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Amanda Starc

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Who Benefits from Medicare Advantage

Summary

The Affordable Care Act calls for significant cuts in reimbursements to insurers providing Medicare Advantage (MA) coverage, which has been the most popular alternative to traditional fee-for-service Medicare. Opponents of these cuts argue that they carry serious negative repercussions for seniors, and have lobbied successfully to force their postponement. But research coming out of the Wharton School suggests that cuts to MA reimbursements actually are unlikely to harm consumer welfare.

Keywords

Affordable Care Act, Medicare Advantage, ACA, MA, medicare, fee-for-service, health insurance, reimbursements, medical, welfare

Disciplines

Health Economics | Health Policy | Public Policy | Social Welfare

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ISSUE BRIEF



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WHO BENEFITS FROM MEDICARE ADVANTAGE?

BY AMANDA STARC

Medicare, the federal health insurance program for elderly Americans, covers 52 million people in the United States.¹ Because health care spending has increased dramatically since the program's inception in 1965, the program has a large and growing impact on the federal budget.

As baby boomers retire, both the number of enrollees and the costs are expected to rise. The Congressional Budget Office (CBO) estimates that Medicare spending will increase to 4.9% of GDP in 2038, a 63% jump from 2013.² While spending has slowed over the last few years, the Medicare program represents an increasing strain on the federal budget. Especially in the wake of the Affordable Care Act (ACA), the need to cut costs and develop innovative financing is more important than ever.

Medicare Advantage (MA) has been the most popular alternative to traditional fee-for-service (FFS) financing in the program's nearly 50 year history. In traditional FFS Medicare, the federal government pays hospitals and physicians directly for services. Under MA, the federal government

pays private carriers on a per-member, per-month basis to insure Medicare beneficiaries, who enroll voluntarily. Insurers have been able to attract consumers by adding a variety of benefits and lowering consumers' share of the costs, compared with traditional Medicare fees. However, critics contend that the MA program actually costs the federal government *more* than traditional Medicare, because MA enrollees tend to be healthier than average and therefore would rack up much lower costs if enrolled in FFS.

The ACA calls for cuts in reimbursements to insurers providing MA coverage that would save the federal government \$156 billion over the next nine years.³ This issue brief examines the potential impact of those cuts.

BRIEF IN BRIEF

- The Affordable Care Act calls for significant cuts in reimbursements to insurers providing Medicare Advantage (MA) coverage, which has been the most popular alternative to traditional fee-for-service Medicare.
- Opponents of these cuts argue that they carry serious negative repercussions for seniors, and have lobbied successfully to force their postponement.
- But research coming out of the Wharton School suggests that cuts to MA reimbursements actually are unlikely to harm consumer welfare.
- The research indicates that higher MA reimbursements do not translate into less expensive or higher quality care for consumers. But they do benefit insurance firms, which see higher profits, some of which they channel into increased advertising to encourage more people to enroll in the MA plans they offer.
- While lower reimbursements likely would reduce insurance firm profitability, they would substantially improve the federal budget—without negatively impacting the quality of care received by patients.

MEDICARE ADVANTAGE VS. TRADITIONAL MEDICARE

MA plans, originally known as Medicare Part C plans, were created in the 1980s as a way to introduce to the Medicare program the choice, competition, and innovation typically associated with health maintenance organizations (HMOs).⁴ Since then, MA has been subject to changing regulations and reimbursement rates relative to traditional Medicare. Perhaps as a result, the program's popularity has fluctuated over time and across the country. Figure 1 shows the percentage of the Medicare population that purchased MA plans, also called MA penetration rates, from 1999 to the present. The program covered 13% of Medicare beneficiaries in 2005 and 28% of Medicare enrollees in 2013. Similarly, Figure 2 shows MA participation by state for 2013: for example, the program covered 39% of Medicare beneficiaries in Pennsylvania but only 16% of Medicare beneficiaries in neighboring New Jersey.

Typically, firms attract consumers by offering more comprehensive coverage than traditional Medicare provides. For example, traditional Medicare exposes beneficiaries to substantial cost-sharing, including a \$1216 deductible for Part A (hospital) services in 2013 and 20% coinsurance for Part B (physician) services, without an out-of-pocket maximum. As a result, most Medicare beneficiaries buy some form of supplemental or additional health insurance, either through a former employer or from the individual market. MA is an example of a type of policy sold on the individual market (Medigap is another). In addition to offering lower cost-sharing, MA plans may also offer dental, vision, or drug coverage; the latter was especially valuable before the Medicare Part D program went into effect in 2006.

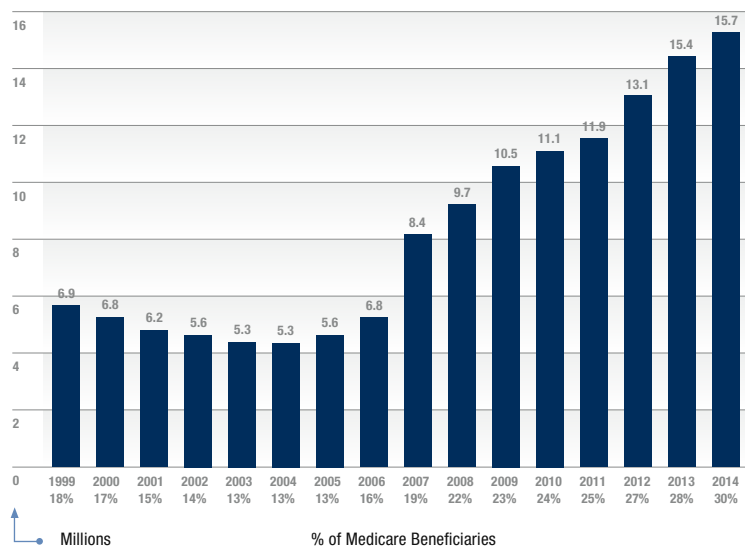
On average, MA can be a very good financial deal for consumers. For example, the Centers for Medicare and Medicaid

Services (CMS) estimates that an Independence Blue Cross plan⁵ in Philadelphia County has a total yearly out-of-pocket cost – the amount the average beneficiary can expect to spend on medical care – of \$3,950, as compared to \$6,180 in traditional FFS Medicare. In exchange for lower cost-sharing, the MA beneficiary typically has a narrower choice of doctors and hospitals.

DOES THE ADDITIONAL COST OF MEDICARE ADVANTAGE BENEFIT CONSUMERS?

While MA may substantially reduce financial risk for many Medicare beneficiaries, there is some concern over the choices available to consumers. The market is largely controlled by a small number of

FIGURE 1: TOTAL MEDICARE PRIVATE HEALTH PLAN ENROLLMENT, 1999-2014



Note: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage Plans. Source: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2014, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April. <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/>

But for many consumers, this is a reasonable tradeoff. A number of the large, national insurers offer MA plans. United Healthcare sold 21% of total plans across the country in 2013; Blue Cross Blue Shield affiliates and Humana also had substantial national market share.⁶ Marketing, both directly to consumers and through agents and brokers, plays a potentially important role in driving market share. There is also some evidence that advertising may be used to attract healthier than average consumers.⁷

insurers who advertise extensively and may attempt to select healthier than average beneficiaries. Insurers certainly have an incentive to select such beneficiaries, since the federal government pays insurers on a per member, per month basis, rather than reimbursing for the actual expenses that members incur for medical services.

To reduce costs, the ACA has proposed large cuts to insurer reimbursements, which the insurance industry has successfully protested. This raises a natural question: How much does additional

¹ <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/>

² <http://www.cbo.gov/publication/44582>

³ <http://www.cbo.gov/publication/43471>

⁴ <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/>

⁵ Keystone 65 HMO; figures obtained from the Medicare

Compare tool

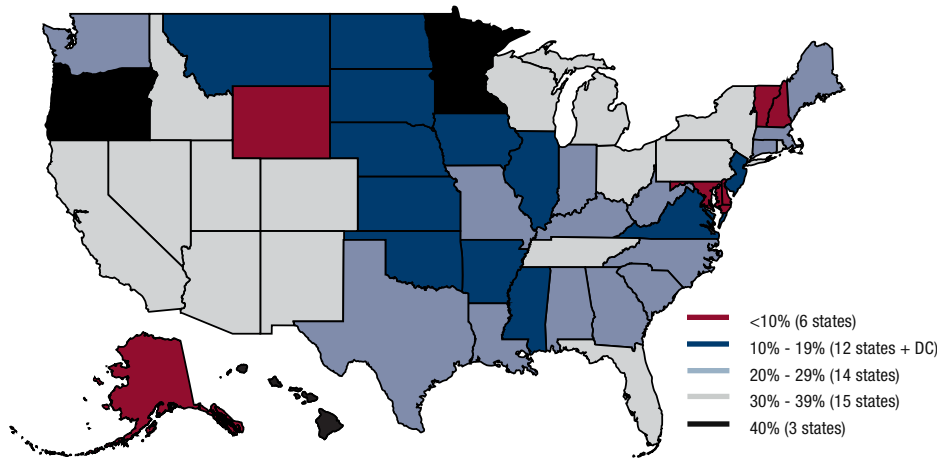
⁶ <http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8448.pdf>

⁷ <http://kff.org/medicare/pitching-private-medicare-plans-an-analysis-of/>

⁸ http://www.nber.org/papers/w19989.pdf?new_win=1

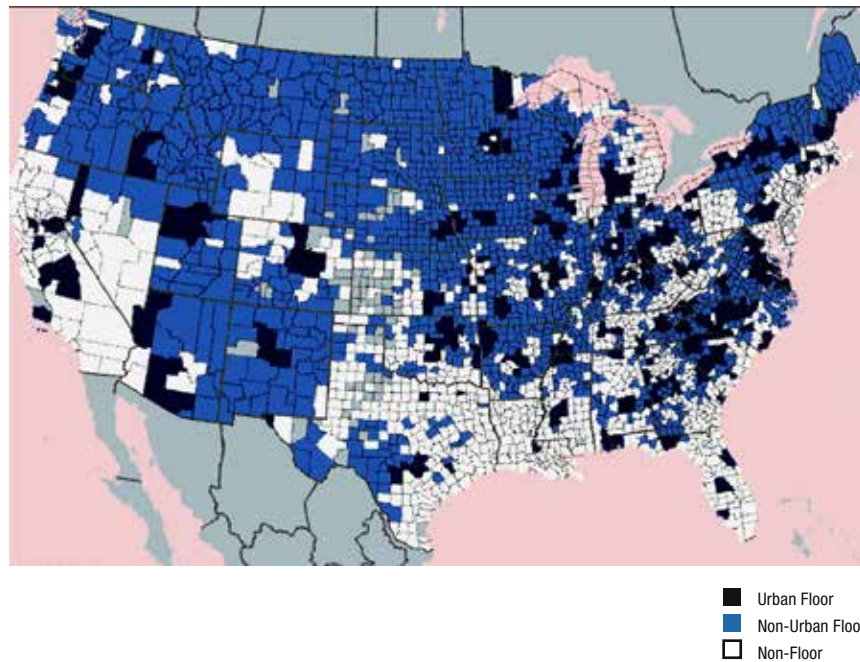
⁹ http://www.u.arizona.edu/~nosal/MA_switching_6_12.pdf

FIGURE 2: SHARE OF MEDICARE BENEFICIARIES ENROLLED IN MEDICARE ADVANTAGE PLANS, BY STATE, 2014



Note: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage Plans.
Source: MPR/Kaiser Family Foundation analysis of CMS State/Country Market Penetration Files, 2014. <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/>

FIGURE 3: NATIONWIDE DISTRIBUTION OF FLOOR COUNTIES



money spent on MA reimbursements benefit consumers?

More money for firms does not necessarily improve the cost of plans or the quality of coverage for the public, according to recent research I co-authored with Mark Duggan and Boris Vabson from the Wharton School of the University of Pennsylvania. Our paper, titled “Who Benefits When

the Government Pays More? Evidence from Medicare Advantage,” does find that higher reimbursement increases both patient enrollment and the number of insurance companies in the market. These increases benefit insurers more than consumers.

We examine a concept called economic incidence—essentially, measuring who (i.e., the supplier or the consumer) truly pays a

tax or benefits from a subsidy. To measure the economic incidence of MA reimbursements, we look across geographic areas with higher or lower payments—called benchmarks—to insurers. The benchmark is the basis for the average payment per member, per month. Benchmarks reflect both the costs of traditional Medicare, which are likely to be correlated with demand for MA, and regulation. In order to establish causation, rather than just correlation, we use unique regulation in the MA market known as payment floors. These are the lowest amounts of reimbursement firms can receive from the government for providing care, intended to spur private firms to participate in the MA program. The government established two payment floors, one for urban counties, which is approximately 10.5% higher than the one for rural counties. A county changes from rural to urban when its associated metropolitan statistical area (MSA) goes from a population of 249,999 residents to 250,000. While the average rural county is likely to be very different from the average urban county, those that are close to either side of this population threshold are likely to be fairly similar. These are the counties the study compares. Figure 3 highlights rural and urban floors; during the 2006–2011 time period of the study, floor counties accounted for the majority of U.S. counties.

As an example of how this threshold works, consider two comparable Illinois counties, Peoria and Sangamon, whose 2008 benchmarks were both set at the payment floor. Peoria County belongs to the Peoria, IL MSA with a population of 367,000, while Sangamon County belongs to the Springfield, IL MSA with a population of just 204,000. As a result, although these counties have similar per capita costs for traditional Medicare FFS coverage (\$601 for Peoria and \$612 for Sangamon), the county-level benchmark of what firms were reimbursed in Peoria County was \$772 per month—corresponding to the urban floor rate—versus just \$699 per month in neighboring Sangamon county—the rural floor rate.⁸

The study examines a number of related questions. First, are insurers more likely

to voluntarily sell MA plans in the more generously reimbursed urban floor counties than in rural floor counties? The answer is yes; on average, 1.9 additional firms enter the market in urban floor counties, where the benchmarks are higher. With more firms, there is substantially lower market concentration: there are more insurers competing for customers in urban floor counties. Second, are more Medicare beneficiaries enrolled in MA plans in counties with higher reimbursements? Again, the answer is yes; the MA participation rate nearly doubles in urban floor counties, an increase of 12 percentage points. For those who believe that MA is either more cost effective or a great deal for consumers on average, this is a good thing.

In addition to the number of firms and participants, the study examines prices. If, for the most part, consumers benefit from increased government spending on the MA program, we should see consumer premiums fall by about \$73 per month—the increase in the subsidy—in urban floor counties. However, MA reimbursements from the federal government are so high that many firms charge no premium beyond what beneficiaries pay for Medicare Part B. We find little effect on premiums. Instead, firms could reduce copayments or deductibles. The Medicare program publishes estimated out-of-pocket costs for each MA plan. If firms reduce deductibles or copayments, the estimated out-of-pocket costs also fall. These costs are \$10 per month lower in urban floor counties than in rural floor counties, but this result is not statistically significant. While this suggests that consumers receive some benefit from higher government payments, the part of the subsidy that passes through to consumers is far from the full amount.

While we find little evidence that plans are more generous in urban floor counties, financial features are only one dimension of insurance that a beneficiary may value. Consumers worry about access to doctors and hospitals, which are affected by insurer networks. They also might care about administrative aspects of plans, such as the quality of customer service or an insurer's reputation. Finally, Medicare beneficiaries may look for which MA plans can help them

manage their own health care effectively.

To examine these dimensions of plans, the study looks at survey data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS), performed by the Agency for Healthcare Research and Quality (AHRQ). The CAHPS includes survey data from about 160 thousand Medicare recipients each year.

Do consumers in urban counties like their doctors more? No; quality ratings are statistically the same between urban and rural counties. Do consumers in urban floor counties go to the doctor more often or like their specialists more than consum-

“The research indicates that an additional dollar of federal spending on the MA program translates into, at most, only 40 cents of additional financial benefit for consumers.”

ers in rural floor counties? No again; the estimates are statistically the same. Finally, do consumers in urban floor counties report that they are in better health? No again; the results are statistically identical.

To summarize, the results show that higher reimbursements lead to higher MA participation rates, which explains some of the variation across the country and over time. More firms enter the market, thus the market appears more competitive, but prices do not fall substantially and quality does not increase.

Consumers may not benefit from higher reimbursements for a couple of reasons. First, consumers in urban floor counties may be sicker and more expensive to insure than those in rural floor counties due to insurance companies being selective. However, the research indicates that this is unlikely. First, MA payments are adjusted for risk, and enrollees look no more risky in urban than in rural floor counties. Second, to account for the results, new enrollees would

have to be about 30% more expensive to insure, which seems unlikely.

If firms being selective cannot explain these results, a lack of competition in the market might. Insurers may be able to control prices in markets where they have an advantage over competing firms. Theoretically, this would explain why plan generosity does not increase. Two facts support this argument. First, larger publicly traded insurers experienced abnormally high returns when proposed cuts to the MA program were delayed by the government. Second, firms have advertised extensively, which according to the study explains the increase in MA enrollment in urban floor counties.

The results indicate that firms spend on average about \$5 more per Medicare beneficiary for television spot advertising in urban floor counties than in rural floor counties. While this is not a large amount, it is almost certainly underestimates the total resources dedicated to plan marketing. This can help explain why so many beneficiaries in urban floor counties choose MA over traditional Medicare, even though the plans themselves do not appear substantially more generous.

The research indicates that an additional dollar of federal spending on the MA program translates into, at most, only 40 cents of additional financial benefit for consumers. Similarly, quality is unchanged, yet advertising spending increases. This has important implications for policy, and the results should play into the decisions regarding proposed cuts to the Medicare Advantage program.

POLICY IMPLICATIONS

The ACA's proposed cuts to the MA program are designed, in part, to fund insurance expansions in Medicaid and subsidized exchange plans. Proponents of these cuts argue that the program overpays insurers relative to traditional Medicare. Critics argue that the cuts would have serious negative repercussions for seniors, and have organized advertising campaigns and lobbying efforts to postpone or even abandon the cuts altogether. Indeed, a few weeks ago, after facing substantial lobbying and politi-

cal pressure, CMS announced that rather than cutting MA rates by 1.9% for 2015, rates would increase by 0.4%.

Our findings indicate that cuts of up to 10% are unlikely to harm consumer welfare by increasing premiums or out-of-pocket costs or lowering the quality of care. By contrast, cuts in MA reimbursements may cause firms to advertise less and leave less profitable markets, which could lead to lower enrollment in MA plans.

While each dollar spent by the government on MA may not greatly improve the value for Medicare beneficiaries, those dollars spent on MA can lower the average consumer costs when measured against traditional Medicare. The mere fact that consumers are more likely to choose MA

plans implies that they prefer them to traditional Medicare. Therefore, policy makers might be concerned that cuts could result in declining enrollment. However, a great deal of evidence suggests that consumers will stick with what they know or what they have done in the past,⁹ which may mean less of an impact on reducing enrollment.

Ultimately, the study predicts that lower reimbursements are likely to reduce insurance firm profitability but improve the federal budget. Lower reimbursement rates are likely to save the federal government money in two ways. Obviously, lower reimbursements mean beneficiaries enrolled in MA cost less. Furthermore, assuming MA is more expensive than traditional FFS, lower enrollment in MA would reduce the overall

costs of the program.

More broadly, the MA program highlights a critical issue facing policy makers and practitioners in a post-health reform world. As the United States builds on its existing private insurance system with publicly financed subsidies and increasing regulation, the government must set rules that encourage private insurers to participate while reducing the burden on taxpayers. Similarly, practitioners must find a way to create value in an evolving marketplace. These challenges exist not only in the Medicare program, but in the newly formed health insurance marketplaces as well. Continuing dialogue among practitioners, academics, and policymakers should spur future research and better policy in this area.

ABOUT THE AUTHOR



Amanda Starc, PhD

*Assistant Professor of Health Care Management,
The Wharton School*

Amanda Starc is an Assistant Professor in the Department of Health Care Management at the Wharton School of the University of Pennsylvania, and a Senior Fellow at the Leonard Davis Institute of Health Economics. She received her BA in Economics from Case Western Reserve University, and her PhD in Business Economics from Harvard University. Dr. Starc's research interests include industrial organization and health economics. Her research examines the Medicare Part D and Medicare Supplement ("Medigap") markets for the elderly, as well as consumer behavior in insurance exchanges. Her work links models of consumer choice and insurer incentives, and uses a range of econometric techniques to analyze data.

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