's role in providing analysis and guidance on Medicare issues, this chapter examines some of the key issues that policymakers may want to resolve if they decide to use premium support in Medicare and discusses some of the potential consequences of taking particular approaches to a number of issues. Because of the complexity of this topic, this chapter does not examine all of the issues raised by premium support. The key issues discussed in this chapter are:

- ***What would be the role of the FFS program, which covers about 70 percent of all Medicare beneficiaries?*** Under many premium support proposals, the FFS program would be maintained and treated as a competing plan when calculating beneficiary premiums. Under this approach, the FFS program would operate much as it does now, but Medicare would develop a "bid" for FFS that would be used, along with bids submitted by managed care plans, to determine the Medicare contribution and beneficiary premium for each coverage option. Maintaining the FFS program's current role would have several advantages. Beneficiaries would face premiums that accurately reflect differences in the relative cost of providing the Medicare benefit package through FFS compared with managed care plans. The presence of FFS would help limit program spending and beneficiary premiums in areas of the country where FFS is less expensive than managed care and would ensure that beneficiaries in areas where no managed care plans are available have a source of coverage. FFS would also limit program spending and beneficiary premiums indirectly by making it easier for managed care plans to negotiate with providers to obtain payment rates that are similar to FFS rates and thus avoid paying the much higher rates that prevail in commercial insurance. Finally, beneficiaries would be free to select the type of coverage that best meets their preferences, with beneficiaries who choose more expensive coverage paying the full incremental cost.

- ***How much should the coverage offered by the FFS program and managed care plans be standardized under a premium support system?*** Standardizing coverage would help ensure that all beneficiaries have access to adequate coverage and would make it easier for beneficiaries to understand and compare their coverage options. Standardizing coverage would also help guard against the possibility of managed care plans selectively enrolling healthier

beneficiaries and make it easier to administer a premium support system. There may be arguments for standardizing coverage options in several ways. The FFS program and all plans could offer a standard package of benefits, although managed care plans could have the flexibility to use alternative forms of cost sharing that are actuarially equivalent, as MA plans can now. Standardizing the benefit package could require changing the FFS benefit structure to make it more comparable with the benefit structures used by managed care plans (for example, by adding an annual cap on out-of-pocket expenditures). Plans could offer additional benefits if they wished, but plan enrollees would not be required to purchase the additional benefits, and those who did would pay an additional premium that reflected their full cost. Beneficiary premiums for all coverage options would also need to be standardized to reflect costs for a beneficiary of average health, to ensure that premiums reflected differences in the underlying efficiency of each coverage option instead of differences in the health of the beneficiaries enrolled. Finally, beneficiaries would need to have access to robust decision support tools that help them understand their coverage options and select the one that best meets their needs.

- ***What method would be used to calculate the Medicare contribution and beneficiary premiums?*** One key feature of a premium support system would be a "benchmark" consisting of two components: the Medicare contribution and a base beneficiary premium. The Medicare contribution would be the same for each coverage option, while the amount that beneficiaries would pay for each option would equal the base beneficiary premium plus any difference between the plan's bid and the benchmark.

  Many premium support proposals would use competitive bidding to determine benchmarks because bids would be the best way to collect information about the relative "price" of providing the standard benefit package in FFS and managed care plans. All bids would need to be risk adjusted to reflect costs for a beneficiary of average health so they could be compared on an "apples-to-apples" basis. If the bidding process used geographic regions that reflected local health care markets, benchmarks would likely vary across areas, given the geographic variation in Medicare spending and service use that now exists.

  Competitive bidding could be used in many ways to calculate benchmarks. The exact method employed would play a key role in determining the impact of premium support on program spending and beneficiary premiums because higher benchmarks would result in higher program spending and lower beneficiary premiums, and vice versa. In this chapter, the Commission

explores two options: (1) using the lower of the FFS bid or the median bid among an area's managed care plans and (2) using the weighted average of all bids. Both methods are appealing because they would produce benchmarks in most areas that fall somewhere in the broad middle of the distribution of bids. Basing benchmarks on lower plan bids would produce larger savings for the government but have correspondingly higher beneficiary premiums. In addition, low-bidding plans (particularly if they are new) may not have the capacity to serve large numbers of enrollees, and their bids could change significantly in later years if they proved to be unrealistically low, which could lead to larger year-to-year changes in beneficiary premiums.

The Commission also explores two ways to set the base beneficiary premium: (1) using a standard amount that is determined nationally (like the current Part B premium) and (2) using a standard percentage of each area's benchmark. The first method would result in lower premiums for beneficiaries in high-cost areas, while the second method would result in lower premiums for beneficiaries in low-cost areas. Some year-to-year volatility in beneficiary premiums would be likely because plan bids would change over time, but premiums would probably be more stable if benchmarks equaled the weighted average of all plan bids rather than the lower of the FFS bid or the median plan bid.

One issue in premium support is how the Medicare contribution and the base beneficiary premium would grow over time compared with the benchmark. Some premium support proposals have sought to reduce the growth in federal Medicare spending by putting a limit on the annual growth in the Medicare contribution that is lower than historical growth in health care spending or Medicare spending. If the benchmark grew more rapidly than this limit, growth in the Medicare contribution would be capped at a lower rate, and the difference would be made up by higher beneficiary premiums. This situation would be problematic because beneficiaries would bear the risk of paying higher premiums without being able to take actions that lower their premiums in a meaningful way (since the added growth in the base beneficiary premium would be a function of broader forces like the overall growth of Medicare spending and growth in the national economy). An alternative approach would be to have the benchmark, Medicare contribution, and base beneficiary premium all grow in tandem with plan bids, as they do now in the Part D program, and see whether competition among managed care plans (driven by beneficiaries' interest in lower cost plans) can achieve sufficient savings.

The method used to calculate the Medicare contribution and beneficiary premiums would play an important role in determining who bears the cost of the regional variation that exists in Medicare spending. Two components would be especially important: the geographic regions used as bidding areas and the method used to set the base beneficiary premium. The use of bidding areas that reflect local health care markets and a standard amount as the base beneficiary premium would provide greater protection against higher premiums to beneficiaries in high-cost areas.

- ***How would high-quality care be rewarded under premium support?*** Under a premium support system, quality of care could be measured by comparing the performance of managed care plans and the FFS program on a set of population-based measures to a common, market area–level standard (i.e., the average performance for all Medicare beneficiaries). Quality could be rewarded in two ways to encourage the delivery of better care to beneficiaries. In the first, the government would require all plans to meet minimum standards that ensure they can provide quality care (such as having adequate provider networks) and publicly release quality data for beneficiaries to use when selecting a coverage option, but it would not adjust the Medicare contribution based on quality. In the second, the government would also require plans to meet minimum standards and publicly release quality data, but plans with higher quality scores would receive a higher Medicare contribution, which would allow them to charge lower beneficiary premiums.

- ***What steps could be taken to mitigate or delay the impact of potentially higher premiums and protect low-income beneficiaries?*** The impact of a premium support system on beneficiaries' premiums would depend on the method used to calculate the benchmark and base beneficiary premium and on beneficiaries' willingness to avoid premium increases by switching to lower cost forms of coverage. We find that the impact would also vary across market areas: In areas where FFS is less expensive than managed care, plan enrollees could face higher premiums; in areas where managed care is less expensive than FFS, FFS enrollees could face higher premiums. The amount of the increase in some areas could be substantial. Some steps to mitigate or delay these effects include phasing in higher premiums over time or limiting the extent to which premiums for the different coverage options could vary. New Medicare beneficiaries could be automatically enrolled in managed care plans instead of FFS in areas where plans have lower premiums, but this approach could be disruptive for beneficiaries who are assigned to plans that do not have all of their current providers in their networks. In addition, low-income beneficiaries would need

to receive premium subsidies to ensure that they could obtain coverage. Those subsidies could be based on the premiums for lower cost plans to ensure that low-income beneficiaries would still have an incentive to enroll in a lower cost coverage option, but this approach would likely require beneficiaries in many areas to pay an additional premium if they chose FFS coverage.

The use of premium support could have significant effects on beneficiaries and managed care plans. Available research on several relevant issues, such as the sensitivity of beneficiaries to changes in premiums, provides some indication of potential effects. However, given the many actors and design choices (which go well beyond the issues raised in this chapter), there is no way to predict with certainty how premium support would play out. Experience in the MA and Part D programs indicates that beneficiaries respond to higher premiums by switching plans and that larger increases in premiums result in more switching. However, most MA and Part D beneficiaries keep their existing plan when premiums increase, and many beneficiaries who would benefit from changing plans do not switch. However, the changes in premiums could be larger under premium support than they have been in MA and Part D, which makes it difficult to estimate how many beneficiaries might switch coverage. Beneficiaries also consider factors besides premiums when selecting a health plan, such as the plan's network of providers and their expected out-of-pocket costs, and many beneficiaries have difficulty choosing a plan when there are a large number available. Beneficiaries would need access to decision support tools (which would ideally be more robust than the tools now used in MA and Part D) to evaluate their coverage options and select the plan that best meets their needs. Managed care plans would likely reassess which markets they serve (entering some markets and leaving others), and the greater emphasis on price competition under premium support could also lead plans to submit lower bids than they do currently. On balance, the use of premium support would likely increase the number of beneficiaries enrolled in managed care plans and reduce the number enrolled in FFS. ■

Introduction

The importance of delivering care in an efficient manner has long been a key concern for the Commission in its work evaluating the Medicare program. Delivering care efficiently is important because it helps to ensure that the program's overall costs, which are borne by both taxpayers (in the form of payroll and income taxes) and beneficiaries (in the form of premiums and cost sharing for covered services), are kept at reasonable levels.

This concern has led the Commission to make numerous recommendations over the years that affect providers. The Commission considers the experience of efficient providers—those with below-average costs and above-average performance on various quality metrics—when developing its recommendations for updates to the payment rates in Medicare's fee-for-service (FFS) program. The Commission has also examined broader changes to the FFS program that would give providers stronger incentives to deliver care efficiently, such as a unified payment system for post-acute care services (Medicare Payment Advisory Commission 2016b), the development of accountable care organizations (Medicare Payment Advisory Commission 2009), and the wider use of gainsharing arrangements among providers such as hospitals and physicians (Medicare Payment Advisory Commission 2008b). The Commission has also made recommendations that would encourage Medicare Advantage (MA) plans to be more efficient, such as setting the benchmarks used to determine MA plan payments at 100 percent of FFS costs (Medicare Payment Advisory Commission 2005).

Beneficiary incentives can also play an important role in ensuring that services are used efficiently. In 2012, the Commission recommended making a series of changes to improve and rationalize the FFS benefit. Those changes included reforming the deductibles for Part A and Part B, replacing coinsurance with copayments that could vary by the type of service and provider, and adding a cap on out-of-pocket expenditures. The Commission also found that supplemental coverage (such as medigap and employer-sponsored retiree plans), which covers some or all of Medicare's cost sharing, leads to higher utilization of services that may be of marginal value. As a result, the Commission recommended imposing a surcharge on premiums for supplemental policies to reflect the additional Medicare costs that these plans generate, which result in higher costs for taxpayers and higher premiums for beneficiaries (Medicare Payment Advisory Commission 2012a). The Commission has also supported the adoption of copayments to moderate the use of certain services such as some home health episodes (Medicare Payment Advisory Commission 2011a).

The Commission's interest in giving beneficiaries greater incentives to use Medicare services more efficiently has also led it to examine the implications of using a premium support model for Part A and Part B.[1] The Commission began its examination of premium support in its June 2013 report to the Congress—using the term *competitively determined plan contributions*—and included a chapter on the topic in its June reports for 2014, 2015, and 2016. The term *premium support* has been used elsewhere in different contexts and is thus somewhat inexact. As the Commission has used the term, premium support refers to a system in which the federal government makes a fixed, competitively determined contribution toward the cost of Medicare coverage, and beneficiary premiums are higher or lower depending on the relative costliness of the chosen plan (either the FFS program or a managed care plan).[2] The higher premiums for more expensive plans would thus encourage beneficiaries to enroll in lower cost plans.

The use of premium support would represent a significant change for the Medicare program and raises numerous concerns about how it could affect federal spending, beneficiaries, health care providers, and managed care plans. To give a few examples:

- Premium support is often viewed as a way to reduce federal Medicare spending, but spending could increase substantially if providers negotiated Medicare payment rates with managed care plans that were comparable with commercial payment rates. There has been substantial consolidation among providers, and many providers (such as hospitals) have been able to negotiate commercial rates that now far exceed Medicare rates.
- The premium support model anticipates that beneficiaries will be able to understand their coverage options and select the one that best meets their preferences. However, beneficiaries may have trouble evaluating their options without accurate, understandable, and comparable information about their coverage options. And some beneficiaries, such as those with cognitive impairments or behavioral health conditions, may have difficulty making an informed choice.

- Beneficiaries consider factors besides premiums when they select a particular type of coverage, such as access to certain providers. These other factors could make beneficiaries less willing to switch to lower cost plans.
- Premium support is based on competition among managed care plans (and the FFS program in some proposals). There would need to be a robust system of risk adjustment to compensate plans that attract a sicker than average mix of enrollees.

This chapter examines some of the key issues that policymakers may want to resolve if they decided to use premium support in Medicare. (Given the complexity of this topic, this chapter does not examine all of the issues raised by premium support.) The Commission makes no recommendation on whether premium support should be used. However, if policymakers decide to pursue the use of premium support, we discuss some of the potential consequences of particular approaches to a number of issues.

This chapter begins by providing some background on the concept of premium support and then discusses six key issues related to its use: (1) the role of the FFS program, (2) standardizing benefit packages and beneficiary premiums, (3) determining benchmarks and beneficiary premiums, (4) incorporating quality into premium support, (5) mitigating the impact of higher premiums on beneficiaries, and (6) providing premium subsidies to low-income beneficiaries. We then assess some of the possible impacts that premium support could have on beneficiaries and managed care plans.

The concept of premium support

The term *premium support* first appeared in a 1995 article by Aaron and Reischauer, but proposals to apply the concept to Medicare in some fashion have been around since the 1980s (Aaron and Reischauer 1995, Kaiser Family Foundation 2012). These proposals differ in many respects, but all envision a program in which beneficiaries would receive their Medicare benefits by choosing among competing managed care plans or (in some proposals) the traditional FFS program. This choice between managed care plans and the FFS program exists now—any beneficiary can enroll in the FFS program, and 99 percent of beneficiaries currently have access to an MA plan, with most having access to multiple plans—but under premium support, the government would use a different method to calculate the beneficiary premiums for each option.

Under current law, beneficiaries do not pay a Part A premium if they are entitled to Medicare through receipt of Social Security or Railroad Retirement Board benefits or through Medicare's end-stage renal disease program.[3] Beneficiaries who choose to enroll in Part B usually pay a monthly base premium ($134 in 2017) that equals about 25 percent of the national average per beneficiary cost of Part B benefits.[4] The base Part B premium is set nationally and does not vary across areas.

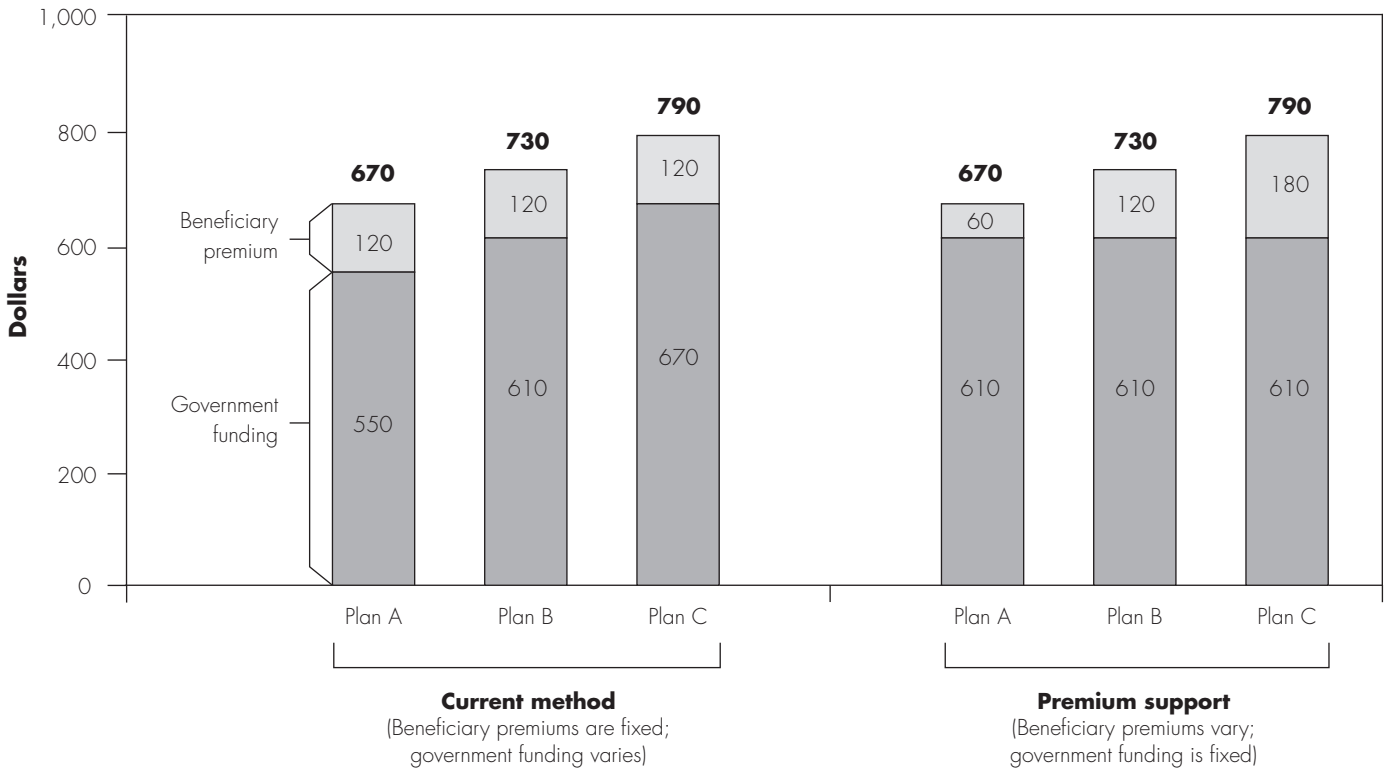
In contrast to the FFS program, premiums for MA enrollees can vary, depending on how plan bids compare with the local MA benchmark. If plan bids are higher than the benchmark (which is relatively rare), MA enrollees pay the Part B premium and the difference between the bid and the benchmark as an additional premium. If plan bids are lower than the benchmark, beneficiaries pay the Part B premium and receive part of the difference between the bid and the benchmark in the form of extra benefits and reduced premiums, including the few cases where plans have elected to offer a reduced Part B premium. However, most MA plans tend to offer extra benefits such as reduced cost sharing instead of reducing the Part B premium. As a result, most MA enrollees pay the same Part B premium as FFS enrollees.

Under premium support, Medicare would contribute a specified dollar amount toward the cost of each beneficiary's coverage in a given market area. (Throughout this chapter, *cost* refers only to expenses that the Medicare program pays for—either directly through the FFS program or indirectly through a managed care plan—and does not include beneficiary cost sharing.) The amount of this contribution would remain the same, regardless of whether the beneficiary enrolled in FFS or in a managed care plan or enrolled in one plan instead of another plan. The beneficiary premium for each coverage option would equal the difference between the total cost of that particular coverage option and Medicare's contribution. Any differences in the total cost of the available coverage options would thus be directly reflected in beneficiary premiums. Beneficiaries who qualify for both Medicare and Medicaid could conceivably be handled through a separate framework because of the challenges of coordinating the two programs.

An illustrative example helps to demonstrate the basic difference in how Medicare spending is financed under

FIGURE 3–1

Illustrative comparison of how Medicare spending is financed under current law versus a premium support system



Note: This comparison assumes that managed care plans do not charge an additional premium.

current law versus a premium support system (Figure 3-1). In this example, beneficiaries have three options for receiving their Medicare benefits—Plan A, Plan B, and Plan C. One of these "plans" is the FFS program, and the other two options are managed care plans. The total monthly cost of providing the Medicare benefit package varies across the three options: Plan A costs $670; Plan B, $730; and Plan C, $790. (For these purposes, we do not need to specify which plan is the FFS program; the key point is simply that the overall cost of the three options varies. In reality, there would likely be areas where the FFS program is the low-cost option, areas where it is the high-cost option, and areas where it falls somewhere in between. The difference in cost between the low-cost and high-cost options would also be, depending on the area, greater or lower than what is depicted here.)

Figure 3-1 shows how beneficiary premiums and government funding are currently used to finance Medicare spending. In this example, all beneficiaries pay a standard premium of $120, similar to the current Part B premium, regardless of the option they choose. (For simplicity, we assume that the two managed care plans bid below the MA benchmark and do not charge an additional premium. Note also that beneficiaries pay this premium to Medicare instead of directly to the plan.[5]) Medicare pays the remaining cost. Since the beneficiary premium does not vary, the differences in the overall cost of the three options are reflected in Medicare funding, which ranges from $550 per month for Plan A to $670 per month for Plan C.

Figure 3-1 also shows how Medicare spending would be financed under a premium support system. Under this approach, Medicare would contribute a fixed amount

toward each beneficiary's coverage—$610 in this example—regardless of which plan the beneficiary chose. Since the Medicare contribution does not vary, differences in the overall cost of the three options are reflected in the beneficiary premiums, which range from $60 for Plan A to $180 for Plan C. Plans with lower costs would thus have lower premiums than plans with higher costs, which would give beneficiaries an incentive to choose a lower cost plan.

In this example, the use of premium support reduces the premium for Plan A (from $120 under the current approach to $60 under premium support), has no impact on the premium for Plan B, and increases the premium for Plan C (from $120 to $180). However, the extent to which the premiums for the three options would change under premium support is heavily dependent on the amount of the Medicare contribution. For example, if the Medicare contribution under premium support were $550, the premium for Plan A would continue to be $120, while the premiums for Plan B and Plan C would be higher than they are today. If the Medicare contribution under premium support were $670, the premiums for Plan A and Plan B would be lower than they are today (Plan A would, in fact, not charge any premium) and the premium for Plan C would remain at $120.

Several federally funded health care programs use at least some elements of premium support to determine beneficiary or enrollee premiums:

- Under the Medicare Part D drug benefit, prescription drug plans and MA plans that offer a drug benefit submit bids that indicate the total monthly cost of providing Part D benefits. Enrollees pay a base beneficiary premium that equals 25.5 percent of the national average bid plus any difference between their plan's bid and the national average bid. Part D enrollees thus pay the full incremental cost if they decide to enroll in a plan that has above-average costs and keep the full incremental savings if they decide to enroll in a plan that has below-average costs.

- Under the Patient Protection and Affordable Care Act of 2010 (PPACA), the government pays part of the premium for eligible individuals who purchase coverage through the health insurance exchanges. The plans in the exchanges are grouped into four tiers (platinum, gold, silver, and bronze) based on their generosity. Platinum plans have the most generous coverage, while bronze plans have the least generous. The government contribution equals the difference between the premium for the silver plan with the second lowest premium in an area and an amount the individual is required to pay based on family size and income. The amount that the government contributes does not change if an individual enrolls in a different plan, so individuals who enroll in a more expensive plan—such as a platinum or gold plan or a more expensive silver plan—pay higher premiums, and individuals who enroll in a less expensive plan, such as a bronze plan, pay lower premiums.

- Under the Federal Employees Health Benefits Program (FEHBP), the federal government provides health coverage to eligible federal employees, retirees, and their dependents. The government limits its contribution for each participating health plan to either 72 percent of the weighted average premium for all FEHBP plans or 75 percent of the plan's premium, whichever is less. As a result, individuals who enroll in plans that are more expensive than the weighted average premium pay the full amount of any difference between their plan's premium and this benchmark.

- Under the MA program, local plans (plans with service areas composed of one or more counties rather than larger, CMS-specified regions) submit bids that are compared with a benchmark amount. Plans that submit bids greater than the benchmark are required to charge beneficiaries a premium that equals the difference between the plan's bid and the benchmark, so the benchmark serves as an upper bound on the government contribution. In this respect, the MA benchmark performs the same function as the weighted average premium in the FEHBP, although the MA benchmark is based on historical FFS spending while the weighted average premium in the FEHBP is determined through competition. The MA program also includes regional preferred provider organization (PPO) plans that have service areas specified by CMS and are composed of one or more states. The benchmarks for those plans are partly determined through competition because they equal a weighted average of the region's historical FFS spending and the regional PPOs' bids.

Although the basic concept of premium support is relatively straightforward, the development of a premium support system for Medicare would require policymakers to address multiple key issues, starting with the role of the FFS program.

The role of the FFS program

For its supporters, the appeal of premium support is based on the fact that managed care plans in some areas of the country submit bids to provide the Medicare benefit package at a lower cost than the FFS program.[6] However, about 70 percent of all Medicare beneficiaries are enrolled in the FFS program, the FFS program costs less than managed care plans in some areas of the country, and some beneficiaries may want the option of choosing between FFS coverage and a managed care plan. As a result, the role of the FFS program in a premium support system is a key issue to consider.

Proposals to use premium support have varied in how they treat the FFS program. For example, some proposals use premium support only to modify how Medicare pays managed care plans and leave the FFS program untouched. Other proposals continue to offer the FFS program while treating it as a competing plan when calculating beneficiary premiums. Still other proposals eliminate or phase out the FFS program and move to a system that relies entirely on managed care plans to provide Medicare benefits.

There are arguments for the FFS program to remain available under a premium support system and to be treated as a competing plan when calculating beneficiary premiums. Under this approach, the FFS program would operate much as it does now. Beneficiaries in the FFS program would essentially have no restrictions on their choice of providers and would face few constraints on their service use compared with beneficiaries enrolled in managed care plans. Providers who deliver care to FFS beneficiaries would continue to be paid under the existing FFS payment rules.

However, Medicare would also develop a "bid" for the FFS program that would be used, along with bids submitted by managed care plans, to determine the Medicare contribution and beneficiary premium for each coverage option in a given market area. The FFS bid would equal the estimated average per capita cost of providing the Medicare benefit package for a market area's FFS beneficiaries, and the bid would need to be standardized to reflect the cost for a beneficiary of average health. FFS spending data currently include some payments that are not included in MA plan bids, such as hospice, direct graduate medical education, and indirect medical education.[7] Depending on how those payments were handled under a premium support system, CMS may need to adjust FFS spending data to develop an FFS bid that could be compared with managed care plan bids.

There would be several advantages to treating the FFS program as a competing plan under a premium support system. First, it would ensure that beneficiaries face premiums that accurately reflect the difference in the cost of providing the Medicare benefit package through the FFS program compared with managed care plans. Given the number of FFS beneficiaries and the difference between the cost of the FFS program and managed care plans in many areas, switching from the FFS program to a managed care plan—or, in some areas, from a managed care plan to the FFS program—is one of the main ways that beneficiaries would be able to obtain coverage at less cost. (Some beneficiaries who are now enrolled in MA plans would also be able to obtain less expensive coverage by switching from a higher cost plan to a lower cost plan.)

Second, the presence of the FFS program would help limit program spending in areas where the FFS program is less expensive than managed care plans. Under the MA program, 18 percent of beneficiaries live in counties where the MA benchmark equals 115 percent of FFS spending, and most MA plans in those counties are more expensive than the FFS program. These areas tend to have low rates of service use, which makes it difficult for plans to offset their operating costs by reducing unnecessary service use; these areas are also more rural, so there are relatively few providers, and plans may have difficulty negotiating favorable payment rates. Under premium support, the FFS program could be the lower cost option in some counties that now have high MA benchmarks, and some plans in those counties might leave the market if they had to start charging higher premiums than the FFS program. The continued availability of the FFS program would thus serve as a safeguard in areas where managed care plans choose not to participate.

Third, the presence of the FFS program would also limit program spending indirectly because FFS payment rates would serve as a reference point for providers and managed care plans when they negotiate payment rates. Many providers have a substantial amount of market power, and there is widespread evidence that providers negotiate payment rates with commercial insurers that are substantially higher than FFS rates. For example, the rates that commercial insurers pay hospitals are often far more than 50 percent above Medicare rates. Providers that are part of an MA plan's provider network are not required to accept FFS payment rates when they deliver care to the

plan's enrollees and thus might be expected to negotiate payment rates that are closer to commercial rates. However, our discussions with plan representatives and the available research indicate that MA plans pay providers using rates that are similar to FFS rates. Providers may find it more difficult to negotiate higher payment rates with MA plans than with commercial plans because providers have to accept FFS payment rates if they cannot reach agreement with MA plans. (If a provider does not join an MA plan's provider network, the plan is allowed by law to use FFS payment rates to pay for any covered out-of-network care. And more broadly, if MA plans cannot operate profitably in a particular area and decide to leave the market, providers will be paid at FFS rates when the beneficiaries in the area enroll in the FFS program.) We anticipate that the FFS program would continue to have a dampening effect on payment rates under a premium support system if managed care plans can use FFS rates to pay for covered out-of-network care.

Finally, the continued availability of the FFS program is consistent with the Commission's long-standing view that Medicare beneficiaries should be able to receive their benefits through the FFS program or a managed care plan, with the important caveat that the government should not spend more on beneficiaries who enroll in one sector over the other (Medicare Payment Advisory Commission 2005). Enrollment in MA plans has grown substantially over the past decade, but the FFS program remains popular. Although FFS premiums could increase in many areas under a premium support system, some beneficiaries could still prefer FFS coverage for a number of reasons, such as having a free choice of providers. Under a premium support system, beneficiaries would be free to select the type of coverage that best meets their preferences, with beneficiaries who select a more expensive coverage option paying the full incremental cost in the form of higher premiums.

Standardizing benefit packages and beneficiary premiums

Under a premium support system, some level of standardization could be used in three areas—standardization of *benefits* (the items and services that would be covered by the FFS program and managed care plans), standardization of *beneficiary cost sharing*, and standardization of *risk* (adjusting beneficiary premiums and plan bids for differences in beneficiaries' health status). Standardizing these elements of a premium support system would be important for several reasons:

- to facilitate the determination of a government contribution amount that is accurate and established through competition on a level playing field,
- to aid beneficiaries in their decision making by having clear information about the price and features of each option,
- to reduce opportunities for favorable selection through benefit designs, and
- to facilitate administration of the program.

The experience with standardization in certain parts of Medicare can serve as models for a premium support system (Table 3-1). Although such a system would likely be built largely on the current MA framework, the Part D drug benefit also serves as a model, and there are lessons to be learned from the medigap experience with standardization.

If the Congress decides to use premium support and treat the FFS program as a bidding plan, then the FFS Part A and Part B benefit package could serve as the standard for determining plan bids and beneficiary premiums. In that case, beneficiary cost sharing could be standardized at FFS levels, although plans could use alternative forms of cost sharing that are actuarially equivalent. (The Commission has recommended changing the FFS benefit package to make it more like the typical MA plan's benefit package, a topic discussed more fully below.) All bids and payments to managed care plans also need to be standardized to account for differences in the health status of beneficiaries. Insurers would also be allowed to offer benefits beyond those covered by Medicare, which would allow managed care plans to innovate and give beneficiaries options that may be suited to their needs and preferences. (Some argue that enhanced benefit packages or optional supplemental benefits should also be standardized to some degree.) These elements would be similar to the current MA program. However, two features in Table 3-1 differ from current MA standards and borrow from the approach used in Part D—requiring insurers to bid on, *and offer*, a standard benefit package and requiring the cost of any induced demand in plans that offer additional benefits to be financed by beneficiary premiums instead of by the government. (In Part D, a sponsor's bid identifies the actuarial value of each of the components of the bid. In stating the value of the benefit, the bid distinguishes

TABLE 3-1

Program features that could be standardized in a premium support system and parallels in other programs

Program feature	Medicare Advantage	Medicare Part D	Medigap
1. Standardization of covered items and services	Yes (in basic benefit)	Yes (by drug classes)	Yes
2. Standardization of cost sharing	Yes (can be actuarially equivalent for basic benefits)	Yes (for standard package or through actuarial equivalence)	Yes
3. Standardization of enrollee risk for bidding or payment purposes	Yes	Yes	No (but age rating permitted)
4. All plans bid on and offer a standard package	No (offerings can consist solely of enhanced packages)	Yes	Yes (offerings standardized)
5. (a) Enhanced benefit packages are permitted	Yes (required when plans bid below benchmark and receive rebate dollars)	Yes	Not applicable (all offerings are standardized, but authority for innovative designs approved by insurance commissioners)
(b) Beneficiaries bear the full cost of induced utilization beyond the utilization level of basic coverage	No, unlike Part D	Yes	No (induced utilization of covered services is financed by Medicare)
6. Number of plans that an insurer can offer is limited	Yes (offerings must have meaningful differences)	Yes (offerings must have meaningful differences)	Yes (because of standardization)

Note: "Actuarial equivalence" is established by determining whether the dollar value of a given set of benefits and/or cost sharing is equal to the dollar value of an alternative set of benefits and/or cost sharing. A medigap plan is a product offered by a private insurance company that pays Medicare cost-sharing amounts for which a beneficiary is liable. Medigap plans can also cover the cost of care beyond Medicare's coverage limits for certain services or the cost of some additional services Medicare does not cover.

between the cost of the basic (standard) benefit defined in the statute and the separately identified cost of any supplementation of the benefit. The portion of the bid that represents supplemental benefits is financed through beneficiary premiums, not through Medicare program payments (42 CFR §423.265 and §423.286).)

Finally, the question of whether to limit the number of plans that an insurer could offer in a market area may need to be addressed. Given the array of coverage options, improved decision support tools would be needed to help beneficiaries navigate their choices, particularly for beneficiaries residing in areas with an assortment of managed care plans.

Defining standardization and reviewing its use in different programs

The experience of other parts of the Medicare program can be instructive in considering standardization in a premium support system.

Standardization in medigap

Medigap plans pay the cost sharing for Medicare-covered services that beneficiaries would otherwise pay and cover the cost of care after Medicare benefits are exhausted, in the case of inpatient hospital care. Some medigap plans also cover additional benefits such as a foreign travel benefit. The standardization imposed on medigap

policies (originally enacted in the Omnibus Budget Reconciliation Act of 1990) helps illustrate what is meant by *standardization*. With certain exceptions, all insurance companies offering medigap coverage must meet standardization requirements. In almost all states, there is a maximum of 10 standard medigap plans an insurance company can market, identified by letters A through N (E and H through J are no longer available). Each plan is distinguished by the extent of its coverage of Medicare's cost sharing and any extra benefits. One company's Plan A coverage is no different from another company's Plan A coverage. The major differences among the various plans relate to their coverage of the Part A and Part B deductibles, cost sharing for care in a skilled nursing facility, the difference between the limiting charge and the Part B payment amount for claims submitted by providers that do not accept assignment, and non-Medicare benefits.

The standardization of coverage applies to both the benefits included beyond those covered by Medicare and cost sharing for items and services. For example, Plan A and Plan F differ in terms of the non-Medicare benefits and cost-sharing coverage. Plan A does not include a foreign travel benefit, while all Plan F policies include a standard foreign travel benefit (which is a non-Medicare-covered benefit). For cost sharing, Plan A does not cover the Medicare inpatient hospital deductible; Plan F does. Thus, medigap standardizes the items and services to be covered as well as any associated cost sharing. Because insurers can offer only the standardized plans, standardization extends to the "plan offerings" that insurers can market.

The impetus for the standardization of medigap policies was the confusion that beneficiaries faced in choosing among a wide array of coverage options and the lack of transparency in the pricing of policies. After standardization, in choosing among insurance companies, a beneficiary knows that the coverage under Plan A, for example, is the same across all companies. This level of transparency in coverage would aid beneficiary decision making in a premium support system.

Despite the standardization of benefits and cost sharing in medigap, beneficiary premiums vary greatly. Policies' premiums depend on several factors: the plan's administrative costs and profit level (which are capped by a required minimum medical loss ratio); a beneficiary's age and other factors that medigap insurers can use when setting premiums; and—to a great extent—the use of health care services by a plan's beneficiary risk pool. If a given company's Plan F, for example, has an especially unhealthy pool of enrollees, its premium is likely to be higher than the Plan F premium of another company that operates in the same market area but has a healthier pool of enrollees. Because the outlays of medigap insurers are a function of the utilization of Medicare services, the geographic variation in service use seen in the FFS program also has an effect on medigap premiums. An insurer can have different premiums for the same standardized plan in different geographic rating areas. For example, New York State has 10 geographic rating areas for the pricing of medigap policies. Other factors that have been cited as contributing to the variation in medigap premiums are the limited competition in the market (where there are often dominant insurers in a state) and high "search costs" (that is, the time and effort of finding and comparing medigap options may discourage extensive comparison shopping) (Maestas et al. 2009).

Standardization in Medicare Part D

The premium support concept of using competition among plans to determine a government contribution level has a close parallel in the Medicare Part D (prescription drug) program. In terms of standardizing drug coverage, the program affords plans wide latitude once a plan meets certain minimum requirements for the number of drugs covered in each therapeutic class and coverage of most drugs in six protected therapeutic classes.

Compared with drug coverage in Part D plans, there is greater standardization of beneficiary cost sharing under the Part D drug benefit. Each year, CMS announces a set of statutorily based benefit parameters, such as the deductible and out-of-pocket maximum, that apply to all Part D plans. Part D uses standardized bids to determine the enrollment-weighted national average premium that serves as the reference point for determining the beneficiary premium for each plan. Each prescription drug plan must develop a bid for a plan using the CMS-specified standard benefit parameters or a plan with cost sharing that is actuarially equivalent. An actuarially equivalent bid has different benefit parameters (for example, a lower deductible), but the dollar value of its cost sharing is equal, on average, to the dollar value of cost sharing in a plan that uses the standard benefit parameters. Part D plans can offer enhanced packages that have less overall cost sharing, but such plans must develop a bid that breaks out the plan's standard component so that the government contribution covers only that component. Among beneficiaries who were enrolled in stand-alone plans in 2016 and did not receive Part D's low-income

subsidy, 63 percent were in enhanced plans and 37 percent were in standard, or actuarially equivalent, plans.

In Part D, plan bids are based on expected costs for a person of average health (i.e., with a risk score equal to 1.0). The weighted national average standard bid (74.5 percent of which is subsidized by Medicare) determines how much a beneficiary will pay for a given plan, with the premium in each plan also based on a person of average risk.

Standardization in Medicare Advantage

Under current bidding rules, MA plans are required to cover the full range of Medicare Part A and Part B services for their enrollees and to generally follow the same coverage guidelines used in the FFS program. The MA program's "basic" benefits are thus standardized, in the same way that a given medigap plan's set of benefits is standardized. For the evaluation of bids and determination of a plan's premium, plans are required to submit bids "with cost-sharing for those services as required under parts A and B or . . . an actuarially equivalent level cost-sharing" (Section 1852(a)(1)(B)(i) of the Social Security Act). In other words, a plan's bid may not reduce the cost sharing that, in statute, is the beneficiary's responsibility (nor may the bid include higher overall cost sharing). In MA, plans can offer supplemental benefits, but they can also require beneficiaries to purchase extra benefits as a condition of enrolling in the plan. That is, there is no requirement that a sponsor offer a plan that consists only of the standard benefit package.

In MA, premiums for basic coverage are based on the premium for a person of average health—or a 1.0 risk score—as in Part D (but not in medigap, where the premium reflects the actual relative health status of beneficiaries choosing a particular plan). The MA premium for basic coverage is determined by comparing a risk-standardized plan bid (representing a bid for a person of average health) with that plan's benchmark, which is also standardized to a 1.0 risk score. Plans with a standardized bid that exceeds the standardized benchmark are required to charge a premium equal to the difference between the two amounts. Because the premium is set for a person of average health, the premium differences among plans represent the relative efficiency of such plans as measured by their costs in relation to FFS. The premium differences do not reflect different levels of risk among the actual enrollees of the plan, as they do in medigap.[8]

Using standardization in a premium support system

Based on the experience in MA and other programs, we explore the rationale for standardizing several elements of a premium support system—the items and services that would be covered, beneficiary cost sharing, beneficiary premiums and plan payments, and the ability of managed care plans to offer additional benefits that are not covered by Medicare. There are arguments for using standardization in a particular way to address these elements.

Covered items and services

The MA and Part D programs both feature a standardized package of benefits. In MA, the plan bids that determine whether plans must charge an additional premium for Part A and Part B coverage (beyond the standard Part B premium) are based on the cost of providing the FFS benefit package. In Part D, plan bids that determine the national average premium are based on the cost of providing a basic benefit that is specified in statute. In either program—or in a premium support system—if benefits were not standardized, one plan could have a relatively lower bid than another plan simply because the lower priced plan provides less generous coverage. The standardization of benefits also guards against strategies to achieve favorable selection through benefit design.

A premium support system relies on the establishment of a reference point that can be used to compare bids for the purpose of setting the government contribution. In a premium support system where the FFS program functions as a competing plan, the FFS benefit package could serve as the reference point—that is, the standard benefit package—as is the case now for MA plans. The FFS benefit is uniform across the country and should not be modified in different market areas, particularly if the FFS program is the only coverage option available in some areas (a situation that can change, in any area, from year to year). In addition, the FFS program is used (for now) to establish the expected cost of a beneficiary with average health and thus serves as the foundation for the current risk adjustment system.

Ideally, the FFS benefit package that would exist under a premium support system would have a design different from the current package. The Commission has recommended several changes to the FFS benefit package, such as adding an annual limit on beneficiary out-of-pocket spending and using copayments rather

The Commission's recommendations to modernize the FFS benefit package

In its June 2012 report to the Congress, the Commission considered ways to reform the traditional benefit package with two main goals: (1) to give beneficiaries better protection against high out-of-pocket (OOP) spending and (2) to create incentives for them to make better decisions about their use of discretionary care (Medicare Payment Advisory Commission 2012a). The current fee-for-service (FFS) benefit design includes a relatively high deductible for inpatient stays, a relatively low deductible for physician and outpatient care, and a cost-sharing requirement of 20 percent of allowable charges for most physician care and outpatient services. Under this design, no upper limit exists on the amount of Medicare cost-sharing expenses a beneficiary can incur. Without additional coverage, the FFS benefit design exposes Medicare beneficiaries to substantial financial risk. In part because the FFS benefit design is not comprehensive, almost 90 percent of FFS beneficiaries receive supplemental coverage through medigap, employer-sponsored retiree plans, or Medicaid. This additional coverage addresses beneficiaries' concerns about the uncertainty of OOP spending under the FFS benefit. However, it also reduces incentives for beneficiaries to weigh their decisions about the use of care. As currently structured, many supplemental plans cover all or nearly all of Medicare's cost-sharing requirements, regardless of whether there is evidence that the service is ineffective or, conversely, whether it might prevent a hospitalization. Moreover, most of the costs of increased utilization are borne by the Medicare program.

In the 2012 report, the Commission included a recommendation on the redesign of the FFS benefit package. A primary goal of the recommendation is to protect beneficiaries against high OOP spending, thus enhancing the overall value of the FFS benefit and mitigating the need for beneficiaries to purchase supplemental insurance. The recommendation creates clearer incentives for beneficiaries to make better decisions about their use of care while holding the aggregate beneficiary cost-sharing liability about the same as under current law. It also allows for ongoing adjustments and refinements in cost sharing as evidence of the value of services accumulates and evolves. Finally, by adding a charge on supplemental insurance, the recommendation aims to recoup at least some of the additional costs resulting from the higher service use encouraged through supplemental insurance while allowing risk-averse beneficiaries the option to buy supplemental coverage if they wish to do so.

Recommendation 1-1 from the Commission's June 2012 report to the Congress

The Congress should direct the Secretary to develop and implement a fee-for-service benefit design that would replace the current design and would include:

- **an out-of-pocket maximum;**
- **deductible(s) for Part A and Part B services;**
- **replacing coinsurance with copayments that may vary by type of service and provider;**
- **secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services, including cost sharing after the beneficiary has reached the out-of-pocket maximum;**
- **no change in beneficiaries' aggregate cost-sharing liability; and**
- **an additional charge on supplemental insurance.** ■

than coinsurance for some services, which would make the FFS benefit more like the typical MA plan's benefit package. The Commission has also recommended imposing an additional charge on supplemental coverage because it leads to higher utilization and higher program expenditures (see text box) (Medicare Payment Advisory Commission 2012a). The combination of the annual limit on out-of-pocket spending and the additional charge would likely reduce the number of beneficiaries who buy medigap coverage.

Beneficiary cost sharing

The rationale for standardizing cost sharing is similar to the argument for standardizing covered items and services. In the MA program, standardization of Medicare cost sharing—and specifying that it is equivalent to the cost sharing in the FFS program (either exactly equivalent or actuarially equivalent)—maintains comparability between MA plans and FFS and comparability in pricing among MA plans. The Part A and Part B benefit package includes specific levels of cost sharing that Medicare does not cover and for which beneficiaries are liable. A managed care plan cannot incorporate a lower level of cost sharing into its bid in order to increase the government contribution, and neither can a plan impose higher cost sharing—reducing the plan's stated costs for the Part A and Part B benefit package—so that its bid appears lower than it should be.

Although plans can use the actuarial value of FFS cost sharing to establish a standardized bid, CMS has rules that limit cost sharing for some categories of services. These limits are service specific and aim to prevent plans from using cost sharing to discourage the enrollment of sicker beneficiaries. Some limits were enacted in statute (such as those for chemotherapy administration services, renal dialysis services, and care in a skilled nursing facility) and the Secretary has the authority to identify additional services for which the cost sharing "shall not exceed the cost-sharing required for those services under parts A and B" (Section 1852(a)(1)(B)(iv) of the Social Security Act). For example, the cost sharing for Part B drugs may not exceed the 20 percent coinsurance used in the FFS program. In the advance notice of MA rates and call letter for 2018, CMS stated that it may impose additional standards for cost sharing (Centers for Medicare & Medicaid Services 2017). One area of concern is inpatient mental health, where cost-sharing levels in some MA plans appear to far exceed FFS levels. Such oversight of plans' cost-sharing structures may need to continue in a premium support system, as would the general MA rule that allows CMS to reject plan benefit designs that are discriminatory.

Permitting plans to meet the requirement through an actuarial equivalence standard gives plans great flexibility in benefit design so that cost sharing can be a tool used to promote effective care. Another cost-sharing feature that CMS is testing—value-based insurance design (VBID)—could be accommodated in a model that standardizes cost sharing based on actuarial equivalence. Under VBID, reduced cost sharing is used to promote use of certain services that improve care and increased cost sharing is used to reduce the use of low-value care. Differences in cost-sharing amounts could also target beneficiaries with specific diseases—for example, by eliminating copayments for primary care physician visits for diabetics.[9]

Beneficiary premiums and plan payments

If bids are not standardized to reflect the cost of a beneficiary of average health, the bid of an inefficient plan could be lower than the bid of a much more efficient plan only because the former could have the advantage of favorable selection—that is, it would attract healthier enrollees. Allowing premiums to vary based on differences in health status is inconsistent with the notion of using premium support to establish a "best price" determined through competition on a level playing field. If bids and premiums are not standardized, the system would have the premium variation seen in medigap.

Requiring all plans to market a basic package

In Part D, the most popular plans are those with enhanced benefits such as reduced deductibles, but all plan sponsors that wish to offer an enhanced package must also offer the standard benefit (or an actuarially equivalent design). A beneficiary can compare the price and other features of the standard and enhanced options in choosing between the two.

Unlike Part D, MA plans are not obligated to offer a benefit package that consists only of the Part A and Part B benefit package. Instead, a plan can include non-Medicare-covered benefits in its package and require enrollees to pay for the cost of such benefits through a premium. These additional benefits are known as "mandatory supplemental benefits," and they originated in the early use of private plans in Medicare, when the only organizations permitted to have Medicare contracts were HMOs and HMO-like entities that, by definition, included preventive benefits as covered benefits. Medicare did not originally cover preventive benefits, and HMOs were allowed to cover them using premium revenue from plan members. In the current MA program, plans that feature mandatory supplemental benefits must be designed in a way that does not discourage the enrollment of certain beneficiaries (for example, low-income beneficiaries who cannot afford a high premium).

There are a number of reasons for requiring plans to bid on and offer a basic benefit under premium support. This approach would help ensure that plan bids provide true estimates of the cost of providing the standard benefit and

TABLE 3–2 **Illustrative example of the impact of induced utilization on plan costs**

	Total visits	Total copays	Total allowed amount ($200 per visit)	Plan cost	Additional plan cost	Plan cost due to lower copay	Plan cost due to induced utilization
Scenario 1: $40 copayment for physician visits	1	$40	$200	$160			
Scenario 2: $20 copayment without induced utilization	1	$20	$200	$180	$20 ($180 – $160)	$20	$0
Scenario 3: $20 copayment with induced utilization	2	$40	$400	$360	$200 ($360 – $160)	$40 ($2 × $20)	$160 ($200 – $40)

would make it easier to set the government contribution and beneficiary premiums. From a beneficiary point of view, this approach would facilitate comparison among coverage options and is consistent with the concept that plans should have some flexibility in benefit design so that their offerings can meet the needs of beneficiaries looking for different benefits. There are beneficiaries who may not want any extra benefits and would be satisfied with paying a lower premium and paying for other services out of pocket.

Dowd and colleagues point out how, if plans were not required to offer a standard package, they could manipulate the bidding system to influence the determination of the government contribution through the pricing of supplemental benefits (Coulam et al. 2013, Dowd et al. 1996). The exact strategy that a company would use depends on the manner in which the government contribution is set. However, Burke and colleagues note that the manipulation of the basic bid is illegal and is something that CMS guards against when it reviews MA bids (Burke et al. 2013). We would expect a premium support system to have a bid review process that is similar to, or perhaps more intensive than, the review process for the MA program so that CMS would continue to guard against manipulation of bids. In addition, the strategy of having a product with a higher basic bid to increase the government contribution may not be feasible in a market that is highly competitive and plans are offering options that consist only of the basic plan.

In sum, then, leaving aside the issue of possible manipulation of bids, a premium support system that requires plans to offer a standardized basic package that is directly comparable with FFS would:

- help beneficiaries determine the cost of a given plan;
- help address selection bias (because supplemental benefits can be designed to attract healthier beneficiaries);
- simplify the determination of the government contribution; and
- simplify CMS oversight of the bidding process.

As a result, under premium support, each managed care plan could be required to offer an option that beneficiaries can directly compare with the FFS program.

Allowing plans to offer additional benefits

A "pure" version of premium support could require all differences among plans to be expressed in terms of their premiums, with the least expensive plans potentially offering cash rebates. Beneficiaries who wanted extra benefits not covered in Medicare's standard benefit package—such as hearing aids and routine eyeglasses—

would pay for them out of pocket. However, the practice in both MA and Part D has been to allow plans to offer multiple benefit packages that can involve the payment of an additional premium. Requiring plan sponsors to bid on, and offer, a basic package would not preclude them from offering additional benefits that beneficiaries could purchase to enhance their insurance coverage.

An important difference exists between MA and Part D in how premiums for additional benefits are determined. If policymakers decide to use premium support, the Part D approach, in which the costs of induced demand (greater service use) are included in the premium for additional benefits, could be more appropriate in a premium support system. Table 3-2 illustrates the problem with the approach used in the MA program.

In Scenario 1, a plan's benefit package has a $40 copayment for physician visits; in Scenario 2, a plan's benefit package is the same as the first plan but has a $20 copayment for physician visits. If this difference prompted a beneficiary to have two visits rather than one (Scenario 3), the second plan would need additional revenue to pay for both the difference between the $40 and $20 copayments and the cost of the additional visit. A $200 office visit with a $40 copayment would entail a $160 cost to the plan, while two $200 visits with a $20 copayment would entail a cost of $180 per visit for the plan, or $360 in total. With the lower copayment, the plan's revenue would have to increase by $200 to cover its additional costs (the difference between Scenario 3's $360 and Scenario 1's cost of $160). The induced utilization accounts for most of the additional cost ($160 of the $200). The MA program allows plans to include the entire $360 cost of the physician services in their bid for the basic Part A and Part B benefit, in effect raising program costs for taxpayers and all beneficiaries, who pay higher Part B premiums because of the higher program costs. If MA rules did not permit induced utilization to be considered part of the basic benefit (as is the case in Part D), the additional cost of $160 from induced utilization would have to be financed through beneficiary premiums.[10]

This approach would be similar to the Commission's recommendation to impose an additional charge on supplemental coverage such as medigap in recognition of the higher Medicare program costs that occur when beneficiaries who pay little or no cost sharing use more services (see text box, p. 90) (Medicare Payment Advisory Commission 2012a).[11]

Currently in MA, supplemental benefits can take the form of reduced cost sharing for Part A and Part B benefits, additional benefits that Medicare does not cover, or a combination of the two. None of these supplemental benefits are standardized. Given the experience with medigap plans, policymakers may want to consider standardizing supplemental benefits in some fashion in a premium support system (although the need for standardization would be somewhat lessened if all plans were required to offer a standard Part A and Part B benefit package). For example, the coverage of hearing aids by MA plans varies widely. A total of 2,400 MA plans covered hearing aids in 2016, but among those plans there were 123 unique variations of hearing aid coverage—by in-network or out-of-network providers; by type of hearing aid; by type of cost sharing (copayments or coinsurance); and, most commonly, by a dollar limit on the amount of coverage. However, in considering whether and how to standardize additional benefits, policymakers would need to weigh the benefits of making it easier for beneficiaries to understand their coverage options against the benefits of allowing plans to have innovative benefit designs and provide a greater range of coverage options.

Other issues related to standardization

Several issues related to standardization deserve mention: program features that would not be standardized under premium support, the importance of giving beneficiaries adequate decision support tools, the potential need for other reforms in the medigap market, and the possible need to limit the number of available managed care plans.

Under premium support, not all features would need to be standardized

We have emphasized the importance, for premium support, of standardizing the benefit package and standardizing risk for bidding purposes. It is equally important to be clear about the flexibility plans would have under this approach with respect to cost sharing and plan offerings. For cost sharing, an actuarial value standard—rather than an item-by-item set of cost-sharing parameters—gives plans latitude in designing their cost-sharing structures and facilitates their ability to develop value-based insurance designs or use different levels of cost sharing to encourage the use of preferred providers. Nevertheless, an actuarial value standard means that variation would continue to exist among plans, and beneficiaries would have to be able to understand and evaluate those differences. Requiring insurers to offer a plan that covers only the standard package of FFS benefits would help beneficiaries in their

decision making, but there could still be a wide range of varying cost-sharing structures.

Decision support tools for beneficiaries

To facilitate beneficiaries' evaluation of plans' various cost-sharing structures in a premium support system, beneficiaries would need access to decision support tools. The Health Plan Finder tool of the Medicare.gov website has a number of features to assist beneficiaries in understanding differences among plans. One such feature is the out-of-pocket cost calculator that determines how much these costs are for beneficiaries with different levels of health (poor, fair, and excellent) and/or three different diseases (diabetes, congestive heart failure, heart attack), based on a plan's premiums and cost-sharing structure. Such a tool would continue to be necessary in a premium support system that uses an actuarial value standard instead of specific, service-by-service cost-sharing parameters. In past work, we noted that the manner in which premiums are displayed through the Health Plan Finder could be more transparent so that beneficiaries can see all premiums displayed—the Part B premium and plan premiums for Part C and Part D (Medicare Payment Advisory Commission 2015b).

A plan's provider network is important to beneficiaries. Although CMS has undertaken efforts to make it easier for beneficiaries to know which providers are in a plan's network, more work is needed to convey accurate information on provider participation and whether providers are accepting new patients. In this regard, the tools available to facilitate choice in MA and Part D (such as Medicare Plan Finder) could be improved. The Commission has also recommended additional funding for the State Health Insurance Assistance Programs (SHIPs) that provide one-on-one counseling to Medicare beneficiaries (Medicare Payment Advisory Commission 2008a).

Possible reforms in the medigap market

Currently, an MA plan may change its provider network from year to year, which can result in enrollees losing the ability to see the providers they typically use. While beneficiaries can freely move among MA plans during the annual election period, MA enrollees who are interested in switching to the FFS program (and buying medigap coverage to go with it) may not be able to find an affordable medigap policy because there is a limited one-time open enrollment period for most beneficiaries to buy medigap coverage. This feature restricts beneficiaries' freedom of movement between FFS and MA and makes the playing field between the two sectors uneven. However, making it easier to obtain medigap coverage could result in greater service use and result in higher program costs, particularly if no additional charge were imposed on supplemental premiums or the additional charge did not fully offset the additional program costs. Allowing beneficiaries to move from managed care plans to the FFS program and obtain medigap coverage without allowing medigap insurers to underwrite prospective new subscribers would also likely raise medigap premiums, particularly if the beneficiaries switching to FFS were high-need, high-cost beneficiaries.

Limiting the number of plans that are offered

In both MA and Part D, CMS will not approve an insurer's plans in a given market unless there are "meaningful differences" between them. Insurers that wish to offer multiple plans in a service area "must guarantee the plans are substantially different so that beneficiaries can easily identify the differences between those plans in order to determine which plan provides the highest value at the lowest cost to address their needs" (Centers for Medicare & Medicaid Services 2017). In MA, plans do not meet this requirement if the difference between plans in their expected out-of-pocket costs is less than $20 per member per month. Such a policy would be consistent with the design of a premium support system. For example, when the Congressional Budget Office (CBO) examined premium support, it outlined an illustrative option that had a high degree of standardization of benefits and cost sharing. CBO suggested that companies be limited to offering a maximum of four plans in a market: up to two basic plans that cover the basic Part A and Part B benefits (but which could differ based on their provider networks, for example), and one "package of enhanced benefits (with a single fixed higher actuarial value that would be the same for all insurers) to go along with each basic package offered. Enrollees would pay the full additional cost of the enhanced packages through higher premiums. Under such rules regarding packages with enhanced benefits, beneficiaries would find it easier to compare plans, and thus competition would be heightened" (Congressional Budget Office 2013).

Policymakers could also consider limiting the number of plans by disqualifying plans that submit especially high bids. This option would improve competition by giving plans an added incentive to submit the lowest possible bids. However, such an approach may not be feasible in markets where the number of companies offering Medicare plans is limited. In addition, plans could respond by submitting

TABLE 3-3 **Summary rationale for standardizing some features of a premium support system**

Program feature	Rationale for using standardization
1. Covered items and services are standardized.	Standardization of these items facilitates beneficiary decision making, with clear price signals about relative premium costs and delineation of what is covered. It ensures a level playing field among bidding plans, one of which (the fee-for-service program) is standardized in each market area. Plans can neither offer lower bids by reducing benefits or increasing cost sharing nor offer a higher bid because of reduced cost sharing or enhancement of benefits.
2. Cost sharing is standardized.	Standardized cost sharing also ensures a level playing field for bidding purposes. A standard plan can have actuarially equivalent cost sharing, as is the case under current rules for Medicare Advantage and Part D. Such a policy maintains the comparability of bids but gives plans flexibility in designing cost-sharing rules that can promote more effective care. For beneficiaries, standardized cost sharing will mean that all standard plans will have the same level of cost sharing, on an actuarial basis.
3. Enrollee risk for bidding and payment purposes is standardized.	Standardization of this feature ensures a level playing field among plans by identifying the most efficient plans. Setting premiums based on the cost for a beneficiary of average health will provide the right price signal for beneficiaries by identifying which plans are the most efficient. (Some redistribution of funds across plans may be necessary.)
4. All plans bid on, and offer, a standard package.	The use of a standard bid would make it easier to determine the government contribution and would simplify program administration. Requiring plans to offer a standard package would enhance beneficiary choice by offering a private plan that is directly comparable with the fee-for-service program.
5. (a) Enhanced benefit packages are permitted, but (b) beneficiaries bear the full cost of induced utilization beyond the utilization level of basic coverage.	The first element continues current Medicare Advantage policy, but the second element is patterned after Part D, where induced utilization is not financed by the government. The second element is also consistent with the Commission's recommendation to impose an additional charge on fee-for-service beneficiaries who have supplemental coverage.
6. Number of plans that an insurer can offer is limited.	The Medicare Advantage program limits the number of plan offerings by requiring them to have meaningful differences. Such a policy helps beneficiaries understand differences among plans, but plans should also have flexibility in designing innovative benefit packages.

bids that were too low initially with an intent to gain market share that could be retained in future years with higher bids. Moreover, if plans were disqualified for high bids in a given market, the plans could be unavailable to bid in that market in future years, which could reduce the overall level of competition in the long run.

Summary of the rationale for standardizing some features of a premium support system

Table 3-3 lists the same features of a premium support system that we used in Table 3-1 (p. 87) and summarizes the rationale for using standardization.

Determining benchmarks and beneficiary premiums

A key issue in developing a premium support system in Medicare is the method for determining the government's contribution toward each beneficiary's coverage. Under premium support, the government would first establish a benchmark that would serve as a reference point for the cost of providing the standard Medicare benefit package. This benchmark would consist of two components: the Medicare contribution and a base beneficiary premium. The Medicare contribution would remain the same,

regardless of whether beneficiaries received their Medicare benefits through the FFS program or a managed care plan.[12] In contrast, the premiums paid by beneficiaries would vary across plans and would equal the base beneficiary premium plus any difference between the benchmark and the plan's cost of providing the Medicare benefit package.

In a premium support environment, there are arguments for using competitive bidding to determine the benchmark. Under this approach, the FFS program and managed care plans would each submit bids that indicate the revenue needed to provide the Medicare benefit package, and bidding would be conducted using geographic areas that reflect local health care markets. The government could determine the benchmark in a variety of ways. We believe that two methods for determining the benchmark could have merit: (1) comparing the FFS bid with a representative measure of the bids from among the area's managed care plans and using the lower of the two as the benchmark or (2) using the enrollment-weighted average of all plan bids. Under either method, using local health care markets as bidding areas would result in benchmarks that vary across areas because of the regional variation in health care service use and spending.

Once an area's benchmark had been established, the base beneficiary premium could be a standard dollar amount that is determined nationally and is the same in every area, like the current Part B premium. Under an alternate approach, the base beneficiary premium could equal a standard percentage of the benchmark, which would result in base beneficiary premiums that vary from area to area. Under either approach, the beneficiary premium for any given plan could be higher or lower than the base beneficiary premium, depending on how the plan's bid compared with the benchmark. Regardless of how the base beneficiary premium is set, the Medicare contribution under this approach (like the benchmarks) would also vary from area to area, but would be the same for every plan within a given area.

Establishing the benchmark

Medicare could set the benchmark by using competitive bidding or some form of administered pricing. With competitive bidding, the government would collect bids from managed care plans—and prepare an FFS bid—and use those bids to determine the benchmark. Medicare follows this approach in the Part D program, where stand-alone prescription drug plans and MA plans that have drug coverage (there is no FFS program in Part D) submit bids that indicate the cost of providing drug coverage. CMS uses the bids to calculate the national average bid and uses that average to determine the base beneficiary premium and the Medicare contribution. With administered pricing, Medicare would set the benchmark using a formula that relies on certain historical data, such as FFS spending. Medicare uses this approach in the MA program, where CMS determines beneficiary premiums and plan payment rates by comparing plan bids with benchmarks that are based on historical FFS spending projected forward.

There are arguments to support using competitive bidding to establish the benchmark under a premium support system. Since the primary benefit of a premium support system would be to give beneficiaries an incentive to consider the difference in the cost of the FFS program and managed care plans, collecting accurate information about the relative "price" of the Medicare benefit package in the two sectors (i.e., FFS vs. managed care) would be essential. Under competitive bidding, the price of the benefit package would become evident through plan bids. Since we assume the bidding would be conducted annually, as in the MA program, the information provided by the bids would be updated regularly to account for changes in service use.

Policymakers would also need to decide whether the bidding process should be conducted nationally or using smaller geographic areas. The MA program uses geographic areas that are composed of individual counties or one or more states, while the Part D program conducts some bidding at the national level and some bidding using regions composed of one or more states.[13] The Commission has previously recommended that the MA program switch from its county-level system to a set of larger areas that better reflect local health care markets (Medicare Payment Advisory Commission 2005). Under this approach, urban counties would be grouped into a market area if they were located in the same state and the same core-based statistical area; rural counties would be grouped into a market area if they were located in the same state and the same health service area as defined by the National Center for Health Statistics (Medicare Payment Advisory Commission 2016b). This method would produce 1,231 market areas in the 50 states and the District of Columbia. These geographic areas could also work in a premium support system.

Once the bidding areas were defined, health care insurers would decide which areas they would serve and would submit a bid for each plan offered in a particular area.

TABLE 3–4 **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 (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 to make it comparable with MA plan bids. For comparison, FFS spending has been 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 and MA enrollees included 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 is due to enrollment in MA plans that we excluded from our analysis, such as employer group plans and special needs plans.

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

As part of the bidding process, plans would be required to serve the entire area and accept all beneficiaries who wished to enroll.[14] Each bid would indicate the monthly amount of revenue that plan required to provide the standard package of Medicare benefits and would include the plan's administrative costs and any profits. Since the FFS program would be treated as a competing plan under a premium support system, CMS would also prepare a "bid" for each area's FFS enrollees.

The experience of the MA program suggests that the number of managed care plans would vary considerably across areas (Table 3-4). We used MA plan bids for 2016 and the market areas defined above to determine how many MA plans are currently available in each area. We counted only MA plans that met three criteria: (1) the plan was available to at least half of the area's beneficiaries (making it more likely that the plan would be willing to serve the entire area under premium support); (2) the plan was open to all beneficiaries (which excluded special needs plans and employer-sponsored plans that, by definition, are available only to certain beneficiary groups); and (3) the plan had at least 100 enrollees. Under these criteria, more than 90 percent of beneficiaries had at least 3 eligible MA plans available in their areas, and more than 25 percent had more than 20 MA plans available. The areas with many plans tended to have higher FFS spending, on average, than the areas with fewer plans. These figures should be viewed only as an approximation; a premium support system would differ from the MA program in numerous respects, and an area's number of available plans could be higher or lower than it is now.

The bids from managed care plans and the FFS program could vary for two reasons—differences in the underlying efficiency of each plan (i.e., its ability to deliver the standard package of benefits at a lower cost) and differences in the health of the beneficiaries enrolled in each plan. Greater efficiency and healthier enrollees would each tend to lower a plan's bid; lower efficiency and sicker enrollees would each tend to increase a plan's bid. Consistent with the goal of giving beneficiaries an incentive to enroll in more efficient plans, any differences among an area's plans in beneficiary premiums would need to be based only on differences in the underlying efficiency of the plans. CMS would thus need to standardize all bids so that they represented the cost of serving a beneficiary of average health status, which would eliminate any variation in plans' bids that reflected differences in the health status of their respective enrollees. CMS makes similar adjustments to plan bids in MA and Part D using a combination of demographic and diagnostic information.

Once the bids were standardized, the government would establish each area's benchmark. The method used to establish the benchmark would be very important because

the benchmark is the basis for determining both the Medicare contribution and the base beneficiary premium. Relatively speaking, a method that produced higher benchmarks would result in higher Medicare contributions and higher overall Medicare spending than a method that produced lower benchmarks. Higher benchmarks would also mean lower beneficiary premiums: Because the Medicare contribution would be higher, the difference between a plan's bid and the Medicare contribution (i.e., the beneficiary premium) would be smaller than it would be using lower benchmarks.

There may be arguments for establishing the benchmark using one of two methods. The first method would compare the FFS bid with a representative measure of the bids from managed care plans and use the lower of the two as the benchmark. We used this method to develop many of this chapter's illustrative examples, with the median bid serving as the representative measure of plan bids. The second method would set the benchmark equal to the enrollment-weighted average of all bids (both FFS and managed care plans). The latter approach would be similar to the method that Part D uses to calculate its benchmark, although that program does not have an FFS component.

Both methods are appealing because they would produce benchmarks that fall somewhere in the middle of the distribution of bids. In particular, they would avoid setting the benchmark equal to one of the lower bids.[15] Although policymakers could set the benchmark equal to one of the lower bids (this method would save the government more money), such an approach could have some undesirable effects. First, the resulting benchmarks would be less generous, which means that beneficiary premiums would be correspondingly higher and more extensive measures might be needed to mitigate undesirable consequences for beneficiaries. Second, the lower bids might be unrealistically low (for example, if the plans submitting them are entering new market areas and bid low in an effort to gain enrollment), which could result in larger changes in premiums (up or down) from year to year.

Policymakers would need to consider several factors in deciding whether to use the lower-of method or the weighted-average method. First, the lower-of method would result in lower benchmarks in most market areas and thus generate more program savings. In our earlier work on premium support, we compared MA plan bids with FFS costs using the urban and rural market areas previously described, and we found that while MA plans were the lower cost option in many areas, the FFS program was the lower cost option in other areas (Medicare Payment Advisory Commission 2015a). Consistent with this finding, the lower-of method would base the benchmark on the lower cost delivery system in each area. Under this approach, benchmarks would always be equal to or lower than the FFS bid but could never be higher. In contrast, the weighted-average approach would use all bids to calculate the benchmark (not just the bids from the lower cost delivery system), resulting in higher benchmarks that could conceivably exceed the FFS bid in some areas.

Another factor to consider would be a market area's overall level of managed care penetration. Under the lower-of approach, an area's benchmark could be based on a plan's bid even if the penetration rate was very low (for example, 5 percent). This approach would result in higher premiums for FFS enrollees and give them an incentive to switch to a managed care plan, but it could also raise concerns about the plan's capacity to handle a substantial increase in enrollment. By comparison, under the weighted-average method, the benchmark for an area with 5 percent penetration would also be lower than the FFS bid, but the difference between the benchmark and the FFS bid would be relatively small because almost all of the area's beneficiaries (95 percent) would be enrolled in FFS. To address this concern, the use of competitive bidding between the FFS program and managed care plans could be limited to markets with a minimum level of managed care penetration.

Under the lower-of method, policymakers would also need to decide what to use as a "representative measure" of the bids from an area's managed care plans. Policymakers would have a number of options, such as the lowest bid, median bid, or average bid. Using the lowest bid instead of a higher figure, such as the median or average bid, would make it more likely that benchmarks would be based on managed care plan bids rather than the FFS bid. To demonstrate this point, we compared the MA plan bids that we analyzed in Table 3-4 (p. 97) with each area's FFS costs, which we used as a proxy for an FFS bid (Table 3-5). We compared FFS costs with the lowest MA bid in each area and found that FFS costs were lower in 473 of the 1,231 areas (38 percent), although the areas where FFS costs were lower had a relatively small number of Medicare beneficiaries (6.1 million, or 11 percent of the total). However, the use of the lowest bid could have some undesirable effects, as discussed earlier. Compared with either the median or average MA bid, FFS costs

TABLE 3–5

Comparison of local FFS costs and MA plan bids, 2016

	Number of areas where:		Millions of beneficiaries living in areas where:	
	FFS is lower	MA is lower	FFS is lower	MA is lower
Compare local FFS costs to ***lowest*** MA bid in area	473	758	6.1	48.4
Share of total	38%	62%	11%	89%
Compare local FFS costs to ***median*** MA bid in area	739	492	18.0	36.5
Share of total	60%	40%	33%	67%
Compare local FFS costs to ***average*** MA bid in area	722	509	18.0	36.5
Share of total	59%	41%	33%	67%

Note: FFS (fee-for-service), MA (Medicare Advantage). For this analysis, we excluded hospice, direct graduate medical education, and indirect medical education payments from FFS costs to make them comparable with MA plan bids. FFS costs and MA plan bids have both been standardized for a beneficiary of average health status. Areas consist of core-based statistical areas and health service areas in the 50 states and the District of Columbia. Number of Medicare beneficiaries are as of January 2016. Some areas did not have any eligible MA plan bids in our analysis because either (1) no MA plans were available in those areas or (2) we excluded all of the available MA plans based on the criteria we used for our analysis. The areas without any eligible MA plan bids are included in the "FFS is lower" columns.

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

were lower in about 60 percent of all areas, and those areas accounted for about 33 percent of beneficiaries.[16] Under any of these scenarios, a substantial majority of beneficiaries—two-thirds or more—would live in areas where benchmarks under a premium support system would likely be based on the bids submitted by managed care plans.

Under either method, policymakers would need to decide whether all plan bids would be used in the benchmark calculation. The MA and Part D programs do not restrict the number of entities that can sponsor plans as long as each entity meets the program's requirements to participate, but there are some limits on the number of plans that an individual sponsor can offer. Furthermore, Part D uses all plan bids to calculate its national average bid. Under premium support, CMS could follow similar policies or use a two-step process in which the agency would first disqualify some higher bidding plans from participating in a market area and then calculate benchmarks using the remaining bids. This two-step process could encourage plans to submit lower bids, given the size and importance of the Medicare market. However, it could also cause greater disruption for beneficiaries (who would need to find new coverage if they were in a plan that became ineligible to participate in Medicare) and might reduce the number of competing plans if sponsors that lose access to a market have difficulty maintaining or re-establishing their presence in the market for later rounds of bidding.

Establishing the base beneficiary premium and the Medicare contribution

Once the area benchmarks had been determined, their constituent pieces—the base beneficiary premium and the Medicare contribution—could be calculated. This calculation can be done in one of two ways: establish the base beneficiary premium first and let the remainder be the Medicare contribution or establish the Medicare contribution first and let the remainder be the base beneficiary premium.

The base beneficiary premium, if established first, could equal either a standard dollar amount or a standard percentage of the benchmark. For the standard dollar amount method, CMS would calculate a standard premium that would be the same for all areas. For example, the standard premium could equal 25 percent of the national average per beneficiary cost of Part B benefits to maintain some similarity between the base beneficiary premium and

the current Part B premium. Given the expected variation in benchmarks across areas, the use of a standard dollar amount means that the base beneficiary premium would equal a higher percentage of the benchmark in some areas compared with others. For example, if the benchmark were $900 in one area and $1,000 in another area, a standard premium of $125 per month would equal 13.9 percent of the benchmark in the first area and 12.5 percent of the benchmark in the second area.

If a standard percentage of the benchmark were used to calculate each area's base beneficiary premium, areas with low benchmarks would have lower base premiums than those with higher benchmarks. For example, the base beneficiary premium could equal 13.5 percent of the benchmark (since Part B premiums currently equal about 13.5 percent of total Part A and Part B spending). Under our contrasting hypothetical areas, this approach would produce a base beneficiary premium of $121.50 in the first area compared with $135 in the second area.

Once the base beneficiary premium had been set, each area's Medicare contribution would be the difference between the benchmark and the base beneficiary premium. Using bidding areas that reflect local health care markets would necessarily result in benchmarks that vary across areas, as would the Medicare contribution, regardless of whether the base beneficiary premium was set at a standard dollar amount or a standard percentage. In our hypothetical example, if the base beneficiary premium in both areas were set at $125, the Medicare contribution would be $775 in the first area and $875 in the second area. If the base beneficiary premium were set at 13.5 percent of the benchmark, the Medicare contribution would be $778.50 in the first area and $865 in the second area.

If the Medicare contribution is established first, the same methods—the use of either a standard dollar amount or a standard percentage of the benchmark—could be used to make the calculation. Medicare's contribution and the distributional implications for different areas would be similar to those in the examples given for the base beneficiary premium.

In the debate over premium support, one issue is how the base beneficiary premium and Medicare contribution would grow over time compared with the benchmark. Under the Part D program, the base beneficiary premium and Medicare contribution are set at 25.5 percent and 74.5 percent of the national average bid, respectively, which means that they both grow at the same rate as the national average bid. In contrast, some premium support proposals would seek to reduce the growth in federal Medicare spending by limiting the annual growth of the Medicare contribution. This limit would usually not apply until sometime after the first year of premium support, with the initial values of the benchmarks based on historical spending or determined by a bidding process. The limit itself would typically be linked to the U.S. economy's growth rate, which historically has grown more slowly than health care spending or Medicare spending. As a result, if the benchmark grew more rapidly than this limit, growth in the Medicare contribution would be capped at a lower rate. The share of the benchmark that is financed by the Medicare contribution would thus decline over time in this scenario, and the difference would be made up by higher base beneficiary premiums.

This situation would be problematic because beneficiaries would bear the risk of paying higher premiums without being able to take actions that would lower premiums in a meaningful way (since the added growth in the base beneficiary premium would be a function of broader forces like the overall growth in Medicare spending and the growth in the national economy). An alternative approach would be to have the benchmark, Medicare contribution, and base beneficiary premium all grow in tandem with plan bids, as they do now in the Part D program, and see whether competition among managed care plans (driven by beneficiaries' interest in lower cost plans) could achieve sufficient savings.

Illustrative examples of the bidding process

The bidding process under a premium support system would be fairly complex, and two illustrative examples help demonstrate how the process would work (Table 3-6). In these examples, an area has a total of six bids—the FFS bid and five managed care plan bids. Each bid shows the cost of providing a standard package of benefits to a beneficiary of average health. The bids from the managed care plans are sorted from low (Plan A, with a monthly bid of $680) to high (Plan E, with a bid of $800). In these examples, we assume that the benchmark would be set at the lower of the FFS bid or the median managed care plan bid and that the standard base beneficiary premium would be $125 in every area. (Different assumptions could be made, depending on policy choices.)

In Table 3-6, Example 1 shows how premiums would be determined in an area where the FFS bid is $700, a relatively low amount. In this instance, CMS would compare the FFS bid with the median managed care plan

TABLE 3–6

Illustrative examples of how the benchmark, base beneficiary premium, and Medicare contribution could be determined under premium support

		Managed care plans				
	FFS program	Plan A	Plan B	Plan C (median plan bid)	Plan D	Plan E
Example 1: Benchmark equals the FFS bid						
Plan bid	$700	$680	$710	$740	$770	$800
Beneficiary premium						
Base beneficiary premium	$125	$125	$125	$125	$125	$125
Difference between plan bid and benchmark	$0	–$20	$10	$40	$70	$100
Total premium	$125	$105	$135	$165	$195	$225
Medicare contribution	$575	$575	$575	$575	$575	$575
Example 2: Benchmark equals the median of the managed care plan bids (Plan C)						
Plan bid	$800	$680	$710	$740	$770	$800
Beneficiary premium						
Base beneficiary premium	$125	$125	$125	$125	$125	$125
Difference between plan bid and benchmark	$60	–$60	–$30	$0	$30	$60
Total premium	$185	$65	$95	$125	$155	$185
Medicare contribution	$615	$615	$615	$615	$615	$615

Note: FFS (fee-for-service). These examples express all plan bids as per beneficiary per month amounts for a beneficiary of average health status. In these examples, the benchmark would equal the lower of the FFS bid or the median bid from the managed care plans, and there would be a standard base beneficiary premium of $125 in all bidding areas. The exact methods used to determine the benchmark and the base beneficiary premium are both policy choices.

bid—Plan C's bid of $740. Since the FFS bid is lower than the median plan bid, the area's benchmark would be set at $700. The area's base beneficiary premium would be the standard dollar amount of $125. The premiums for each plan in the area would equal the base beneficiary premium plus the difference between the plan's bid and the benchmark. Since the FFS bid is the benchmark, the premium for FFS coverage in this area would equal the base beneficiary premium of $125. The bid for Plan A would be $20 lower than the benchmark ($680 versus $700), so the premium for Plan A would also be $20 lower than the base beneficiary premium ($105 instead of $125). The bids for Plans B through E are higher than the benchmark, resulting in premiums that are higher than the base beneficiary premium, ranging from $135 to $225 per month. The Medicare contribution for all plans would be the difference between the benchmark and the base beneficiary premium, or $575, with any payments for beneficiaries who enroll in managed care plans adjusted to account for differences in health status.

Example 2 shows how premiums would be determined in an area where the managed care plan bids are the same as in the first example, but the FFS bid is $800 per month instead of $700. Since the FFS bid is higher than the median plan bid ($740 from Plan C), the area's benchmark would be $740. The area's base beneficiary premium in the area would be the standard dollar amount of $125, and the Medicare contribution would be $615 (the difference

between the benchmark of $740 and the base beneficiary premium of $125). The bids from Plan A and Plan B are lower than the benchmark, so their premiums would be lower than the base beneficiary premium. The bid for Plan C equals the benchmark, so its premium would equal the base beneficiary premium of $125. The bids for the FFS program, Plan D, and Plan E are higher than the benchmark, so their premiums would be higher than the base beneficiary premium.

Year-to-year changes in benchmarks and premiums

If benchmarks were determined through competitive bidding, some degree of volatility in benchmarks and beneficiary premiums would be expected because plan bids would inevitably change over time. The impact that changes in individual plan bids would have on benchmarks and beneficiary premiums would depend partly on the method used to determine benchmarks.

The simplified example in Table 3-7 illustrates the interplay between changes in plan bids and the method used to determine benchmarks. The table shows plan bids, benchmarks, and beneficiary premiums over a two-year period, using one of the illustrative markets that appears in Table 3-6 (p. 101) and similarly assuming that beneficiaries would pay a base premium of $125 plus the difference between the plan's bid and the benchmark. For simplicity, we assume that all plans submit the same bid in years 1 and 2, except for Plan C, which lowers its bid by $30 (from $740 to $710). A change of that magnitude is well within the range of annual changes seen in MA plan bids.

The table shows the outcome for a benchmark that equals the lower of the FFS bid or the median plan bid. In this market, FFS spending is relatively high, and the benchmark is based on the median plan bid (Plan C in both years). The change in Plan C's bid lowers the benchmark from $740 in year 1 to $710 in year 2. Because of the lower benchmark, premiums for the market's other plans increase by $30. The premium for Plan C does not change; that plan sets the benchmark in both years, so its premium remains the base amount of $125. In this scenario, the government reaps the benefits of the lower bid, which reduces the government contribution by $30.

The table also shows the outcome for a benchmark that equals the enrollment-weighted average of all bids. We assume that half of the beneficiaries in this market are in the FFS program and the rest are divided equally among the five managed care plans. Here the change in Plan C's bid lowers the benchmark from $770 in year 1 to $767 in year 2. The $3 decrease is much smaller than the $30 decrease under the lower-of method because Plan C represents only 10 percent of total enrollment. The lower benchmark means that premiums for the market's other plans increase by $3. In contrast, the premium for Plan C decreases by $27—the net effect of the $30 decrease in the plan's bid and the $3 decrease in the benchmark. In this scenario, the government benefits less from the lower bid, and more of the gains go to Plan C's enrollees in the form of lower premiums. The table's examples show that a weighted-average method would likely produce more stable benchmarks and beneficiary premiums than a lower-of method, but at the expense of higher program spending.

Premium support and regional variation in Medicare spending

It is well known that Medicare spending varies significantly across the country. For example, in 2014, FFS spending per beneficiary on Part A and Part B benefits ranged from an average of $14,930 in Miami to $6,670 in Grand Junction, CO (Centers for Medicare & Medicaid Services 2016b).[17] This variation stems from regional differences in payment rates, beneficiaries' health status, and service use. The Commission has found that differences in service use accounts for about half of the overall variation in spending (Medicare Payment Advisory Commission 2011b). Researchers do not agree about the underlying cause of the variation in service use; some attribute the variation primarily to differences in provider practice patterns, while others find that variation is largely driven by differences in beneficiaries' health status (Cassidy 2014). MA plan bids also tend to be higher in areas with high FFS spending, even after bids have been risk adjusted to account for differences in beneficiaries' health status. However, there is less regional variation in MA plan bids than in FFS spending (Medicare Payment Advisory Commission 2013a).

As a general proposition, a premium support system would likely reduce the regional variation in spending to some degree. Figure 3-2 (p. 104) shows how plan bids and FFS spending compare across the counties in the four spending quartiles that are currently used to calculate MA benchmarks. MA plan bids tend to be relatively close to FFS costs in areas with low FFS spending (the median bid in the lowest spending quartile equals 106 percent of FFS costs, on average). However, MA plan bids are often much lower than FFS costs in areas with high FFS

TABLE 3–7

Illustrative examples of how benchmarks and beneficiary premiums could vary over time under premium support

		Managed care plans				
	FFS program	Plan A	Plan B	Plan C (median plan bid)	Plan D	Plan E
Distribution of enrollment	50%	10%	10%	10%	10%	10%
Benchmark equals lower of FFS bid or median plan bid						
Year 1:						
Plan bids (benchmark = $740)	$800	$680	$710	$740	$770	$800
Beneficiary premiums	$185	$65	$95	$125	$155	$185
Year 2:						
Plan bids (benchmark = $710)	$800	$680	$710	$710	$770	$800
Beneficiary premiums	$215	$95	$125	$125	$185	$215
Change from year 1 to year 2:						
Plan bids	$0	$0	$0	–$30	$0	$0
Beneficiary premiums	$30	$30	$30	$0	$30	$30
Benchmark equals enrollment-weighted average of all bids						
Year 1:						
Plan bids (benchmark = $770)	$800	$680	$710	$740	$770	$800
Beneficiary premiums	$155	$35	$65	$95	$125	$155
Year 2:						
Plan bids (benchmark = $767)	$800	$680	$710	$710	$770	$800
Beneficiary premiums	$158	$38	$68	$68	$128	$158
Change from year 1 to year 2:						
Plan bids	$0	$0	$0	–$30	$0	$0
Beneficiary premiums	$3	$3	$3	–$27	$3	$3

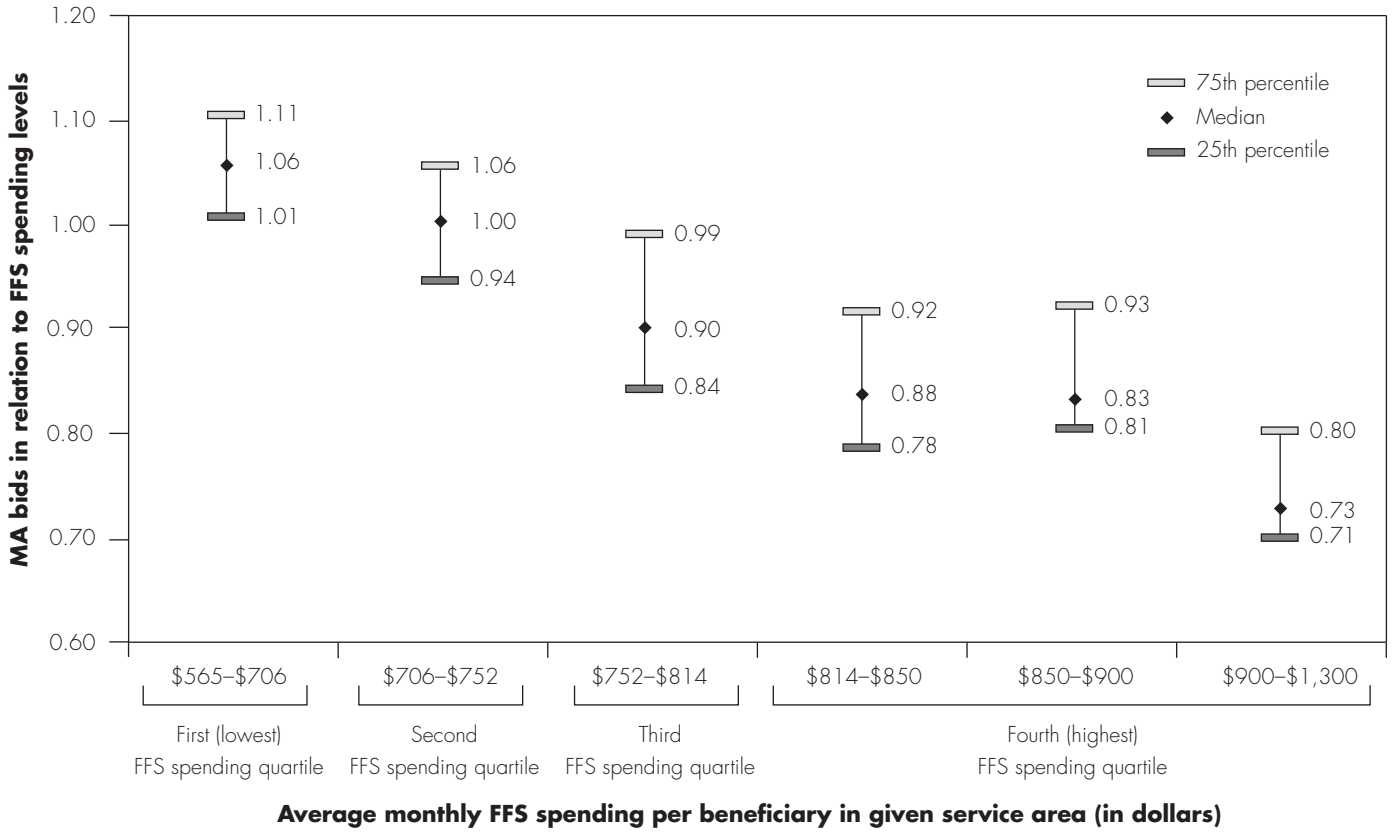
Note: FFS (fee-for-service). These examples express all plan bids as per beneficiary per month amounts for a beneficiary of average health status. In these examples, the benchmark would equal the lower of the FFS bid or the median bid from the managed care plans, and there would be a standard base beneficiary premium of $125 in all bidding areas. The exact methods used to determine the benchmark and the base beneficiary premium are both policy choices. These examples assume that the distribution of enrollment across plans would be the same in both years.

spending (the median bid in the highest spending quartile ranges from 73 percent to 88 percent of FFS costs). Under premium support, beneficiaries would face premiums that varied based on the relative cost of an area's FFS program and its managed care plans. The range in premiums would likely be smaller in areas with low FFS spending and larger in areas with high FFS spending. As a result, beneficiaries in high-spending areas would have a larger financial incentive to enroll in lower cost plans. Even so, a substantial degree of regional variation would likely remain, given the difficulty of addressing its underlying causes.

Given this regional variation in spending, in a premium support system, policymakers would need to decide how much of the additional spending in high-cost areas should be paid by the beneficiaries living in those areas and how much by the Medicare program and beneficiaries living

FIGURE 3–2

Medicare Advantage bids in relation to FFS spending levels, 2016



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

Source: Medicare Payment Advisory Commission 2016c.

in other areas. Under current law, Medicare premiums are set nationally and do not vary across areas (except for the supplemental premiums that some MA plans charge). When premiums are set nationally, the additional spending in high-cost areas is largely paid for by the government (in the form of higher Medicare payments) and by beneficiaries living in lower cost areas (who spend more on Part B premiums relative to the cost of their Medicare benefits than beneficiaries who live in high-cost areas).

Under premium support, the specific contours of the bidding process would play an important role in determining who bears the cost of the regional variation in spending. Two components of the bidding process would be especially important: the geographic regions used as bidding areas and the method used to set the base beneficiary premium. Larger bidding areas, such as the entire country or regions made up of one or more states, would be more likely to have a mix of high-cost and low-cost regions within a given area. The benchmarks in these larger areas would probably be based on some sort of overall average—much like the Part D program uses the national average bid as its benchmark—and would thus obscure the underlying variation in spending within each region. As a result, the Medicare contribution would be the same for an area's high-cost and low-cost regions. The cost of the additional spending in the high-cost regions would largely be borne by the beneficiaries who live there, in the form of higher premiums. In contrast, smaller bidding areas, such as areas that reflect local health care markets, would tend to be more uniform. Compared with larger bidding areas, spending would vary less within areas but more across areas. This distinction would result in benchmarks and Medicare contributions that would

be higher in high-cost areas and lower in low-cost areas, which means that the Medicare program would bear more of the cost of the additional spending in high-cost areas.

If the base beneficiary premium equaled a standard dollar amount, beneficiaries in high-cost areas would benefit because they would not pay a penalty (in the form of a higher base beneficiary premium) for living in a high-cost area. This benefit would be paid for by beneficiaries who live in low-cost areas, where the base beneficiary premium would equal a higher share of the benchmark than it would in high-cost areas. Conversely, if the base beneficiary premium equaled a standard share of the local benchmark, beneficiaries who lived in high-cost areas would bear more of the added costs because their base beneficiary premiums would be higher than those in low-cost areas.

One concern about using premium support is that beneficiaries would be penalized simply for living in a high-cost area. Beneficiaries in high-cost areas would, of course, have an incentive to enroll in their area's lower cost plans since the premiums for the FFS program and managed care plans would vary based on the differences in their overall cost. But even if those beneficiaries switched to lower cost plans, their overall costs would probably still be higher than in low-cost areas. Furthermore, there would be little that beneficiaries in high-cost areas could do to reduce the remaining additional costs, short of moving to a lower cost area. This concern could be addressed through a bidding process that has local bidding areas to set benchmarks and charges a standard base beneficiary premium based on a fixed dollar amount in all areas.

Incorporating quality into premium support

In a premium support system, beneficiaries should have the information they need to choose higher quality coverage options and could be rewarded for selecting higher quality coverage by paying lower premiums. Toward this end, CMS would need to measure and rate the quality of care for each area's FFS program and managed care plans.

There is currently no overall quality rating in FFS. In MA, plans receive quality bonuses (in the form of higher benchmarks) based on quality measure results that have been converted to a star rating. The star rating provides a relative ranking of overall quality for each plan, predominantly based on three types of clinical quality or patient experience measures: the Health Effectiveness Data Information Set® (HEDIS®), the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®), and the Health Outcomes Survey (HOS).[18,19] The Commission has previously questioned whether HEDIS and HOS measures can provide a valid comparison across FFS and MA (Medicare Payment Advisory Commission 2010).

In previous reports to the Congress, the Commission outlined an alternative to Medicare's current system for measuring the quality of care. It contends that Medicare's current quality measurement programs, particularly in FFS Medicare, have a fundamental problem: They rely primarily on clinical measures of process (as opposed to clinical outcomes) to assess the quality of care provided by hospitals, physicians, and other providers. Tying a portion of a provider's payment to performance on specified clinical processes can exacerbate incentives in FFS to overprovide services. Such measures can also contribute to uncoordinated and fragmented care, while burdening providers and CMS with the costs of gathering, validating, analyzing, and reporting on measures that have little value to beneficiaries and policymakers (Medicare Payment Advisory Commission 2015a, Medicare Payment Advisory Commission 2014).

Under an alternative policy, Medicare would use a small set of population-based quality measures to compare the quality of care in a local area under each of Medicare's three payment models—FFS, MA, and accountable care organizations (ACOs). Population-based measures that are intuitively easy to understand and meaningful for beneficiaries could include rates of potentially preventable hospital admissions, emergency department visits, readmissions, and mortality, as well as information on patient experience and the use of low-value care. CMS would calculate measure results for FFS enrollees using claims and patient survey data and for MA enrollees using encounter data and patient survey data.[20] More population-based quality measures could be developed when additional data sources (such as lab values and electronic clinical quality data) became available.

Assuming that CMS can accurately measure a market area's FFS and plan quality (with appropriate risk adjustment), the Commission has considered two approaches to incorporate quality results in a premium support system: one approach that relies on minimum standards for managed care plans and public reporting of quality-measure information and a second approach that combines those efforts with financial rewards for high-

quality coverage. Elements of these approaches would require at least a year of information about quality and thus could not be incorporated until the second year of premium support at the earliest if policymakers want to provide quality information that reflects the care provided under premium support, not the prior Medicare program.

Minimum standards and public reporting

Under the first approach, CMS would require managed care plans to meet minimum standards to participate in Medicare and would calculate and publicly report quality measure results for the FFS program and each managed care plan in a market area. This approach resembles the way the Part D program works to ensure that beneficiaries have the information they need to choose higher quality coverage options. The MA program also has standards for participation and public reporting of quality results, but unlike Part D, it rewards plans financially for higher quality through the star bonus program.

Minimum standards for participation

CMS could require plans to meet initial and ongoing minimum standards for participation, and these standards could be based on current MA requirements. Under current MA rules, a health plan must be licensed as a risk-bearing entity in the state(s) in which it operates, and its license must be appropriate for the level of risk involved in administering an MA contract. The entity must also demonstrate to CMS that it has the capacity and readiness to function as a viable health plan. Before having a Medicare contract, an organization must have at least 5,000 enrollees (or 1,500 for a rural area) who are receiving health benefits through the organization, although this requirement is often waived. Before enrolling any beneficiaries, plans must demonstrate that they have an adequate network of contracted providers to ensure reasonable, timely access to the full range of Medicare-covered services for the plan's expected population. New MA plans are also required to have a quality assurance system and quality improvement operations that allow the plans to track and improve quality.

Once an MA plan has met CMS's standards for participation and signed a contract with CMS, the plan must continue to meet regulatory requirements for quality, including reporting encounter data and patient experience survey results, to remain in good standing. Plans must also maintain at least a three-star rating (based on clinical quality and patient performance measures). Plans that do not meet these requirements can be subject to civil monetary penalties and suspension of enrollment, payment, or both until they have corrected their deficiencies, and CMS can ultimately terminate their Medicare contracts when warranted.[21] Similar requirements would presumably continue in a premium support system.

Public reporting of quality-measure information

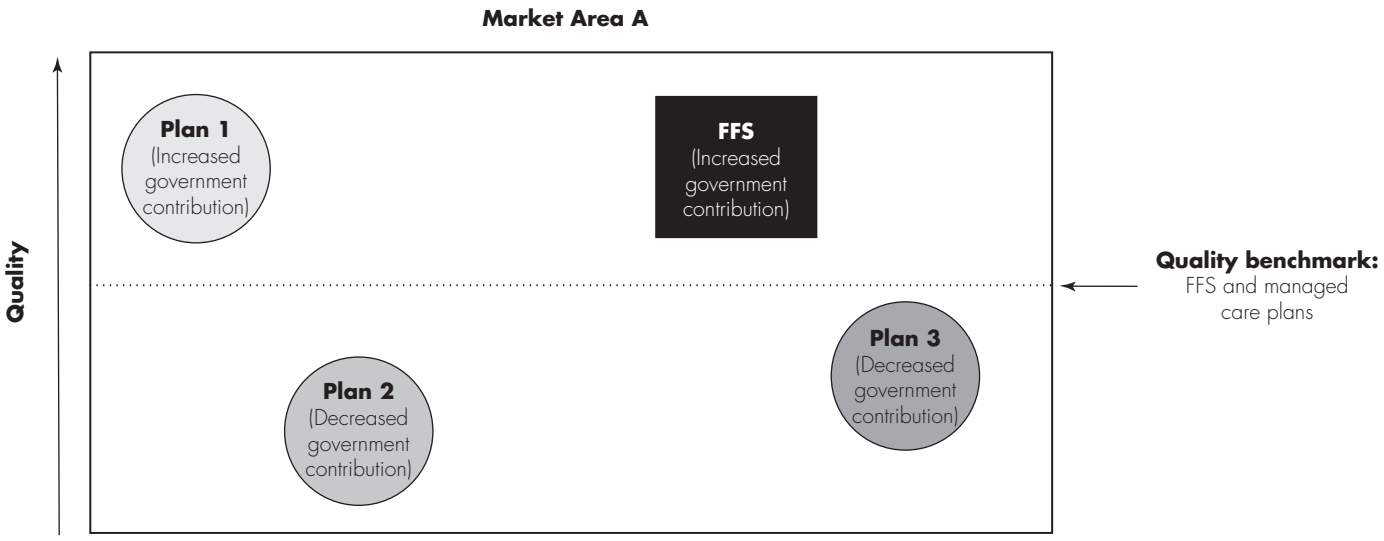
To select the best coverage option, beneficiaries would need accurate information on each option's cost, provider networks, quality, and other benefits presented through a comparison tool like the current Medicare Plan Finder website. CMS could calculate and publicly report quality results, such as the population-based outcome measures that the Commission has previously suggested (e.g., mortality, readmissions, potentially preventable emergency department visits, and patient experience) for each market area's FFS program and managed care plans. CMS could also enable more precise comparisons within a market area by reporting quality results for ACOs and the FFS program using smaller geographic units such as hospital referral areas.

CMS could also facilitate comparisons by calculating and reporting overall quality data for all of a market area's Medicare beneficiaries (both FFS and plan enrollees). The Commission's alternative quality model would use the FFS program as its benchmark, but combined market-level data might be more appropriate in a premium support system because the share of beneficiaries enrolled in FFS versus plans would probably vary significantly across markets and over time. Quality information would need to be relevant to consumers and presented in a way that is easy to understand—for example, by providing a summary overall rating (like an overall star rating) as is currently done on Medicare Plan Finder for MA and Part D plans. Detailed quality measure results would also need to be reported for beneficiaries interested in drilling down to plan and FFS measure-level results. Such detailed reporting could help plans, providers, and policymakers understand and improve the quality of care in a premium support system.

Financially rewarding higher quality

Under the second approach to incorporating quality in a premium support system, CMS would financially reward plans that provided higher quality care (in addition to meeting minimum standards for participation and publicly reporting quality-measure information). The plans in an area (which could include the FFS program) that had higher quality would receive a higher government

FIGURE 3–3 **Providing a higher government contribution to plans with higher quality**



Note: FFS (fee-for-service). Although Plan 3 has higher quality than Plan 2, both fall below the quality benchmark and receive a lower government contribution.

contribution that would be used to lower premiums and attract beneficiaries. CMS would determine which plans qualified for the higher contribution by comparing their performance with their market area's overall quality, using outcomes-based measures the Commission has recommended for the current Medicare program. This approach would be budget neutral in each market area. Once CMS reviewed the plan bids each year, it would take out a set percentage (e.g., 1 percent to 2 percent) of an area's projected FFS and MA spending and redistribute that to the higher quality coverage options in the market area. In the example in Figure 3-3, Plan 1 and the FFS program exceed the quality benchmark in Market Area A and would receive a bonus in the form of a higher government contribution, which would be used to lower the beneficiary's premium. Plans 2 and 3 have lower quality and would receive a lower government contribution and charge higher beneficiary premiums.

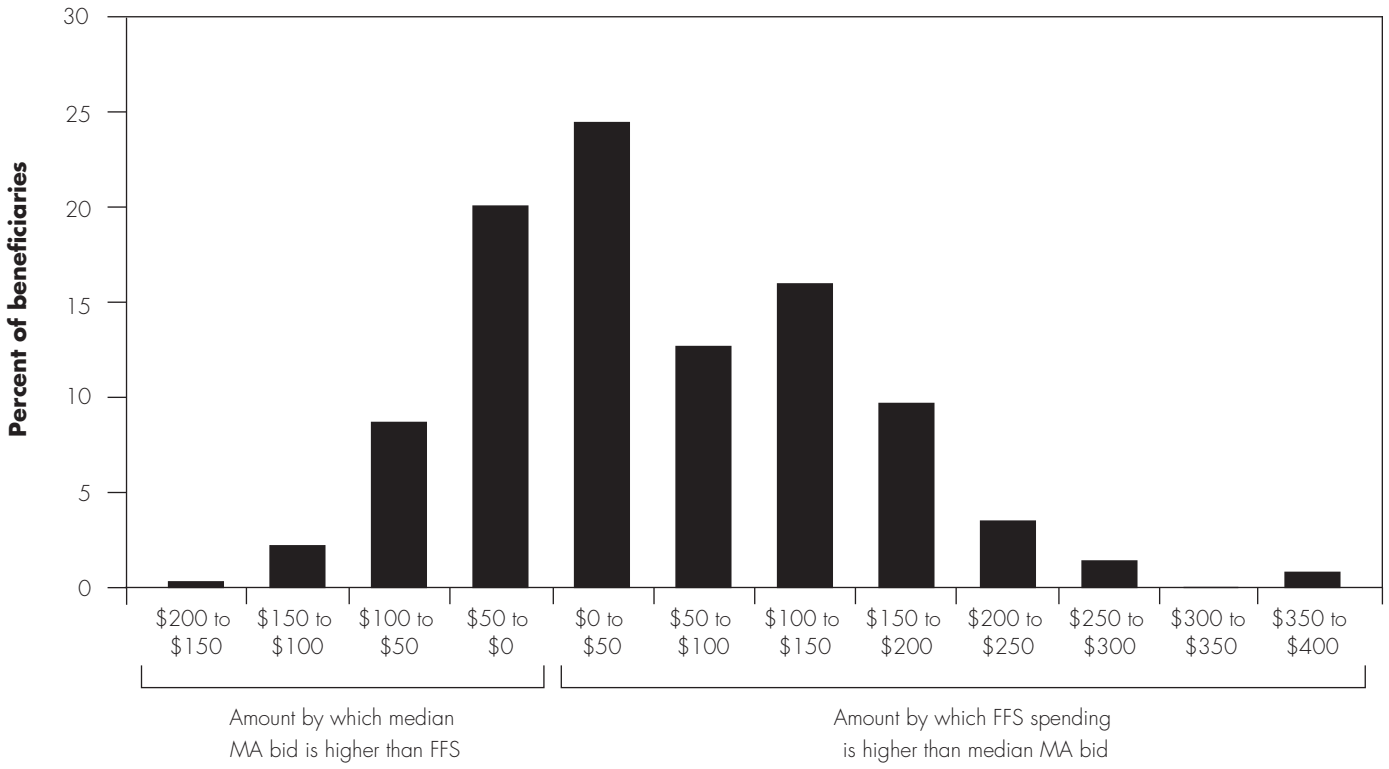
National budget neutrality for the quality reward program is assumed. However, the model would need to define a limit to the reward program that would be triggered if overall Medicare spending increased too rapidly. For example, the reward program could end if the average national managed care plan bid was above average FFS costs by a certain percentage. As with the minimum standards and public reporting of quality-measure information, the higher government contribution could not be implemented until the second year of premium support at the earliest since CMS would need quality information for the FFS program and managed care plans under the new system.

Mitigating the impact of higher beneficiary premiums

One of the biggest concerns about using premium support in Medicare is its potential impact on beneficiary premiums. Under premium support, any differences in the cost of providing the standard benefit package through the FFS program or managed care plans would be reflected in each plan's premium. Beneficiaries who are now enrolled in higher cost forms of coverage would see their premiums increase. They would either need to pay the higher premium or switch to a lower cost option. If the base beneficiary premium equaled a standard dollar amount that was determined nationally in a manner similar to the Part B premium, beneficiaries would always be able to avoid any increase in their premium by switching to a

FIGURE 3–4

Distribution of 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 month per beneficiary 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 in each area is as of January 2016. Out of 1,231 market areas in our data set, 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 Medicare enrollment data for January 2016.

plan whose bid was equal to or less than the benchmark in their area.

To illustrate how much premiums could change, we examined the impact of a premium support system in which each area's benchmark would equal the lower of the FFS bid or the median managed care plan bid (the same method shown in Table 3-6, p. 101). The base beneficiary premium would be set nationally at 25 percent of Part B spending per beneficiary, as is done currently for Medicare's Part B premium. For this analysis, we used MA plan bids and projected FFS spending for 2016 and the geographic areas that reflect local health care markets. Using these data, the base beneficiary premium would be $106 per month—that is, 25 percent of $424, the projected average Part B spending per beneficiary. This base beneficiary premium is lower than the 2016 Part B premium of $121.80 per month, but this difference is to be expected given the adjustments we made in calculating FFS spending in our data.[22] In this example, the coverage option that the base beneficiary premium pays for would vary across areas depending on how FFS spending compares with the median MA bid. In areas where FFS spending is lower than the median MA bid, the base beneficiary premium would pay for the FFS program; in areas where FFS spending is higher than the median MA bid, the base beneficiary premium would pay for the MA plan with the median bid. This analysis does not account for possible behavioral responses such as beneficiaries switching to lower cost plans or plans changing their participation or bidding behavior.

TABLE 3–8

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

	Medicare beneficiaries (in thousands)			Monthly premium under illustrative example		Change from current premium under illustrative example	
Market area	**Total**	**FFS**	**MA**	**FFS**	**MA**	**FFS**	**MA***
Rochester, NY	214	82	132	$106	$241	$0	$88
Honolulu, HI	168	87	81	106	210	0	90
Lancaster, PA	101	63	37	106	226	0	100
Erie, PA	55	30	25	106	207	0	100
Hawaii-Kauai, HI	52	33	19	106	287	0	93
Lebanon, PA	29	18	11	106	226	0	100
Braxton-Doddridge-Gilmer-Harrison-Lewis-Upshur, WV	32	22	9	106	245	0	94
Gratiot-Ionia-Mecosta, MI	27	19	9	106	211	0	46
Schuyler-Steuben, NY	26	17	8	106	219	0	91
La Crosse, WI	21	13	8	106	282	0	84

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 month per beneficiary 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. Number 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 this illustrative example account for supplemental MA premiums that beneficiaries now pay under current law.

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

This example is merely illustrative and differs from current law in several respects. MA plans now bid against benchmarks that are set administratively through statutory provisions specifying benchmark levels rather than through competitive bidding. Plans that bid below the benchmark receive a portion of the difference as a rebate that they can use to provide extra benefits. Under this example, the administratively set benchmarks would be eliminated, and the competition between FFS spending and MA plan bids would set the benchmark used to determine the Medicare contribution and beneficiary premium. The current system of rebates and extra benefits for MA plans would also be eliminated. This system 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 the Table 3-6 (p. 101) example, the difference between an area's average FFS spending and the median MA bid is a key variable in calculating beneficiary premiums. This difference is the additional monthly premium that beneficiaries would pay if they were to choose the higher cost option between FFS and the median-bid plan. Figure 3-4 summarizes the distribution of the differences between FFS and MA for all areas. About 45 percent of beneficiaries are in areas where the monthly difference is less than $50. About 3 percent of beneficiaries are in areas where the median MA bid is higher than FFS spending by $100 or more. In contrast, about 31 percent of beneficiaries are in areas where FFS spending is higher than the median MA bid by $100 or more. Even among areas where FFS is higher by a large amount, the Miami area is an outlier, with a difference of $358. In all other areas, the difference between FFS and MA is less than $300.

Markets that would see large changes in premiums

In contrast to the nationwide distribution of differences shown in Figure 3-4, Table 3-8 highlights the 10 largest

TABLE 3–9

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

	Medicare beneficiaries (in thousands)			Monthly premium under illustrative example		Change from current premium under illustrative example	
Market area	**Total**	**FFS**	**MA**	**FFS**	**MA**	**FFS**	**MA**
Chicago, IL	1,177	934	243	$253	$106	$147	$0
New York, NY	1,493	923	570	254	106	148	0
Los Angeles, CA	1,372	720	652	301	106	195	0
Northeastern New Jersey	700	581	119	247	106	141	0
Houston, TX	743	453	289	394	106	288	0
Nassau-Suffolk, NY	518	424	94	261	106	155	0
Baltimore, MD	454	410	43	243	106	137	0
Phoenix, AZ	672	392	280	265	106	159	0
Dallas, TX	535	369	166	290	106	184	0
Tampa-St. Petersburg, FL	602	307	295	322	106	216	0

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 month per beneficiary 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. Number 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 Medicare enrollment data for January 2016.

market areas (based on MA enrollment) in 2016 where the median MA plan bid exceeded average FFS spending by $100 or more under our static assumptions about beneficiary and plan bidding behavior. These are areas in which enrollees in the median-bid plan would have to pay a significantly higher premium to remain in their plan.

There are 51 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 spending under the current MA payment system. The 10 largest areas in this group, shown in Table 3-8 (p. 109), together account for about 75 percent of the group's MA enrollees. The group's largest single 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 3-8 (p. 109) also shows the estimated monthly premium that FFS and median-bid plan enrollees would pay in 2016 under our illustrative example. Since FFS spending in these areas is lower than the median MA bid, the base beneficiary premium (which is $106 in all areas in this example) would buy FFS coverage, and beneficiaries would have to pay an additional premium to enroll in the median-bid plan. For example, in the Rochester area, average FFS spending is $586 and the median MA bid is $721, or $135 higher (not shown in the table). The premium for the median-bid plan would thus be $135 higher than the base beneficiary premium of $106, for a total premium of $241. The median bid actually exceeds the current MA benchmark, so the beneficiaries enrolled in that plan now pay a supplemental premium of $47 (data not shown). As a result, the change in their premium, relative to current law, would be $135 minus $47, or $88. For the 10 largest areas, the additional premium would range from $46 to $100 per month.

At the other end of the distribution are 123 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 areas, and about 10.8 million are in the FFS program. These areas 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 3-9 shows the 10 largest areas in this group, based on FFS enrollment. These areas together account for about 50 percent of the group's FFS enrollees and include many of the nation's largest metropolitan areas. Each of the 10 areas has at least 300,000 FFS enrollees.

Table 3-9 also shows the estimated monthly premium that FFS enrollees and enrollees in the median-bid plan would pay in 2016. In these areas, the base beneficiary premium of $106 would buy coverage in the median-bid plan, and beneficiaries would have to pay an additional premium to enroll (or remain) in FFS. In the Chicago area, where the median MA bid is $720 and average FFS spending is $867, the premium for FFS coverage would thus be $147 higher than the base beneficiary premium of $106, for a total premium of $253. For the 10 largest areas, the additional premium for FFS coverage would range from $137 to $288 per month.

Options for mitigating or delaying the impact on beneficiaries

While a premium support system would give beneficiaries an incentive to choose a lower cost option and beneficiaries could switch options to mitigate the impact of large premium increases, some beneficiaries may not be immediately able to switch. Given the size of the premium increases in some areas, measures to mitigate the impact on beneficiaries could be considered. The key questions would be how much of the premium increase beneficiaries would ultimately face and how quickly premiums would reach that level. In addition, policymakers could consider automatic enrollment of beneficiaries in low-cost plans and subsidies for low-income beneficiaries.

Since the goal of premium support is to encourage beneficiaries to choose a lower cost option for receiving Medicare benefits, policymakers could decide that a smaller differential in premiums would still be sufficient encouragement and could therefore limit the allowable difference between the FFS premium and the benchmark to a specific dollar or percentage amount. (This type of limit could be used for all beneficiaries or limited to those with low incomes.) Another option would be to grandfather existing Medicare beneficiaries and use the new method of calculating premiums only for future Medicare beneficiaries, but this option would raise equity issues for beneficiaries and could be challenging for CMS to administer.

The method of calculating premiums under premium support could also be implemented over several years to minimize disruptions and give beneficiaries time to adjust. 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. Another option would be to 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 lived in areas where premiums changed significantly.

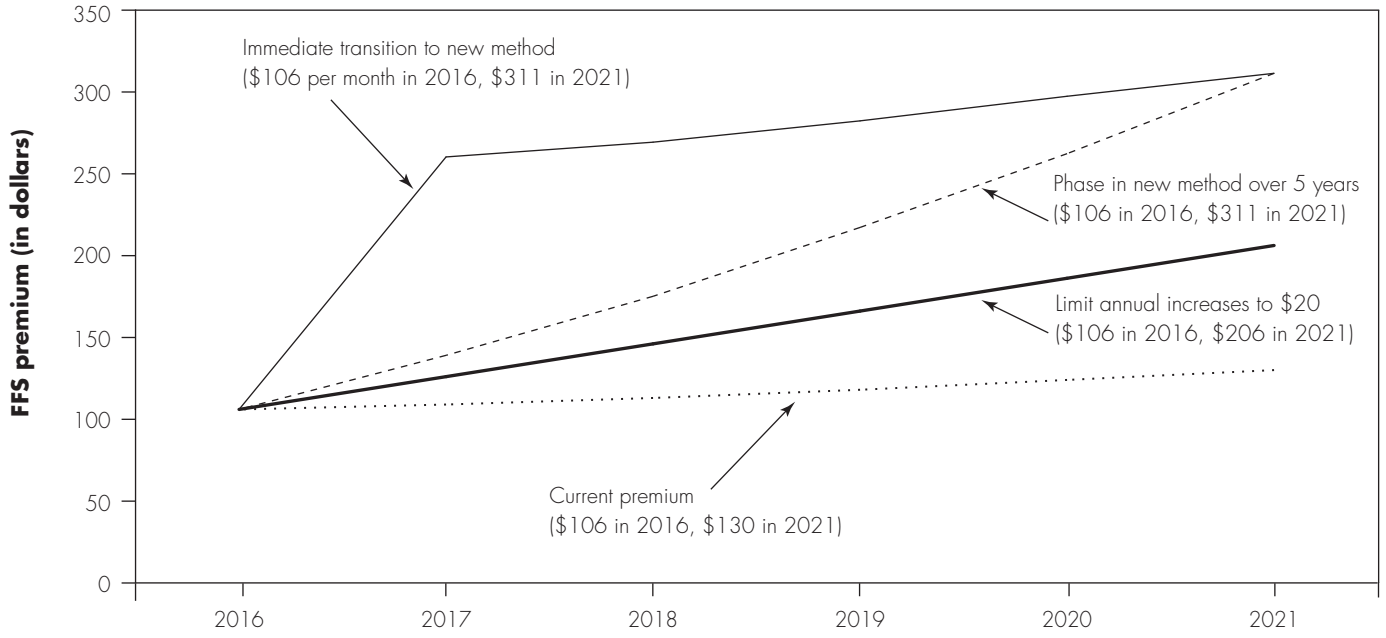
As part of the transition, beneficiaries would need to be informed of the trade-offs between FFS and a managed care plan and of differences among managed care plans themselves in such aspects as premiums and each plan's network of providers. Additional funding for SHIPs and improved decision-making tools could strengthen efforts to inform beneficiaries.

Figure 3-5 (p. 112) demonstrates how different approaches could be used to mitigate or delay premium increases. The figures here are based on the illustrative example previously used in which a nationally set base beneficiary premium pays for either FFS or the median-bid plan, whichever costs less. We use the Chicago area as an example because it is the largest market where FFS costs exceed the median bid by $100 or more. Premiums for 2016 are projected through 2021 using growth rates from the Medicare Trustees' report and assume that the transition to the new system starts in 2017.

Figure 3-5 (p. 112) shows what happens to premiums by 2021 if Medicare switched immediately in 2017 to the new system, if the higher premiums could be phased in over a five-year transition period, if FFS premium increases were limited to $20 annually, and if Medicare maintained the status quo. Given the size of the difference between this area's FFS spending and the median bid, the transition to the new system using the $20 annual limit would still be under way in 2021 and would likely take more than a decade to fully implement. These options are for illustration only, but they demonstrate how the impact of higher premiums under a premium support system could be substantially mitigated.

FIGURE 3–5

Illustrative examples of mitigating or delaying increases in FFS premiums in the Chicago area



Note: FFS (fee-for-service).

Automatically enrolling beneficiaries in lower cost plans

Under current law, new Medicare beneficiaries are automatically enrolled in the FFS program unless they select an MA plan.[23] Since premium support would lead to substantially higher FFS premiums in many areas, some of the impact in these areas could be mitigated by enrolling new beneficiaries in managed care plans with lower premiums instead of FFS.

Under this approach, individuals on the verge of eligibility for Medicare would be given a period of time to choose a coverage option on their own. Those who did not make a choice would be automatically enrolled in a lower cost plan to ensure that they had coverage in effect when they reached Medicare eligibility. For example, beneficiaries could be randomly assigned to plans with premiums equal to or lower than the base beneficiary premium. (The Part D program uses a similar approach to assign new enrollees who receive the low-income subsidy for drug plans.) Such a strategy might also encourage managed care plans to submit lower bids so that they could benefit from automatic enrollment of new beneficiaries.

As part of this process, policymakers would need to decide when automatically enrolled beneficiaries could switch to another plan. One option would be an approach used in the Medicaid program, where beneficiaries are required by many states to enroll in managed care and are automatically assigned to a Medicaid managed care plan if they do not select one on their own. In such cases, the state typically gives the beneficiary 60 to 90 days to choose a different Medicaid managed care plan. After that, beneficiaries cannot switch to another plan until the next open enrollment period.

Policymakers could also decide that existing beneficiaries should be automatically assigned to lower cost plans in certain circumstances. For example, CMS periodically reassigns beneficiaries who receive the Part D low-income subsidy to new drug plans to ensure that they remain enrolled in a plan with a zero premium. Beneficiaries who have chosen a plan on their own are not reassigned.

The potential benefits of automatically enrolling beneficiaries in lower cost plans (mitigating the financial impact of higher premiums) would need to be weighed against possible drawbacks. Some beneficiaries could have difficulty obtaining care, at least initially, if they are assigned to a plan that does not have their providers in its network. In addition, under current law, new Medicare beneficiaries who enroll immediately in MA plans may later have difficulty buying a medigap policy if they later switch to FFS coverage because there is a limited one-time open enrollment period for most beneficiaries to buy medigap coverage.

Providing premium subsidies to low-income beneficiaries

Under a premium support system, as with any financing system in Medicare, the goals of reducing program spending while ensuring adequate access to care need to be balanced. This latter concern applies in particular to low-income beneficiaries who may have difficulty paying their premiums. Medicaid currently provides subsidies that pay the Part B premium (and the Part A premium, if necessary) for low-income beneficiaries through the Medicare Savings Programs (MSPs), and Medicare provides similar subsidies for Part D premiums through that program's low-income subsidy (LIS).[24] However, in a premium support environment, the MSPs' role would need to be reassessed.

Developing a system of premium subsidies for low-income beneficiaries would involve three key issues: (1) which beneficiaries would be eligible for a subsidy, (2) what kind of subsidy they would receive, and (3) how the subsidies would be financed by the federal government and the states. We explore each issue in more detail below, drawing on the experience with the MSPs and the LIS. Since the MSPs are a Medicaid benefit, developing a system of premium subsidies would likely require changes to Medicaid as well as Medicare.

Who would be eligible for premium subsidies?

To qualify for the MSPs and the Part D LIS, beneficiaries must have both limited income and limited assets. Both programs exclude certain items when calculating an individual's income and assets and determine eligibility based on the remaining "countable" income and assets. For example, countable income does not include the first $20 in monthly income (such as wages or Social Security benefits) and countable assets do not include the value of a primary residence. The eligibility limits for the LIS are slightly higher than the limits for the MSPs. For the MSPs, beneficiaries must have income below 135 percent of the federal poverty level ($16,280 for an individual) and no more than $7,390 in assets. For the LIS, beneficiaries must have income below 150 percent of the federal poverty level ($18,090 for an individual) and no more than $13,820 in assets.[25] In 2008, the Commission recommended that the Congress raise the MSP income and asset limits to LIS levels to simplify the enrollment process for beneficiaries and improve MSP participation rates (Medicare Payment Advisory Commission 2008a).

In 2015, Medicaid covered about 9.2 million people through the MSPs and spent about $11.3 billion on Part B premiums, counting both federal and state payments (Centers for Medicare & Medicaid Services 2016d, Congressional Budget Office 2017).[26] The LIS covered about 11.7 million people and spent about $3.5 billion on Part D premiums (Centers for Medicare & Medicaid Services 2016c, Medicare Payment Advisory Commission 2016c). The higher LIS enrollment is partly due to its more generous eligibility limits but also stems from differences in the enrollment processes for the two programs. Beneficiaries who qualify for one of the MSPs are automatically enrolled in the LIS, but the reverse is not true.

Under a premium support system, decisions would need to be made regarding what income and asset limits would qualify beneficiaries for premium subsidies and whether those limits should be lower than, equal to, or higher than existing MSP limits. Several factors would inform these decisions, such as the number of eligible beneficiaries, the relationship between beneficiaries' incomes and their premiums, and the process for obtaining a subsidy.

As for the number of eligible beneficiaries, Table 3-10 (p. 114) provides information on the income distribution of the Medicare population, both as a share of the federal poverty level and in dollars. The cut-offs for each income band are based on the federal poverty level for 2017; the share of beneficiaries in each income band is based on data from the Medicare Current Beneficiary Survey (MCBS) for 2012. These figures are still reasonably accurate in 2017 because the Medicare population's income distribution is relatively stable from year to year.[27]

TABLE 3–10 **Income distribution of the Medicare population**

Annual income as a percentage of the federal poverty level	Annual income thresholds		Share of Medicare beneficiaries
	Individual	Couple	
Less than 100 percent	<$12,060	<$16,240	17%
100 to 135 percent	12,060–16,280	16,240–21,920	13
135 to 150 percent	16,280–18,090	21,920–24,360	4
150 to 175 percent	18,090–21,110	24,360–28,420	6
175 to 200 percent	21,110–24,120	28,420–32,480	6
200 to 400 percent	24,120–48,240	32,480–64,960	31
More than 400 percent	>48,240	>64,960	24

Note: The cutoffs for each income band are based on the poverty thresholds for 2017 and have been rounded to the nearest $10. We used total beneficiary income to calculate the share of beneficiaries in each income band (i.e., we did not apply the income exclusions that the Medicare Savings Programs use to determine a beneficiary's income). The share of beneficiaries in each income band is based on 2012 data. The total does not sum to 100 percent due to rounding.

Source: Office of the Assistant Secretary for Planning and Evaluation 2017 (for annual income thresholds) and MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file 2012.

About 46 percent of Medicare beneficiaries have income below 200 percent of the poverty level. Within that group, 30 percent of beneficiaries have income below the MSP income limit of 135 percent of the federal poverty level. The share of beneficiaries eligible for the MSPs is lower because some beneficiaries who meet the income limit do not meet the program's asset limit, and not all beneficiaries who are eligible actually participate. The remaining 55 percent of beneficiaries have income that exceeds 200 percent of the federal poverty level (Table 3-10).

The share of beneficiaries who qualify for a subsidy would be lower than the figures in Table 3-10 if policymakers included an asset limit. The rationale for an asset limit is that it better targets premium subsidies by excluding beneficiaries who have low incomes but can afford to pay their premiums by spending some of their assets. But there are also arguments against using an asset limit. Under Medicaid, states have the flexibility to raise or eliminate the MSP asset limit. Nine states have eliminated the asset limit entirely, and three other states have adopted a higher limit (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2017). Some states argue that the asset limit is not cost-effective because it is difficult to administer and screens out relatively few MSP applicants. However, an asset limit could have a larger impact if policymakers increased the income limit for premium subsidies above the current MSP limit of 135 percent of the federal poverty level.

Research suggests that beneficiaries' income and assets are highly correlated, and, as a result, a larger share of beneficiaries at higher income levels would be affected by an asset limit (Summer and Thompson 2004).

In setting the eligibility parameters for a premium subsidy, policymakers would also need to consider the relationship between beneficiaries' income and their premiums (as well as expected spending on cost sharing). This relationship would be difficult to assess with precision because of uncertainty regarding the potential impact of the new system on beneficiary premiums, but the method used to determine benchmarks and beneficiary premiums would be an important element. Because benchmarks and beneficiary premiums in a premium support system would be inversely related—higher benchmarks would mean lower beneficiary premiums and vice versa—beneficiaries would spend a larger share of their income on premiums under a system with relatively low benchmarks, which could necessitate broader eligibility for premium subsidies than under the MSPs. On the other hand, if the new system produced higher benchmarks and beneficiary premiums were more affordable, current eligibility limits could be considered sufficient.

A third factor in determining eligibility for premium subsidies would be the process for beneficiaries to obtain the subsidy. For both the MSPs and the LIS, some groups of beneficiaries qualify automatically for benefits while

others must submit an application. For example, Medicare beneficiaries who qualify for Supplemental Security Income (which provides cash benefits for disabled or elderly individuals with low incomes) are automatically eligible for Medicaid in most states and receive MSP premium subsidies as part of their package of Medicaid benefits. In contrast, some beneficiaries are eligible for MSP benefits only and must apply to receive them. For the LIS, all beneficiaries dually eligible for Medicare and Medicaid are deemed eligible for the LIS, but others must apply for benefits. A premium support system could use this kind of mixed approach.

The two programs also have different application processes. Since the MSP premium subsidy is a Medicaid benefit, beneficiaries apply through their state Medicaid office. The LIS gives beneficiaries the choice of applying through either the Social Security Administration (SSA) or their state Medicaid office, but in practice almost all LIS applicants use the SSA. Either approach could be used in a premium support system, depending in part on whether premium subsidies would be a Medicaid benefit (like the MSPs) or a federally administered program (like the LIS). Even if the premium subsidies were part of Medicaid, giving beneficiaries the option of applying through the SSA could encourage higher participation. One shortcoming of the existing system is that beneficiaries who apply for LIS benefits through the SSA are not screened for MSP eligibility, even though many applicants likely qualify for both programs. In 2008, the Commission addressed this issue by recommending that the Congress require the SSA to screen all LIS applicants for MSP eligibility and enroll them if they qualify (Medicare Payment Advisory Commission 2008a). This change could also be appropriate in a premium support system.

What kind of subsidy would be provided?

The MSPs now cover the full Part B premium for all eligible beneficiaries. However, if the premium subsidy under a premium support system fully covered beneficiary premiums no matter what coverage option beneficiaries select, then the beneficiaries receiving the subsidy would have no incentive to use a lower cost option. State spending could also increase in states where MSP enrollees are now primarily enrolled in coverage options that, under premium support, might face higher premiums (such as the FFS program in many large urban areas). However, policymakers would also need to ensure that all subsidy recipients can afford to buy coverage.

The Part D program, which uses a version of premium support, addresses this trade-off by putting an upper limit on the LIS premium subsidy, known as the low-income premium subsidy amount (LIPSA). Calculated separately for each Part D region, the LIPSA equals a weighted average of the monthly Part D premiums for the region's plans that offer basic drug coverage, with each premium weighted by the number of LIS enrollees.

LIS recipients who enroll in plans with premiums that are lower than this upper limit pay no premium. (These plans are often known as zero-premium plans.) Recipients who enroll in more expensive plans pay the difference between the plan's premium and the LIPSA. For example, if the LIPSA equals $30, an LIS beneficiary who enrolled in a plan with a $25 premium would not pay a premium, while an LIS beneficiary who enrolled in a plan with a $40 premium would pay $10. The method that CMS uses to calculate the LIPSA guarantees that there will always be at least one zero-premium plan in each area.[28] As a result, while LIS enrollees always have access to at least one zero-premium plan, they also have an incentive to avoid enrolling in higher cost plans.[29]

This approach could also be used in a premium support system for Part A and Part B. Table 3-11 (p. 116) builds on our previous illustrative examples in Table 3-6 (p. 101), showing benchmarks and beneficiary premiums in a market where the benchmark is based on the FFS bid or the median-bid plan.

The table shows the impact of two illustrative premium subsidies in these hypothetical markets. Like the Part D LIS, premium subsidies would be limited to a specified dollar amount. Beneficiaries who enrolled in less expensive plans would pay no premium; beneficiaries who enrolled in more expensive plans would pay the difference. The first premium subsidy would equal the lowest premium in the market ($105 in Example 1 and $65 in Example 2). The second premium subsidy would equal the standard base beneficiary premium of $125.

The amount of the premium subsidy (along with the distribution of plan bids) would determine the number of zero-premium plans in each market. Under the first approach, the only zero-premium plan in each market would be Plan A, the low bidder. Under the second approach, where the premium subsidy is higher, there would be two zero-premium plans in the first market (FFS and Plan A) and three zero-premium plans in the second market (Plans A, B, and C). Higher premium subsidies

TABLE 3–11

Illustrative examples showing the effects of a premium subsidy for low-income beneficiaries

		Managed care plans				
	FFS program	Plan A	Plan B	Plan C (median plan bid)	Plan D	Plan E
Example 1: Benchmark equals the FFS bid						
Plan bid	$700	$680	$710	$740	$770	$800
Beneficiary premiums; no premium subsidy	$125	$105	$135	$165	$195	$225
Beneficiary premiums; subsidy = low premium ($105)	$20	$0	$30	$60	$90	$120
Beneficiary premiums; subsidy = base premium ($125)	$0	$0	$10	$40	$70	$100
Example 2: Benchmark equals the median of the managed care plan bids (Plan C)						
Plan bid	$800	$680	$710	$740	$770	$800
Beneficiary premiums; no premium subsidy	$185	$65	$95	$125	$155	$185
Beneficiary premiums; subsidy = low premium ($65)	$120	$0	$30	$60	$90	$120
Beneficiary premiums; subsidy = base premium ($125)	$60	$0	$0	$0	$30	$60

Note: FFS (fee-for-service). These examples express all plan bids as per beneficiary per month amounts for a beneficiary of average health status. In these examples, the benchmark would equal the lower of the FFS bid or the median bid from the managed care plans, and beneficiaries would pay a premium that equals a standard amount of $125 plus the difference between the plan's bid and the benchmark. The methods used to determine the benchmark, the base beneficiary premium, and any subsidy amount are all policy choices.

would thus increase the number of zero-premium plans and vice versa. Beneficiaries who received a premium subsidy and enrolled in one of the more expensive plans would have to pay part of the premium themselves.[30] However, a higher premium subsidy would lower the amount that beneficiaries had to pay. In Example 1, the more generous subsidy would reduce the premium that eligible beneficiaries would pay to enroll in Plan C from $60 to $40.

If the new system limited the amount of the premium subsidy, the FFS program would not qualify as a zero-premium plan in all markets. In Example 1, FFS is less expensive than most managed care plans, and FFS would qualify as a zero-premium plan under the higher premium subsidy of $125. In Example 2, FFS is more expensive than most managed care plans and would not qualify as a zero-premium plan unless the premium subsidy were increased to $185. Under premium support, the FFS program would probably have one of the higher bids in many market areas, and any effort to limit the amount of the premium subsidy would result in areas where the FFS program did not qualify as a zero-premium plan. Higher premium subsidies would reduce the number of such areas, but would not eliminate them completely.

Some beneficiaries, particularly those with relatively higher incomes, could also receive a partial premium subsidy. Although the MSPs do not provide partial subsidies, the Part D LIS provides partial subsidies for beneficiaries with income between 135 percent and 150 percent of the federal poverty level. The subsidies for these beneficiaries taper off as income rises: Those with income between 135 percent and 140 percent of the federal poverty level receive a subsidy that equals 75 percent of the LIPSA, those with income between 140 percent and 145 percent receive a subsidy that equals 50 percent of the LIPSA, and those with income between 145 percent and 150 percent receive a subsidy that equals 25 percent of the LIPSA. The use of partial subsidies in this manner would allow eligibility for subsidies to be broadened while still limiting program spending.

Enrollment in zero-premium plans could be encouraged by using passive enrollment in certain situations. With passive enrollment, CMS automatically enrolls beneficiaries in a particular plan unless they take some action to change it. For beneficiaries receiving a premium subsidy, a zero-premium plan could be the default coverage option, as it is under the Part D LIS. CMS also uses passive enrollment to ensure that LIS beneficiaries remain enrolled in zero-premium plans over time. Exactly which plans qualify as zero-premium plans changes from year to year because of changes in plans' Part D bids and the LIPSA. When LIS beneficiaries are in plans that do not qualify as zero-premium plans in the following year, CMS reassigns them at the start of that year to another zero-premium plan to ensure that they do not have to start paying a premium (Centers for Medicare & Medicaid Services 2016a).[31]

The benefits of using passive enrollment (ensuring that low-income beneficiaries do not have to pay a premium) would need to be weighed against other considerations, such as respecting beneficiary choice and the potential disruption that some beneficiaries could experience if they were enrolled in a plan that did not have their providers in its network. In Part D, CMS does not use passive enrollment for LIS beneficiaries who have selected a Part D plan on their own, including those enrolled in plans with premiums that are higher than the LIPSA. One study found that 42 percent of LIS enrollees in 2010 had selected their own plan, with many choosing a zero-premium plan (Hoadley et al. 2015). Another study found that 17 percent of LIS enrollees in prescription drug plans would pay a premium in 2017 if they stayed in their current plan. These beneficiaries would pay an average of $24 per month in 2017 for their drug coverage, and 72 percent of them were in plans that also required them to pay a premium in 2016 (Hoadley et al. 2016). In 2010, CMS considered using passive enrollment to reassign some of these so-called choosers (those paying more than $10 per month in premiums) to zero-premium plans, but did not finalize its proposal (Centers for Medicare & Medicaid Services 2010).

The annual reassignment process helps keep LIS enrollees in zero-premium plans, but it is also disruptive for beneficiaries whose new plan does not cover all of the drugs they use. Something similar could happen in a premium support system if beneficiaries were reassigned to a plan that did not have all of their providers in its network. In Part D, policymakers have decided that the costs of reassigning beneficiaries outweigh the benefits when a plan's premium exceeds the LIPSA benchmark by a small amount ($2 in 2017). In these cases, CMS allows plans to retain their LIS enrollees if the plans waive payment of the remaining premium. (However, these plans cannot receive new LIS enrollees through passive enrollment.) This policy has reduced the number of LIS enrollees who are reassigned to new plans, and it could be used in a premium support system for Part A and Part B.

How would the subsidies be financed?

The MSPs and the LIS offer two examples of how premium subsidies could be financed in a premium support system. Because the MSPs are part of the Medicaid program, the federal government and the states both pay part of the cost. The federal match rate for each state is determined by a formula and ranges from 50 percent to 75 percent in 2017 (Office of the Assistant Secretary for Planning and Evaluation 2015). Across all states, the federal government pays about 61 percent of the cost of the MSP payments for Part B premiums; states pay the rest. In contrast, the Part D LIS is financed entirely by the federal government.

Under premium support, the simplest way to provide premium subsidies would likely be to build on the existing MSPs and modify them as needed, leaving the current federal–state system of financing in place. This arrangement could be revised as needed by adjusting the federal match rate. For example, if the eligibility limit for premium subsidies were raised, the federal government could pay a larger share of the costs for the newly eligible population. The Congress used this approach in 1997 when it raised the MSP eligibility limit from 120 percent to 135 percent of the federal poverty level and specified that the federal government would pay the full cost of the premium subsidies for beneficiaries in that income range.[32]

Even if MSP eligibility limits remained the same, states would be concerned that premium support might result in higher Medicaid spending, which could occur if premiums for MSP enrollees proved to be higher, on average, than the current Part B premium. Whether spending would be higher depends on numerous other factors, such as the method used to set benchmarks and beneficiary premiums and the amount of the premium subsidy. For example, a premium support system that had relatively low benchmarks and generous premium subsidies would be more likely to result in higher Medicaid costs, particularly in states where many MSP enrollees are in the FFS program.

Instead of the Medicaid-based structure of the MSPs, a new system of premium subsidies could be administered by the federal government, like the Part D LIS. Under this approach, the SSA would determine whether beneficiaries were eligible for the subsidy, and CMS would make subsidy payments for those who qualified. Since the SSA would determine eligibility for the new premium subsidies as well as the LIS, this arrangement would make it easier for policymakers to align the eligibility standards for the two programs, which would simplify the enrollment process for beneficiaries and likely improve beneficiary participation.

A major concern with creating a federally run system is the likely additional cost for the federal government. Since the MSPs are part of the Medicaid program, the states pay some of the cost of its premium subsidies. A federally run system that replaces the MSPs' premium subsidies would thus increase federal spending while reducing state spending. Some of these costs could be offset by requiring states to make maintenance-of-effort (MOE) payments to the federal government that equal what the states would have spent on MSPs under current law.[33]

Cost-sharing subsidies would be another important consideration in federalizing the MSPs and deserve mention. As noted earlier, one of the MSPs (the Qualified Medicare Beneficiary Program, for beneficiaries with income below the federal poverty level) also covers Part A and Part B cost sharing. Under a federally run system of premium subsidies, policymakers would need to decide whether these cost-sharing subsidies also would be federalized and, if so, how much of this cost sharing Medicare would pay. States can limit their spending on qualified Medicare beneficiary (QMB) cost sharing by using their Medicaid rates, which are often lower than Medicare rates, to determine their liability, and research has found that most states limit payments to some degree (Medicaid and CHIP Payment and Access Commission 2017). Prior Commission research estimated that, in aggregate, states now pay about 35 percent of cost sharing for QMBs. If Medicare paid the full amount of cost sharing under a federally run system, payments for the remaining 65 percent that states do not cover now would significantly increase federal spending because the additional federal payments would not be offset by state MOE payments. In addition, the combination of full Medicare payment of cost sharing and state MOE payments would create inequities among states because the states that now pay the smallest amount of cost sharing would benefit the most (Medicare Payment Advisory Commission 2016b).

Potential implications of a premium support system for beneficiaries and plans

Converting Medicare to a premium support model would likely have significant effects on beneficiaries and plans. Available research on several relevant issues, such as the sensitivity of beneficiaries to changes in premiums, provides some indication of potential effects. However, given the many actors and design choices (which go well beyond the issues raised in this chapter), there is no way to predict with certainty how premium support would play out.

Implications for beneficiaries

If the goal of using premium support is to encourage beneficiaries to use lower cost options for their Medicare coverage, how beneficiaries respond to premium changes and select coverage from multiple options are key considerations in designing a premium support system. The experiences of consumers in MA, the Part D program, and the PPACA exchanges (which serve a different population) can provide insight into the possible effects of premium support on beneficiaries.

Beneficiary willingness to switch plans

Available research suggests that MA enrollees and Part D prescription drug plan (PDP) enrollees switch plans at similar rates, while individuals who receive coverage through the PPACA exchanges switch plans at higher rates. Enrollee behavior in these three programs suggests certain considerations for the development of a premium support model.

Lessons from MA The share of beneficiaries who move from one Medicare sector to another (switching from FFS to MA or from MA to FFS) is roughly the same each year (Jacobson et al. 2015). However, since more beneficiaries are starting out in the FFS program, most of those who switch move from FFS into MA (Riley 2012). Between 2013 and 2014, about 17 percent of MA enrollees switched plans: 11 percent voluntarily switched to another MA plan, 2 percent voluntarily switched to the FFS program, and 5 percent were involuntarily switched (usually to another MA plan). The share of MA enrollees who voluntarily switch to another plan has been about the same every year, averaging 9 percent annually between 2007 and 2013 (Jacobson et al. 2016).

MA enrollees are more likely to switch plans as their premiums increase. Enrollees who saw their premiums increase by less than $20 switched at a rate of 11 percent compared with higher switching rates by enrollees who faced larger increases: 21 percent of those facing a $20 to $29 increase, 24 percent of those facing a $30 to $39 increase, and 29 percent of those facing an increase of $40 or more. On average, beneficiaries who switched plans saved $15.87 per month in premiums, while those who stayed in the same plan paid $4.26 more, on average. Beneficiaries who switched plans also lowered their out-of-pocket spending limit by an average of $401 (Jacobson et al. 2016).

Some observers have claimed that half of newly eligible Medicare beneficiaries join MA plans, but the Commission found that only about a quarter of the new beneficiaries in 2012 chose an MA plan. The Commission also found that new MA enrollees tended to be former FFS enrollees in their late 60s and early 70s and had thus experienced one or more MA open enrollment periods. This finding suggests that many beneficiaries may not consider enrolling in MA until they have been exposed to FFS cost sharing or MA plans' marketing efforts (Medicare Payment Advisory Commission 2015b).

Among MA enrollees, voluntary switching rates did not vary by gender, the number of plans available in the county, or the MA payment quartile for the county. However, switching rates were somewhat higher for beneficiaries ages 65 to 75 (12 percent) compared with those 85 and older (7 percent). Enrollees living in nonmetropolitan areas were more likely to be switched involuntarily than those living in metropolitan areas (8 percent vs. 4 percent) because MA plans in nonmetropolitan areas are more likely to exit the market (Jacobson et al. 2016). Among FFS enrollees, some beneficiaries with medigap coverage may be reluctant to join an MA plan because they could be subject to medical underwriting if they later switched back to the FFS program and tried to buy a new medigap policy.

The beneficiaries most likely to switch from MA to FFS are high-need, high-cost patients (McWilliams et al. 2011, Medicare Payment Advisory Commission 2012b, Newhouse et al. 2012). Their higher rate of switching could be accounted for by dual-eligible beneficiaries (who are more likely to have high costs and can switch plans at any time), unmet needs under their current plans, and provider or plan encouragement to switch. However, dual-eligible beneficiaries who are enrolled in MA special needs plans switched at lower rates (9 percent) than those enrolled in regular MA plans (13 percent) (Jacobson et al. 2016).

Focus groups have found that seniors do not find the differences between MA plans to be significant enough for them to consider shopping around (Jacobson et al. 2014). High beneficiary retention rates can send plans both positive and negative signals. On the one hand, high retention rates encourage sponsors to properly manage their enrollees' health because they will likely be enrolled in the plan for years. On the other hand, plans could conclude that the risk of losing enrollees is low unless there are large increases in premiums or significant disruptions in care.

Lessons from Part D During the first few years of the Part D program, the majority of beneficiaries remained with the plan they selected in the program's first year (Hoadley 2008). Research at the time showed that many beneficiaries were satisfied with their plan and did not intend to switch, but over one-third of enrollees stated that it was too much trouble to compare and choose a new plan (Kaiser Family Foundation 2006). The complexity of the Part D drug benefit may also have discouraged enrollees from switching plans (Hoadley 2008).

The Commission found that, between 2009 and 2010, 15 percent of enrollees in MA plans with prescription drug coverage (MA–PDs) and 13.6 percent of non-LIS enrollees in PDPs voluntarily switched plans. Among those who switched, about 90 percent of MA–PD enrollees switched to another MA–PD, and about 80 percent of PDP enrollees switched to another PDP. As with MA, gender did not affect the rate of switching; beneficiaries in nonmetropolitan areas were more likely to switch plans than enrollees in metropolitan areas

(17 percent vs. 13 percent, respectively); and older beneficiaries were less likely to switch plans. The share of Part D enrollees who switched plans was not affected by the number of PDPs available in their region. The beneficiaries who switched plans had lower out-of-pocket costs than they would have had under their old plan (Medicare Payment Advisory Commission 2013b).

Lessons from the PPACA exchanges Research indicates that individuals who receive health coverage through the PPACA exchanges switch plans at a much higher rate than those in MA or Part D in an effort to lower their premiums. In 2017, exchange enrollees could choose from an average of three participating insurers in each county, with 79 percent of enrollees having a choice of two or more and 56 percent having a choice of three or more (Office of the Assistant Secretary for Planning and Evaluation 2016b). Within the exchanges, each participating insurer can sell multiple plans across the four "metal levels" (bronze, silver, gold, and platinum) that indicate the generosity of a plan's coverage. A majority of exchange consumers select plans with low premiums (Burke et al. 2014). Exchange consumers are sensitive to premium changes and have been willing to switch plans to maintain low-cost coverage (Office of the Assistant Secretary for Planning and Evaluation 2016a). During the 2016 open enrollment period, 43 percent of the individuals who were re-enrolling switched to lower cost plans, saving $42 per month on average. However, many exchange enrollees who could switch to a lower premium plan remained in their current plan: 76 percent of the individuals who re-enrolled in the same plan for 2016 could have switched to a lower premium plan, even within the same metal level as their current plan, suggesting that beneficiaries consider other factors besides premiums in making coverage decisions (Office of the Assistant Secretary for Planning and Evaluation 2016a).

The exchanges differ from Medicare in several respects, which makes it difficult to know whether the high rates of plan switching in the exchanges would also occur in a Medicare premium support system. First, the exchanges do not have an FFS coverage option, and the competitive dynamic between the FFS program and managed care plans in a premium support system could be different (Office of the Assistant Secretary for Planning and Evaluation 2016a). Second, there was more news coverage about shopping and plan switching in the exchanges than in Medicare. Third, the premiums for exchange plans have been more volatile from year to year than MA premiums. Fourth, the exchanges serve a younger and more technologically knowledgeable population that may be more willing or better able to shop around than Medicare beneficiaries.

Evaluating coverage options and choosing a plan

Although the notion of having a wide variety of choices when deciding is appealing, research suggests that many consumers, particularly the elderly, have difficulty making decisions when faced with many choices. A premium support system will not work as well if Medicare beneficiaries struggle to understand their coverage options and have trouble selecting the coverage that best meets their needs (Hibbard et al. 1998).

Factors that beneficiaries consider when selecting coverage Interviews with focus groups conducted by the Kaiser Family Foundation and the Commission's annual beneficiary survey indicate that beneficiaries strongly consider certain factors when selecting an MA or Part D plan, such as access to particular providers (their doctors, certain hospitals and cancer treatment centers, and nearby pharmacies and physicians) and the brand name of the insurance provider (Jacobson et al. 2014, Wesolowski 2016). Beneficiaries in poorer health believed that it was more important to retain access to their current providers (Wesolowski 2016). As for specific plan features, beneficiaries in poorer health gave more consideration to out-of-pocket costs such as deductibles and copayments, while healthier beneficiaries focused more on premiums (Jacobson et al. 2014). Once beneficiaries were enrolled in a plan, they often preferred to keep that plan (even if its premiums increased) instead of searching for and changing to an unfamiliar one. They also expected annual premium increases and looked suspiciously on premium decreases and low-cost plans because they believed that lower costs indicate poorer quality or less coverage (Jacobson et al. 2014). Focus group participants were most likely to turn to friends, family, neighbors, and insurance agents for help in choosing a plan (Jacobson et al. 2014, Wesolowski 2016). Beneficiaries gave more weight to the experiences of family and friends than information they received from advertisements.

Beneficiaries often do not take full advantage of the low-cost options that are available, but may still make rational decisions given the other factors that they consider when selecting a plan. For example, a study of beneficiaries enrolled in PDPs in 2006 found that only 6 percent to 9 percent of beneficiaries had chosen the lowest cost plan (Gruber 2009). Their decision making nevertheless aligned with expected models of decision making (Abaluck and

Gruber 2011). The characteristics that determine which plan is best for a beneficiary evolve over time because of changes in the plans that are available, health status, and prescription drug needs (Heiss et al. 2016). Beneficiaries were more likely to consider switching plans when they overspent the previous year, but they remained sensitive to potential drawbacks, such as risk of losing a familiar physician and the time needed to select a new plan. (The decision to switch plans is often as complex as the initial plan selection.) With these two considerations—price and the potential drawbacks of switching—sometimes at odds with each other, tools that help beneficiaries understand their coverage options would be important elements of a premium support system because they would make it easier for beneficiaries to focus on price differences (Heiss et al. 2016). Beneficiary decisions eventually affect how plan sponsors structure their premiums and plan offerings (Ho et al. 2015, Polyakova 2016).

Helping beneficiaries evaluate their coverage options

For beneficiaries in a premium support system, the process of selecting a plan could be complex because of the number of available coverage options in some areas and the many ways that these options could differ (such as cost sharing, provider networks, and additional benefits). The selection process would be unfamiliar for many FFS enrollees in particular—although most have gone through the process of selecting a Part D plan—and could also be more challenging than the process of selecting employer-sponsored insurance, which some beneficiaries encountered during their working years. The shopping experience would be especially challenging if there is little use of standardization and few limits on the number of plans that insurers can offer.

Beneficiaries could find it particularly challenging to select a plan that best meets their needs if too many coverage options are available. Participants in consumer choice studies made better choices when confronted with 6 options as opposed to 24 or more (Iyenger and Lepper 2000). Another study found that Medicare beneficiaries were more likely to enroll in MA when they lived in an area where 15 or fewer plans were available (McWilliams et al. 2011).

The availability of tools such as the Medicare Plan Finder for Part D plans can make the selection process easier. A similar online comparison tool for managed care plans would be essential for a premium support system. The existing Medicare Compare tool would be a logical starting point, but it could be improved with better information about the providers that participate in each plan's network and better use of standardized vocabulary.

CMS would also need to engage in advertising and outreach activities to inform beneficiaries about these tools. In the MA and Part D programs, many beneficiaries are unaware of the consumer tools that can help them select a plan (Jacobson et al. 2014). In addition, some beneficiaries would not have access to online comparison tools or be comfortable using them. Additional funding for state health insurance assistance programs could provide additional decision-making support to beneficiaries.

Implications for managed care plans

Beneficiaries cannot make good plan choices unless an adequate number of plans is available. The MA program has a large number of plans and would provide a good foundation for a premium support system. Currently, 99 percent of all beneficiaries have at least one plan available (not including employer-sponsored plans and special needs plans). The average beneficiary has 18 plans available; beneficiaries in some areas have more than 40 plans available. However, the adoption of premium support would affect both the number of plans that are available and how those plans would bid.

Plan participation

The bidding process under premium support would differ from the MA bidding process in several respects and would likely prompt managed care plans to reexamine which markets they serve. In MA, each plan can define its own service area and submit a single bid for that area. That bid is compared with a benchmark that CMS calculates based on FFS spending and announces in advance. (The MA benchmarks are based on counties; when plans serve multiple counties, their bids are compared with a benchmark that equals a weighted average of the county-specific amounts.) In a premium support system, the use of competitive bidding would mean that plans do not know the benchmark in advance and that each plan's bid could affect the area's benchmark and thus the plan's premium in that area. As a result, plans would want to pay more attention to their bids for each area. Plans could decide to leave some areas if they did not expect enough enrollment to make the time and expense of the bidding process worthwhile. Plans could also decide to enter new areas based on updated competitive dynamics. Some areas that currently have few or no MA plans could appear more attractive under premium support. For example, 7 of the 10 largest counties without MA plans have benchmarks that

equal 95 percent or 100 percent of FFS costs. Depending on how they were calculated, the benchmarks in these areas could be higher under premium support than the current MA benchmarks (at least initially).

As discussed earlier, the Commission has recommended replacing the county-based payment areas now used in MA with a set of fewer, often larger, market areas. Some researchers believe that using this approach for defining market areas could lead to increased plan participation and competition (Gaynor et al. 2017).

Another element of a premium support system that could have a significant effect on plan participation would be restrictions or limitations on the number of participating plans. Because beneficiaries might have an easier time choosing plans when there are fewer and clearer plan choices, a premium support system could limit the number of plans that an insurer could offer, limit the total number of plans that can participate in a market area, or both. On the other hand, the system could have relatively few restrictions on the number of plans offered, which would be more consistent with current policies in both MA and Part D. This approach could arguably lead to greater competition. CBO's analysis of Part D bids for 2007 through 2010 found that plans in markets with more competing insurers submitted lower bids (Congressional Budget Office 2014). Another study found that an increase in the number of competing insurers between 2006 and 2009 reduced plan bids in the MA program (Song et al. 2012).

Under premium support, the potential Medicare market for managed care plans would be much larger than the current MA market and the major new markets that have opened over the past decade (Part D, Medicaid managed care, and the PPACA exchanges). Plan interest in participating in a premium support system would thus likely be widespread, even if the number of available plans was limited in some fashion.

How plans would bid

Prior Commission work and the academic literature have found that the MA market does not encourage price competition, as evidenced by plan bidding behavior. The Commission has found that MA plan bids are more strongly related to the program's administratively determined benchmarks than to local FFS spending, local FFS service use, local market prices, or insurer market power (Medicare Payment Advisory Commission 2013a). Academic studies have found that raising MA benchmarks will increase plan bids by about half of the amount of the benchmark increase (Duggan et al. 2014, Song et al. 2013, Song et al. 2012). The authors of the studies concluded that MA plans have market power and that the MA program is not perfectly competitive.

Other Commission work has shown that MA plan bids can decline when benchmarks are lowered. In 2011, the benchmarks for nonemployer MA plans equaled 113 percent of local FFS spending, on average, and the bids for those plans equaled 99 percent of FFS spending. Between 2011 and 2017, PPACA lowered the MA benchmarks to an average of 106 percent of FFS spending. Plan bids during this period fell to an average of 90 percent of FFS spending. So, while there may not be perfect competition in MA, plans have become more competitive with FFS.

In MA, beneficiaries do not see information on plan bids, and plans therefore do not compete on their bids (and resulting premiums) alone. Most MA plans do not charge an additional premium for their Part A and Part B benefits (almost all MA enrollees are required to pay the same Part B premium as FFS beneficiaries). Under a premium support system where plans bid on a standard package of Part A and Part B benefits, beneficiaries would see premiums that indicate how the bids from the FFS program and managed care plans compare. Each coverage option most likely would have a different premium, a marked change from the MA program in which many plans are displayed as "zero premium." The greater visibility of these premiums could focus the competition among plans toward premiums and away from the extra benefits that seem to dominate competition in MA.

Table 3-12 demonstrates this point with the bids from our previous illustrative examples.

In this hypothetical market, the FFS program has a bid of $800 per month and the five MA plan bids range from $680 to $800. Assume that this market's benchmark is $800 and that plans can offer extra benefits only if they bid below the benchmark and receive rebate dollars. In addition, the national Part B premium in this example equals $125, which is close to its current amount. A comparison of premiums in Medicare Compare would show that each plan's premium is $0, even though beneficiaries would be required to pay the Part B premium ($125) for each plan, and the lowest and highest bids in the market (Plans A and E, respectively) differed by $120. The five MA plans differ in terms of the extra benefits they provide, but depictions of those extra benefits are shown

TABLE 3–12

Illustrative comparison of how beneficiary premiums are displayed in the MA program and could be displayed under a premium support system

		Managed care plans				
	FFS program	Plan A	Plan B	Plan C (median plan bid)	Plan D	Plan E
Plan bid	$800	$680	$710	$740	$770	$800
Under MA:						
Part B premium	$125	$125	$125	$125	$125	$125
Additional plan premium	$0	$0	$0	$0	$0	$0
Premiums that beneficiaries see in Medicare Compare	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Under premium support:						
Base beneficiary premium	$125	$125	$125	$125	$125	$125
Difference between plan bid and $740 benchmark	$60	–$60	–$30	$0	$30	$60
Premiums that beneficiaries see in Medicare Compare	**$185**	**$65**	**$95**	**$125**	**$155**	**$185**

Note: MA (Medicare Advantage), FFS (fee-for-service). The illustrative figures for a premium support system assume that the benchmark equals $740 (the lower of the FFS bid or the median plan bid, which is Plan C) and that the base beneficiary premium equals $125. These are all policy choices.

separately on Medicare Compare, and the differences across plans can be difficult to evaluate.

Under premium support in this example, the benchmark would equal the lower of the FFS bid or the median plan bid (in this market, that means a benchmark of $740, based on the bid from Plan C). Beneficiary premiums would range from $65 for Plan A to $185 per month for the FFS program or Plan E. This information would encourage beneficiaries to enroll in lower bidding plans to save money on premiums. We believe that managed care plans would anticipate this behavior and try to lower their bids to attract enrollment.

Bids might also be lower under premium support because beneficiaries would reap the full savings from lower bids in the form of lower premiums. In MA, beneficiaries receive about two-thirds of the difference between the plan's bid and benchmark in the form of extra benefits, and the Medicare program keeps the rest of the difference. This "tax" on the difference has been cited as a factor that discourages plans from bidding lower (Stockley et al. 2014).

Key findings from CBO's analysis of premium support

Given the level of specificity needed to define what "premium support" would entail and the uncertainty about its effect on the behavior of beneficiaries, health plans, and providers, it is not surprising that few studies have tried to estimate the effects of premium support in any detail. One such study of premium support is an analysis that CBO issued in 2013 (Congressional Budget Office 2013).

In its report, CBO analyzed two possible approaches for designing a premium support system. Under one approach, the benchmark would equal the enrollment-weighted average of private plans' bids and an area's FFS per capita costs (the "average option") and the base beneficiary premium would be calculated in the same manner as the current Part B premium. Beneficiaries who chose a plan that was more expensive than the average bid would pay

the full difference, while beneficiaries who chose a plan that was less expensive than the average bid would receive the full difference back in cash rather than supplemental benefits. We focus on CBO's average option because it more closely resembles the Commission's illustrative approaches outlined in this chapter.[34]

Estimated effects on beneficiaries

Under its average option, CBO expected that beneficiaries would be more sensitive to premium differences than most research about the Medicare population shows for two reasons. First, beneficiaries would be subject to premium differences that were significantly greater than those that had been studied previously. Second, information on plan prices would be displayed to beneficiaries in a way that would encourage comparison of premiums.

Under the average option, CBO estimated that the premiums beneficiaries paid in 2020 would be 6 percent lower, on average, than what they would be under current law because federal spending would be lower and premiums (as they are under current law) would be based on a share of that lower spending. CBO also estimated that beneficiaries' total out-of-pocket spending for Medicare services would be lower because more beneficiaries would be expected to enroll in lower cost plans and use fewer services, thus incurring lower out-of-pocket spending.

However, premiums and out-of-pocket spending would vary considerably by plan choice and by geography. CBO estimated that, on average, the premium for the FFS program would be about 50 percent higher than it is under current law because plan bids in many areas would be substantially lower than FFS per capita spending. Beneficiaries in FFS would have to pay the difference when FFS exceeded the federal contribution. (CBO's analysis assumes that the FFS program would have the same features as it does under current law.) While beneficiaries would face increased price pressure to make a choice under premium support, CBO estimated that, under the average option, about 20 percent of beneficiaries would not make any choice in the first year, and it noted that policymakers would have to decide how to treat those beneficiaries who did not choose.

Estimated effects on plans

CBO reported that the average option would change the incentives that private insurers face when they develop their bids. Some changes would tend to decrease bids, while others would tend to increase bids. On net, CBO estimated that bids would be lower relative to current law by about 4 percent in 2020, but that amount could vary under different program designs. (The decline in beneficiary premiums would be larger than the decline in plan bids because, among other reasons, some beneficiaries would switch to lower premium plans.)

CBO cited several factors under a premium support system that would tend to reduce bids. First, because beneficiaries would experience different premiums based on the plan they chose, the demand for plans with lower bids would be greater. Moreover, the government would not retain a share of the difference between its contribution and the plan's bid, further adding competitive pressure because beneficiaries would retain the full difference. Second, unlike the MA program, where benchmarks are announced before plans submit bids, the government contribution would be based on the bids themselves. CBO noted that, in the MA program, benchmarks can affect bids, and if plans did not know the benchmarks in advance, they would be more likely to submit bids that were reflective of their actual costs. Third, CBO expected that private plans would experience greater favorable selection (that would not be fully corrected for by risk adjustment) than in the current MA program. In other words, people enrolling in private plans would tend to cost less than FFS enrollees with similar risk scores, allowing plans to further reduce their bids.

CBO also cited several factors that would tend to increase plan bids. First, if the FFS program became relatively smaller, private plans might have more difficulty negotiating payment rates with providers that are similar to FFS rates. This change could place upward pressure on plan costs and bids. Second, CBO expected that enrollment in private plans would be significantly higher in many areas than it is today because plan bids in those areas are significantly lower than FFS. Thus, some plans would broaden their networks to accommodate the increased enrollment, and those broader networks would tend to include providers with higher costs. However, CBO has since changed its thinking on this issue. In a recent paper, the agency found that hospital payment rates for MA plans were equal to FFS rates, on average, regardless of the share of Medicare beneficiaries enrolled in MA plans in a given market. As a result, CBO's modeling of premium support proposals now assumes that managed care plans would continue to negotiate hospital payment rates that are comparable with FFS rates, even if the share of beneficiaries enrolled in plans rises substantially. One key part of this assumption is that plans would have the statutory authority to use FFS rates to pay

TABLE 3–13 **Distribution of FFS and MA enrollment, in millions, by type of market area, 2016**

	Number of areas	Number of enrollees (in millions)		
		Total	FFS	MA
Total, all market areas	1,231	54.5	37.1	17.4
Market areas without qualifying MA plans*	208	1.3	1.2	0.1
Market areas where FFS costs ***less*** than the median MA plan:				
FFS is lower by $50 or less	295	10.7	7.3	3.4
FFS is lower by $51 to $100	185	4.7	3.3	1.3
FFS is lower by $101 or more	51	1.3	0.9	0.5
Subtotal	531	16.7	11.5	5.2
Market areas where FFS costs ***more*** than the median MA plan:				
FFS is higher by $50 or less	223	13.0	8.7	4.3
FFS is higher by $51 to $100	146	6.8	4.9	1.8
FFS is higher by $101 or more	123	16.7	10.8	6.0
Subtotal	492	36.5	24.4	12.1

Note: FFS (fee-for-service), MA (Medicare Advantage). The differences between FFS spending and the median plan bid are expressed in monthly amounts. FFS spending for 2016 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments to make it comparable with MA plan bids. FFS spending has been 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. Number of Medicare beneficiaries and MA enrollees are as of January 2016. Components may not sum to totals due to rounding.
*Market areas have no eligible plans if either (1) no MA plans are available in those areas or (2) we excluded all of the available MA plans, such as employer group plans and special needs plans, based on the criteria we used for our analysis.

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

for services provided by out-of-network providers, as they do now in MA (Maeda and Nelson 2017).

CBO emphasized that these outcomes, for both plans and beneficiaries, are highly uncertain because a premium support system would create substantial changes for beneficiaries, private plans, and providers that are all difficult to predict. The effects could vary considerably depending on the design choices that policymakers make. For example, CBO noted that the decision of whether to include the FFS program is very important and that eliminating FFS could result in program spending that is higher than under current law.

Potential shifts in FFS and plan enrollment

Our illustrative framework for setting benchmarks and beneficiary premiums can also be used to provide some impressions about the potential impact of premium support on FFS and managed care enrollment. Under this framework, the benchmark equals the lower of the FFS bid or the median plan bid. The impact of premium support would thus depend heavily on the extent to which managed care plans participated in each market area and the relationship between the FFS bid and the median plan bid.

The potential impact of premium support would vary significantly across market areas. Table 3-13 stratifies market areas based on the relationship between FFS costs and the median MA plan bid in 2016. Under our method for defining market areas, we include 1,231 market areas in our analysis. The differences between FFS costs and the median plan bid are shown as monthly amounts. The table also shows total enrollment, FFS enrollment, and MA enrollment in each type of market area.

Under premium support, managed care plans may not be available in all market areas. Based on our criteria

to measure plan availability in MA, we found that 208 market areas did not have a qualifying plan. Relatively few beneficiaries live in these areas—1.3 million, or about 2 percent of all beneficiaries—and almost all were enrolled in FFS. (The few MA enrollees in these areas were in plans that we excluded from our analysis, such as employer group plans.) For these market areas, the FFS program would likely remain the predominant source of coverage unless managed care plans became more widely available.

In another 531 market areas where MA plans were available, FFS costs were lower than the median MA plan bid. A total of 16.7 million beneficiaries (31 percent of the total) live in these areas. Although FFS costs less than the median plan in these areas, about a third of the beneficiaries living there (5.2 million) were enrolled in MA plans since MA benchmarks in many counties are higher than FFS costs under the MA payment system and most MA plans can use rebate dollars to offer additional benefits (Table 3-13, p. 125).

Under our illustrative framework for calculating benchmarks and premiums, benchmarks in these areas would be based on FFS bids, and premiums for many managed care plans would increase. However, it is unclear how much premiums might increase. On balance, plans would likely submit somewhat lower bids than they do now in MA. Such a change in bidding behavior could reduce or eliminate the increase in premiums for some plans, particularly in areas where the median bid exceeds FFS spending by less than $50. In 2016, there were 295 such market areas, with 7.3 million FFS enrollees and 3.4 million MA enrollees (Table 3-13, p. 125). In these areas, it is difficult to say which type of coverage—FFS or a managed care plan—would have lower premiums and how much enrollment would shift from one sector to the other.

The situation is somewhat clearer for the 236 market areas where, in 2016, the median bid exceeded FFS costs by more than $50 (Table 3-13, p. 125). Under premium support, most plans in these areas would probably be more expensive than FFS, even with a change in bidding behavior. Premiums for most plans in these areas could increase noticeably, and we would expect a significant portion (well above 30 percent, based on experience in the MA program) of the 1.8 million MA enrollees in these areas to switch to FFS coverage or a less expensive plan. This shift in enrollment could lead some managed care plans to stop participating in these market areas, which could either reduce the number of available plans or result in no plans being offered in some areas.

Finally, in 492 market areas, the median plan bid was lower than FFS costs (Table 3-13, p. 125). These areas have 67 percent of the Medicare population—24.4 million FFS enrollees and 12.1 million MA enrollees. Under our illustrative framework, benchmarks in these areas would be based on the median plan bid, and FFS premiums would increase by an amount equal to the difference between the FFS bid and the median plan bid. (In these areas, any effort by plans to lower their bids would only widen the difference between FFS spending and the median plan bid.) Like the areas where FFS is less expensive, in a significant number of areas (223), the difference between FFS spending and the median bid is relatively small (less than $50). The experience in the MA program suggests that somewhere between 10 percent and 30 percent of the 8.7 million FFS enrollees in these areas might switch to a managed care plan.

FFS enrollees would have stronger incentives to switch to managed care plans in areas where FFS spending exceeded the median plan bid by more than $50. (This difference means that the monthly FFS premium in these areas would increase by at least that much.) A total of 15.7 million FFS enrollees live in these areas, and 10.8 million live in areas where the FFS premium would increase by more than $100 (Table 13-3, p. 125). This latter group of market areas includes many of the country's large metropolitan areas. The MA program has not seen premium increases of this magnitude, so its experience is of somewhat limited value in assessing how many FFS beneficiaries in these areas would switch to managed care plans. Nevertheless, it seems plausible that a majority—and possibly a sizable majority—of the 15.7 million FFS beneficiaries in these areas could eventually switch to managed care plans. In market areas where FFS premiums increase by particularly large amounts ($100 or more), the share of beneficiaries who were enrolled in FFS once premium support was in effect for several years could be relatively small.

In the areas where FFS spending exceeds the median plan bid, we could also see a substantial number of MA enrollees switch plans. Since the benchmark in these areas would be based on the median plan bid, about half of the 12.1 million MA enrollees in these areas would be in plans with bids that exceeded the benchmark. As a result, these plans—most of which now provide additional benefits funded by MA rebates and do not charge a supplemental

premium—would have to begin charging premiums (for both standard coverage and any additional benefits). Some beneficiaries in this subset of plans might want to change their coverage. Since the FFS premium would be even higher than their current plan's premium, some of these MA enrollees would most likely switch to other, lower cost plans.

Across all market areas, this rough analysis suggests that about 15 million FFS enrollees would ultimately switch to a managed care plan and 2 million MA enrollees might switch to FFS coverage. If these shifts occurred, more than half of Medicare beneficiaries (roughly 55 percent) would be enrolled in managed care plans, but a significant number of beneficiaries would remain in the FFS program.

These figures are very rough estimates at best and have little predictive value. There are simply too many other elements to a premium support system that would still need to be specified, beyond the illustrative framework in this chapter. For example, the ultimate impact of premium support on FFS and plan enrollment would depend partly on whether the use of premium support was phased in over time, how much premium subsidies would be for low-income beneficiaries, and the default form of coverage for beneficiaries who do not select coverage on their own. These and other policy decisions under a premium support system would have a significant impact on the behavioral responses by beneficiaries, plans, and providers.

Conclusion

The use of premium support for Part A and Part B would fundamentally change the structure of the Medicare program. Premium support would reorient the government's role in financing Medicare and require beneficiaries to pay for the added costs of more expensive coverage in the form of higher premiums. The Commission makes no recommendation on whether premium support should be used. Rather, we discuss an array of complex issues that the Congress may want to address if it decided to develop a premium support system. ■

Endnotes

1 The Part D program already uses a form of premium support. If policymakers decided to use premium support for Part A and Part B, they would need to decide whether the two systems should be combined or the Part D system would continue to operate separately.

2 Throughout this chapter, we use *managed care plan* as a generic term that encompasses any type of Medicare health plan operated by a private health insurance company. Most MA plans are either health maintenance organizations or preferred provider organizations, but a small share of MA enrollees (about 2 percent) are in private FFS plans, which do not "manage" their enrollees' care in any meaningful way. Under a premium support system, policymakers would need to decide what types of plans health insurers could operate.

3 For 2017, individuals who are not eligible for premium-free Part A coverage pay $227 per month if they have 30–39 quarters of Medicare-covered employment and $413 per month if they have fewer than 30 quarters of Medicare-covered employment. Very few individuals are in these two categories.

4 Beneficiaries must pay a higher Part B premium if they have higher income or did not enroll in Part B when they first became eligible. For beneficiaries with higher income, the Part B premium can be as much as $428.60 a month in 2017. For beneficiaries subject to the late enrollment penalty, the Part B premium is increased by 10 percent for each 12-month period that the beneficiaries did not have Part B coverage. In 2017, many beneficiaries actually pay a lower Part B premium than the base amount of $134 because the increase in the Part B premium for 2017 was larger than the increase in their Social Security benefits, and the increase in premium was capped at the amount of the increase in their Social Security benefits.

5 There is an option in the MA program for plans to collect the Part B premium.

6 By itself, the ability of some plans to provide the Medicare benefit package at a lower cost than the FFS program does not necessarily save the government money. The extent of any savings depends on the broader question of how Medicare pays managed care plans. For example, an MA plan that submits a bid that is lower than FFS spending may still receive payments that exceed FFS costs when factors such as rebates, quality bonuses, calculation of benchmarks, and diagnosis coding for risk adjustment are taken into account.

7 Policymakers may also want to consider how payments to disproportionate share (DSH) hospitals should be treated in a premium support system. DSH payments are currently included in FFS payment rates and MA benchmarks, but they could be broken out and paid separately (Medicare Payment Advisory Commission 2016a).

8 Because the beneficiary premium is risk standardized in this manner while the Medicare payment to the plan is based on the actual risk of each enrollee, the government payment is adjusted when the average risk score of plan enrollees is above or below 1.0. A "government premium adjustment" applies to ensure that the revenue from the fixed beneficiary premium combined with the revenue from the Medicare payment that varies by the actual risk scores of enrollees equals the plan's revenue requirements. Plans with enrollees who have an average risk score of 1.1, for example, would require an additional government payment to be made whole, while plans with an average risk score below 1.0 would have reduced government payments in recognition of the excess revenue coming from enrollee premiums that are set at a 1.0 risk level. The premium adjustment mechanism does mean that beneficiaries in plans with relatively lower risk scores would be subsidizing the premiums of beneficiaries in plans with higher average risk scores. This cross-subsidization also happens with the Part B premium today, which is set at a national level and does not vary despite regional differences in demographics, service use, price levels, or the risk status of beneficiaries (for example, in 2012, county FFS risk scores in the 50 states and the District of Columbia ranged from 0.68 to 1.40). A question that may need to be considered in a premium support system is whether premium adjustments would be exclusively *intra*-area adjustments or whether there would need to be *inter*-area adjustments if the intent is to have beneficiary premiums finance 25 percent of Part B program expenditures, as is currently the case.

9 The MA program does not allow cost sharing to vary on a disease-specific basis except through the formation of special needs plans (SNPs) for beneficiaries with chronic conditions and the CMS VBID demonstration project. The Commission has recommended permitting non-SNP MA plans to use VBID cost-sharing structures as a means of eliminating most SNPs for beneficiaries with chronic conditions (Medicare Payment Advisory Commission 2013b).

10 Because the basic benefit package of an MA plan must have cost sharing that is actuarially equal to FFS cost sharing, a plan that has a $20 copayment on a $200 physician visit (whereas FFS would have a $40 coinsurance) would have to raise cost sharing in some other way (such as imposing a deductible higher than Medicare's Part B deductible) to maintain actuarial equivalence with FFS—if the reduced copayment feature was the only difference between the plan's cost sharing and that of FFS.

11 If the additional charge was not enacted, the argument that the government should not finance the induced utilization that occurs in private plans—because it is not consistent with FFS Part A and Part B coverage—would be weaker because the government would also be subsidizing the induced utilization of FFS beneficiaries who have supplemental coverage.

12 For beneficiaries who enroll in managed care plans, CMS would need to adjust Medicare's payments to the plans to account for differences in health status. CMS makes such adjustments in both the MA and Part D programs.

13 MA plans can be either regional, serving CMS-specified regions that are composed of one or more states, or local, serving one or more counties. As of November 2015, more than 90 percent of MA enrollees were in local plans (Medicare Payment Advisory Commission 2016c). The Part D program conducts competitive bidding at the national level to establish its national average bid, base beneficiary premium, and Medicare contribution. However, the program also establishes a separate benchmark in each of its 26 regions that determines which plans will have their premiums fully covered by the program's low-income subsidy.

14 Policymakers could grant exceptions to certain managed care plans, such as those that are sponsored by providers that cannot easily serve an entire market area, particularly larger areas.

15 Under our illustrative approach that would set the benchmark equal to the lower of the FFS bid or the median plan bid, benchmarks in some market areas could conceivably be based on the lowest bid (for example, in areas where only one managed care plan is available and the plan's bid is lower than the FFS bid).

16 How much the benchmark would actually change if the FFS bid were compared with the lowest bid instead of the median bid (or the average bid or some other metric) would depend on the degree of variation in the bids submitted by managed care plans. If there was relatively little variation in the bids from the managed care plans, using one bid instead of another in the comparison with the FFS bid would have relatively little impact on the benchmark. Conversely, if there was substantial variation in the bids submitted by managed care plans, using one bid instead of another in the comparison with the FFS bid could have a much larger effect on the benchmark.

17 These figures are for FFS beneficiaries who have both Part A and Part B and use the hospital referral region as the geographic unit of analysis.

18 HEDIS is a registered trademark of the National Committee for Quality Assurance.

19 CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

20 The validity of using MA encounter data to calculate population-based quality measures for plans has not been tested.

21 CMS's authority to terminate plans based on their star rating is currently suspended.

22 The difference between the estimated and actual Part B premium amounts is also due to the fact that the actual Part B premium included an additional amount that is meant to bolster the reserves of the Supplementary Medical Insurance (Medicare Part B) Trust Fund.

23 There are a few exceptions to this general rule. Sponsors of MA plans may take individuals who have been enrolled in a non-Medicare plan, such as a Medicaid managed care plan or a commercial plan, and passively enroll them in one of their MA plans when those individuals first become eligible for Medicare. In addition, some states that are participating in CMS's financial alignment demonstration passively enroll new beneficiaries who are also eligible for Medicaid in integrated Medicare-Medicaid plans.

24 *Medicare Savings Programs* is an umbrella term for four distinct Medicaid programs that pay the Part A and Part B premiums and Medicare cost sharing for certain low-income beneficiaries. These programs have distinct eligibility rules and benefit packages (for example, only one program covers Medicare cost sharing). The federal government pays the full cost for one of the MSPs, known as the Qualifying Individual Program, using funds from the Medicare Part B trust fund. This section focuses primarily on MSP coverage of the Part B premium since that element would be the one most directly affected by the use of premium support.

25 Both programs have higher income and asset limits for couples. Medicare beneficiaries who receive full Medicaid benefits qualify for the LIS regardless of their income or assets.

26 The spending figure is for federal fiscal year (FY) 2015. Medicaid also spent $3.1 billion on Part A premium subsidies in FY 2015. The vast majority of Medicare beneficiaries do not pay premiums for Part A benefits because they have a sufficient work history. Beneficiaries who do not qualify for premium-free Part A coverage typically have low incomes, and Medicaid often pays their Part A premium.

27 Many researchers believe that the MCBS underreports beneficiaries' income, but how much that income is underreported is unclear. As a result, the survey likely overstates the number of beneficiaries with income below a given threshold (such as 200 percent of the federal poverty

level). We have adjusted the income amounts reported in the MCBS to account for this shortcoming, but figures from other researchers can differ. For example, the Kaiser Family Foundation estimated that about 33 percent of beneficiaries had income below 200 percent of the federal poverty level (Jacobson et al. 2017).

28 For 2017, between 3 and 10 zero-premium prescription drug plans are available in each region (Medicare Payment Advisory Commission 2017).

29 There are usually a number of zero-premium plans available. All of them qualify as low-cost plans under the LIS, but their overall costs vary. Although beneficiaries have an incentive to enroll in a zero-premium plan under this approach, they have no incentive to enroll in one of the lower cost zero-premium plans. This feature may reduce the incentives for Part D plans to submit low bids (Congressional Budget Office 2014).

30 Policymakers would also need to decide what would happen if these beneficiaries did not pay their portion of the premium. One option would be to automatically reassign these beneficiaries to zero-premium plans.

31 If an area has more than one zero-premium plan, CMS randomly assigns LIS beneficiaries among the available plans. This feature may reduce the incentives for drug plans to submit low bids—that is, once a plan has qualified as a zero-premium plan, any effort to submit a lower bid lowers the plan's revenue without any offsetting increase in the number of passive enrollments. Part D plans thus have an incentive to bid as close to the LIPSA benchmark as possible without going over it (Congressional Budget Office 2014).

32 This segment of the MSP population is known in Medicaid parlance as "qualifying individuals" (QIs). Although the federal match rate for QIs is 100 percent, the Congress also enacted annual caps on federal payments for QI benefits, which was a departure from Medicaid's traditional structure as an open-ended entitlement program. However, these caps have had little practical effect because the Congress has periodically raised them to accommodate growth in QI enrollment and the Part B premium.

33 These payments would be similar in nature to the so-called clawback payments that states make as part of the Medicare Part D drug benefit. The creation of the Part D program shifted the responsibility for providing drug coverage for dual-eligible beneficiaries from Medicaid to Medicare and thus lowered state Medicaid spending. However, states are required to make payments to the federal government that are equal to 75 percent of their estimated Medicaid savings, thus allowing the federal government to "claw back" most of the states' savings.

34 The other option that CBO examined based the government contribution on the second lowest plan bid.

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