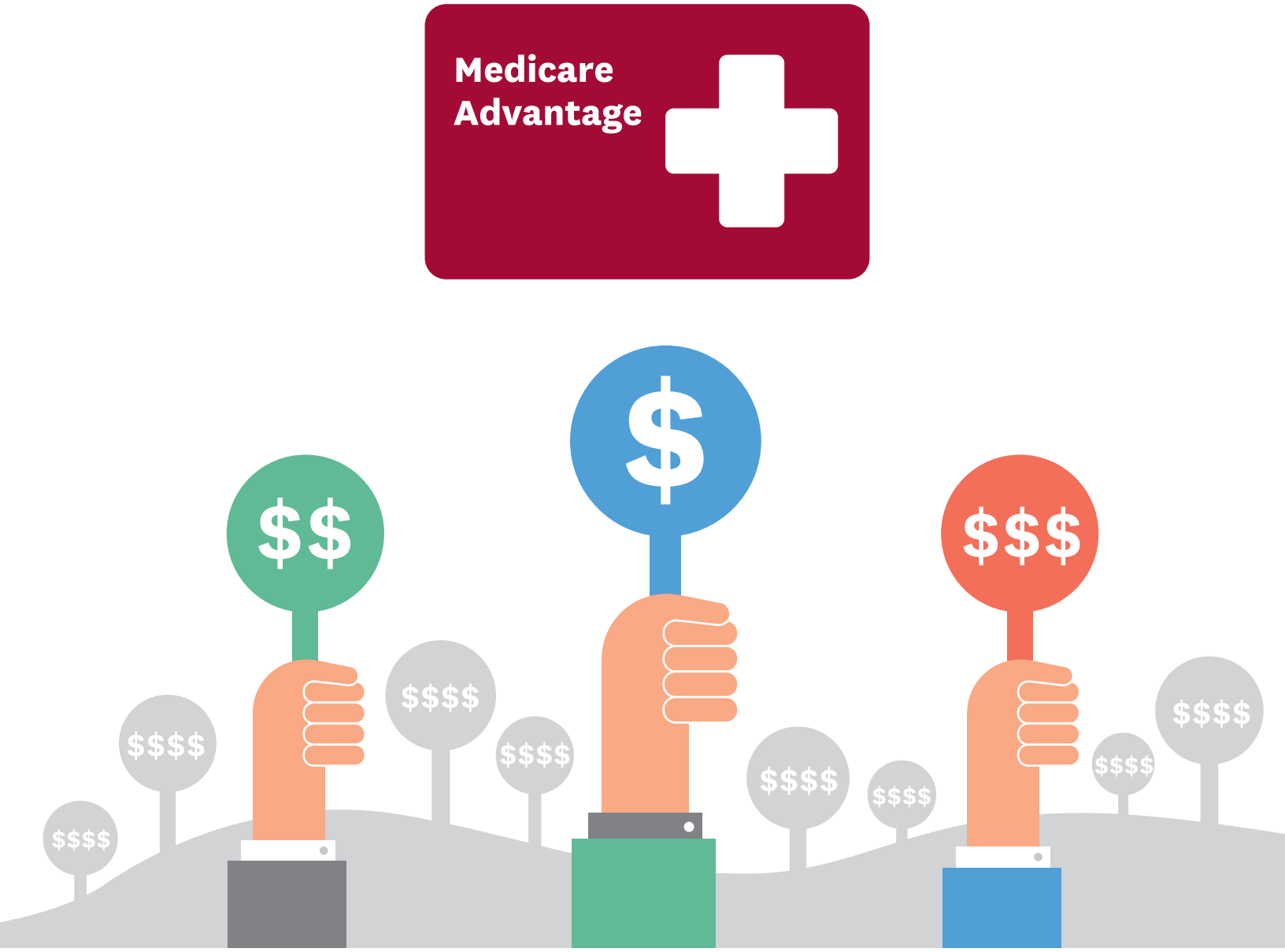
Fixing Medicare Advantage With Competitive Bidding



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Fixing Medicare Advantage With Competitive Bidding

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POLICY CONTEXT

In April 2024, 55% (33.2 million) of Medicare beneficiaries were enrolled in Medicare Advantage (MA) private health plans, 6 million more than those selecting government-administered traditional Medicare (TM).[a,1]

On average, compared to TM, beneficiaries in MA receive $2,142 in enhanced benefits (including a limit on maximum out-of-pocket costs, which is a requirement). While evidence comparing quality of care is mixed, MA quality measures need improvement. Unfortunately, more generous MA benefits cost taxpayers and beneficiaries (through higher Part B premiums) $83 billion—22%—more in 2024 than what TM would have cost. Basing MA payments on TM costs drives most of the overpayments, with payments inflated by more aggressive coding of diagnoses and plans being paid for average-cost beneficiaries while enrolling healthier-than-average beneficiaries (i.e. favorable selection).[2] We begin by analyzing key shortcomings in MA program design and operation that overpay plans, undermine informed beneficiary choice, and limit effective competition among plans. After examining several MA reform options, we recommend using competitive bidding for standardized benefits to set plan payments and enhance beneficiary choice by making available understandable information comparing plans and quality.

KEY TAKEAWAYS

- The current approach to setting MA payment rates overpays plans by 22%—$83 billion—compared to what the government would have spent if the enrollees had instead been in TM in 2024, with taxpayers funding $70 billion and Medicare beneficiaries paying $13 billion in higher Part B monthly premiums.[2]
- Meaningful beneficiary choice is impeded not only by the overwhelming number of plans—an average of 43—but also by the lack of standardization. Limited availability of information further undermines competition and prevents beneficiaries from easily comparing plan quality, provider networks and costs – fundamental details needed for making informed decisions.
- Fixing these problems requires delinking MA rates from TM costs, fostering more competition among plans, and better informing beneficiaries.
- The approach we recommend—competitive bidding—would rely on market forces to set MA rates. For many years, competitive bidding has set payment rates for Medicare prescription drug (Part D) plans, insurance plans offered under the Affordable Care Act, and Medicaid managed care plans in many states.
- Rather than relying on market forces to set MA rates delinked from TM costs, the Centers for Medicare and Medicaid Services (CMS) could administratively set rates but this starkly different alternative may be especially open to influence by the political power of some stakeholders.
- Standardizing plan benefit designs, facilitating enrollee choice by greatly expanding plan-specific information, and shifting from county-based to larger market areas would enhance meaningful competition and the effectiveness of competitive bidding.

a. The enrollment statistics in this paper incorporate the 91.6% of Medicare beneficiaries in the 50 states and the District of Columbia with both Part A and Part B (a requirement to join MA) and exclude those with only Part A, Part B, or living in American Samoa, Guam, Northern Marianas, Puerto Rico, Virgin Islands or foreign countries. (In Puerto Rico, which totals 94.0% of beneficiaries in territories, 85.0% of 0.8 million Medicare beneficiaries—and 95.6% of the 0.7 million beneficiaries with both Part A and Part B—enroll in MA due to MA rates markedly exceeding TM reimbursement.) The April 2024 enrollment data are adjusted by the most recently reported number of beneficiaries (December 2023) with only Part A or Part B. Although MA plans have the option to either include or exclude Part D drug benefits, 91.6% of enrollees enroll in private plans that cover drugs.

ABSTRACT

In April 2024, 55% of Medicare beneficiaries were enrolled in private, Medicare Advantage (MA) plans—outnumbering by 6 million those in the traditional, government-run option. Many are attracted to these private plans by the extra benefits that average $2,142 per MA enrollee. Private plans offer beneficiaries an important option, but flaws in MA rules increase spending, limit competition and hamper beneficiaries from making informed choices. The Medicare Payment Advisory Commission (MedPAC) reports the flawed methods of paying MA plans results in $70 billion in higher taxpayer costs, $13 billion in higher Part B monthly premiums and excess insurer profits. MA rates assume the spending and diagnostic coding practices in traditional Medicare (TM) also apply to MA—that MA members and TM recipients have similar average cost and health status. Unfortunately, neither of these critical assumptions is true: Medicare will overpay plans by $83 billion in 2024 because MA beneficiaries are healthier than average and payments are inflated by more aggressive coding of diagnoses. After summarizing current MA rules and their effects, we propose reforming MA by using competitive bidding for standardized benefits to delink MA payment rates from TM spending and providing information that facilitates beneficiary choice and enhances competition.

INTRODUCTION

In April 2024, private health plans enrolled 55% of Medicare beneficiaries. With 33.2 million enrollees, Medicare Advantage (MA) attracted 6 million more participants than the 27.2 million in government-administered traditional Medicare (TM).[1] The Medicare Modernization Act of 2003 shifted individuals' preferences for MA versus TM and spurred steady increases in MA enrollment from 16.9% (6.6 million) in 2006, the year MA reforms became effective.[3] Between March 2006 and April 2024, MA enrollment grew by 26.6 million, exceeding the 21.4 million overall increase in beneficiaries because TM fell by 5.2 million.

With CMS paying an annual average of 22%—$2,329—more per beneficiary than TM in 2024, plans offered $2,142 in extra benefits not available in TM, a factor influencing beneficiaries to prefer MA.[2] MA averaged gross (profit) margins of $1,730 per enrollee in 2021, two-and-a-half times the $689 average retention of fully insured employer groups and more than double the margins in other market segments.[4] Not surprisingly, richer benefits attract enrollees and greater margins attract insurers.

MA rates reflect the average monthly TM spending in a county adjusted for a "standard" beneficiary—one with a risk score of 1.0. The monthly capitation paid to a plan for each enrollee reflects the rate in the county of residence, increased or decreased by the actual risk score calculated based on demographic information and reported diagnoses.[b,5] Inadequately adjusting for systematic differences between MA and TM beneficiaries will generate $83 billion in MA overpayments in 2024, for two primary reasons. First, more aggressive coding of diagnoses inflates MA enrollee risks scores and will generate $50 billion in estimated MA plan overpayments in 2024. Second, an estimated $35 billion in overpayments will arise from favorable selection, which

b. CMS also factors into MA payments the projected cost each plan submits to CMS six months in advance of a year, its "star ratings" and a statutory formula incorporating the relative costliness of a county. The MedPAC overpayment estimate excludes the statutory minimum adjustment of 5.9% to offset upcoding and $15 billion in annual Star Ratings bonuses (intended as a proxy for plan quality) because Star Ratings statutorily increase plan payments rather than being budget neutral.

occurs because beneficiaries choosing MA have lower actual spending than their risk scores predict.[6] The flip side of favorable MA selection is an increase in average spending by beneficiaries remaining in TM, further distorting the basis for MA rates.[7]

In addition to overpaying plans, current MA rules undermine competition by allowing unlimited non-standardized options without providing information needed to compare plans. The average beneficiary has access to 43 MA plans in 2024, more than double the average of 20 in 2018.[8] Research indicates that too many choices impair decision-making, a problem exacerbated by limited information with which to compare plans on quality, out-of-pocket costs and other key attributes.[9] During annual open-enrollment periods, 10% of MA enrollees shifted plans and less than 1% switched to TM.[10]

This paper proceeds by first summarizing plan bids, plan payments, enrollee premiums, extra benefits and risk adjustment in MA, after which we discuss how the current program limits competition and the inadequacy of information available regarding plan costs, quality and other important factors affecting beneficiary choice. After this background, we explain how competitive bidding can replace the process by which MA plans submit "bids" that set their payments from CMS, while also standardizing and limiting plan offerings and providing beneficiaries with essential information for making informed choices.[11] The final section identifies options to limit potential disruptions when transitioning from the current system to competitive bidding.

BACKGROUND: HOW MA CURRENTLY OPERATES

In 1985, CMS implemented legislation creating a new option that allowed Medicare beneficiaries to join health maintenance organizations (HMOs) that would be paid monthly capitated amounts equal to 95% of average spending by TM beneficiaries. In response to private plans not being available in some areas, Congress enacted legislation in 1997 that led to MA payments in many areas exceeding what the beneficiaries would have cost in TM. In 2019, CMS no longer required plans offered in a market by a MA parent organization to differ meaningfully; this change was associated with a 119% increase in the number of available MA plans by 2023. Nearly all Medicare beneficiaries have access to an MA plan and can join a "$0 premium" MA plan that offers prescription drug benefits (referred to as an MA/PD plan) and other extra benefits without an additional premium above their Part B premium.[2]

Unlike comparing the monthly premium amounts (or $0) that plans charge, beneficiaries frequently face significant challenges in assessing both the extent and significance of MA plan variations in beneficiary cost-sharing, extra benefits and access to care. Although requiring plans to offer a standardized benefit could reduce or eliminate variations in cost-sharing and extra benefits, additional information would be needed to clarify constraints on access to care such as those involving the breadth or narrowness of networks of contracted providers, availability of primary care appointments for new patients, lead time and referral requirements to see specialists, and services requiring prior authorization and the stringency of the applicable criteria.[12]

Plan Bids and Premiums

All Medicare beneficiaries may choose among TM or an MA plan when they initially become eligible for Medicare and during open enrollment from October 15 to December 7 of each calendar year. Before each year's open-enrollment period, plans submit "bids" to CMS that specify their expected monthly cost of benefits covered under Medicare Part A (inpatient care) and Part B (outpatient care) for a standard beneficiary (i.e., with a risk score of 1.0) in the upcoming calendar year.

CMS sets benchmark rates for each county based on average spending by TM beneficiaries residing in the county. If a bid exceeds the benchmark, the plan must charge enrollees the difference as an MA premium (in addition to their Part B premiums). For a bid below the benchmark, 50% to 70% of the difference ("rebate") is retained by the plan, with the specific percentage based on a plan's Star Rating.[13] A plan may use its rebate to lower monthly beneficiary premiums, reduce cost sharing, subsidize the cost of Part D coverage integrated with the MA plan, or provide other extra benefits such as health club memberships or (limited) vision, hearing and dental coverage. Additional premiums or rebates are the same for all enrollees in a county, not varying according to each enrollee's risk. Rebates can also fund higher insurance company profits (potentially constrained by a minimum medical loss ratio). In 2023, 73% of MA enrollees chose plans with a $0 monthly premium that offered lower cost-sharing for Medicare covered services, Part D drug coverage and other benefits.[c,14,15]

Notwithstanding significant increases in the number of Medicare beneficiaries as baby boomers have aged and become eligible for the program, the total number remaining in TM has fallen in recent years due to increasing MA enrollment. As a result, many counties with small populations have too few

c. In contrast to enrollees in $0 MA/PD plans, TM beneficiaries in (standalone) prescription drug plans (PDPs) in 2024 pay an average monthly premium of $34.70 for coverage.

TM beneficiaries to provide a statistically reliable estimate of average TM spending in a year.[16]

Risk Adjustment, Favorable Selection and Plan Payments

The monthly capitation paid to MA plans partially depends on each enrollee's "risk score." Risk scores are intended to statistically adjust expected spending relative to an "average" beneficiary based on reported diagnoses believed to be predictive of future use of care, demographics and basis of Medicare eligibility (e.g., age, disability, also receiving Medicaid). Because reporting additional diagnoses can increase the monthly capitation paid to MA plans, many MA plans have responded by engaging physicians and others in initiatives to report additional diagnoses. In contrast, providers have no incentive to report additional diagnoses in TM. MedPAC estimates that the effect of upcoding on risk scores will increase MA payments by $50 billion in 2024.[6]

Distinct from aggressive coding, the current risk-adjustment methodology does not adequately capture the extent of spending variation among beneficiaries with the same risk score and the propensity of healthier patients to have systematically selected MA. Favorable selection will overpay plans by $35 billion in 2024 by paying rates that reflect average TM spending for MA beneficiaries with below average spending.[6]

Too Many Options Limit Choice and Competition

Behavioral economics research has shown that an excessive number of choices lessens the degree to which consumers make wise choices.[9] Having to evaluate large numbers of plans with complicated designs that have not been standardized precludes most beneficiaries from choosing plans wisely and likely leads many in MA to not even consider changing plans during open seasons.[17] Plan premiums do not convey clear price signals about value given that almost three-quarters of MA beneficiaries enroll in $0 premium plans and are likely not to understand the complexity of differences in benefits, quality, provider networks and access to care.

Because beneficiaries have neither the information nor the wherewithal to assess an overwhelming number of products, plan competition on the basis of value is undermined. In the absence of vigorous competition, plans can retain as profit more of the $2,329 in average annual per beneficiary rebates. Plans prioritize types of extra benefits likely to attract healthier enrollees (e.g., health club memberships) rather than benefits more attractive to sicker enrollees (e.g., lower maximum out-of-pocket costs). The inertia of beneficiaries when it comes to plan choice ameliorates the threat of losing enrollees, allowing plans to inflate their bids, limit the value of extra benefits, sustain lower clinical quality, or adopt particularly aggressive utilization management or network access policies and practices.

APPROACHES TO REFORM MA

Reforming MA involves two interrelated elements. One is basing payments for MA plans on amounts that do not exceed what Medicare would pay for comparable beneficiaries in TM. Given the extensive degree of favorable selection and upcoding, we believe this can best be accomplished by breaking the link between spending in TM and MA payment rates. The other reform involves enhancing competition among MA plans by standardizing benefits and improving information to generate more efficient bids.[18] Offsetting the cost of standardized but somewhat more generous benefits than TM, greater competition among plans would lower MA bids and shift the mix between plan profits and benefits.

The two options to reform benchmarks involve either continuing to set rates administratively—but without linking rates to TM spending—or relying on competitive bidding to determine what Medicare pays plans, an approach similar to that used in Medicare for Part D prescription drug plans. Under either approach, spurring more competition involves steps including strictly limiting the number of benefit designs that plans can offer, the number of options from each MA organization (MAO), and creating easy-to-understand information that enables comparing plans on key dimensions such as price, actuarial value, quality, customer service, provider networks, expected out-of-pocket costs and provisions affecting access to care.[18]

While standardizing plan benefits is required for competitive bidding, it can also greatly increase competition under administered pricing. An advantage of competitive bidding is that since standardization is essential to its functioning, more standardization might, in fact, be achieved.

Administratively Set MA Rates

For decades, CMS has administratively updated payment rates for a wide range of provider services in TM—as well rates for MA plans.[d] At different times and for different payment systems, the range of discretion and specificity of criteria for setting rates have varied widely. In some instances, Congress has delegated essentially unfettered discretion to CMS; in

d. Currently, the rates paid by a plan in a county combine the benchmark that CMS administratively updates with what each plan estimates as its cost of providing Part A and Part B benefits (i.e., what the statute calls a "bid"). Despite requiring notional bids, a plan's payment only reflects its costs, without any relationship to what other plans have bid.

other situations, Congress has specified highly prescriptive directives with little, if any, flexibility for CMS. Administrative payment systems typically involve establishing rates in the first year, with annual update factors for subsequent years. Other rate-setting decisions may involve altering how the rules of a payment system operate or changing specific components; frequently, changes are "budget neutral," whereby an increase in one element requires offsetting reductions elsewhere in the payment system.

The first question when administratively setting a new MA benchmark is how—and for how much—to set it. Without a consensus on the principled basis for determining a new administrative benchmark, any new approach would be subject to intense debate. Setting the new administrative benchmark as a function of either TM costs or existing MA rates would incorporate current inequities, likely limit differences from the current benchmarks and fail to correct overpayments. The rules in a legislative proposal for updating MA rates would heavily influence the 10-year budgetary score estimated by the Congressional Budget Office, as well as projections of effects on beneficiaries and MA enrollment.

One approach would limit administrative flexibility by linking annual updates to external economic factors (e.g., inflation, as measured by a "market basket"), perhaps reduced by a specified productivity factor, similar to rules for the hospital inpatient prospective payment system. By essentially putting updates on autopilot, responding in the future to changed circumstances or concerns about the appropriateness of payment levels would require legislation.

A very different approach would delegate broad discretion to CMS to determine the appropriate annual update based on general criteria, without being tied to a particular formula or parameters. Delegating wide latitude to set rates that affect the majority of Medicare beneficiaries and insurers will generate intense pressure for Congress to intervene if rates are considered too low (regardless of analytic justification). Conversely, overly generous rates would minimize opposition from insurers and be popular with beneficiaries but increase costs for taxpayers and exacerbate concerns about Medicare solvency.[e] Our extensive personal experience with Medicare payment policy calls into question the potential of administrative rate setting to fix MA overpayments and other deficiencies in a program that enrolls 55% of Medicare beneficiaries and costs $500 billion annually. Meaningful reform requires appropriately setting MA rates in the first year that correct for upcoding and favorable selection. Linking updates to exogenous factors such as inflation severely constrains the potential for future rates to appropriately incorporate important (but currently unanticipated) changes. Delegating relatively unfettered rate-setting discretion to CMS invites having interested parties intervene to alter rates based on political factors. While relying on an ideal model of competition may have theorical appeal, the lack of a credible model specifying both how rates affect plan participation and the desired number of plans for differing types of markets makes such an approach both infeasible and likely to incur intense lobbying by dissatisfied stakeholders.

How Competitive Bidding Would Work

The current system differs fundamentally from competitive bidding because payments to MA plans, based on TM costs in a market, remain unaffected by the bids submitted by other MA plans participating in that market. In contrast, competitive bidding uses the bids submitted by plans to set the benchmark, with the difference between the benchmark and a plan's bid determining the beneficiary premium.

Since Medicare drug benefits started in 2006, Part D's competitive bidding process has set the nationally uniform federal subsidy paid plans for each beneficiary equal to the average of standalone prescription drug plan bids to.[19] Competitive bidding sets the monthly premium charged a beneficiary equal to each plan's bid minus the federal payment, which generates clear price signals. Competitive bidding in Part D rewards plans with low bids while penalizing plans with high bids by adjusting a plan's premium dollar for dollar by the amount its bid falls below or above the average of all bids.

Competitive bidding also sets premiums for individual insurance plans offered under the Affordable Care Act (ACA). In this system, subsidies to enrollees in a market are based on the second-lowest plan premium in that market. Experience with the use of competitive bidding in these two federal programs suggests that by relying on market forces competitive bidding effectively insulates rate determinations from stakeholder attempts to alter rates. Modifying rates set through competitive bidding likely requires altering a fundamental system parameter, such as the share of costs subsidized by taxpayers or rules for calculating the benchmark. In contrast, a narrowly focused, incremental change can alter the annual update for the upcoming year in a system of administratively set rates, such as by increasing the update factor by 1%—a seemingly modest change that would have

e. In theory, another approach would have CMS set rate for each market based on plan participation, increasing rates in areas with too few plans and reducing them in areas with too many plans. Such an approach would presuppose a model specifying the characteristics of an ideal competitive market. If such a model were developed, CMS could use simulation results to set updates projected to achieve the desired number of plans to be offered in particular markets. Markets would be characterized by their size and other characteristics; examples of potential types of different markets might include densely populated urban areas, large suburban areas, large areas with sizeable total population but varying density, rural areas with low population, and frontier areas.

an annual cost of over $5 billion and a likely 10-year cost of over $80 billion.

Competitive bidding can work only when benefits are standardized: Without a standard product, bids could be for different products with different underlying costs, precluding meaningful comparison. Relying on standardized bids to set federal subsidies and premiums would also correct a major weakness of MA. Since the program's inception, CMS has set the price (rates), after which plans compete by maximizing the product (benefits). (As discussed previously, MedPAC reports that beneficiaries lack meaningful information on plan quality.[2,20]) This reverses the normal competitive process, which starts by specifying the product, after which vendors compete on price (and product quality).

Competitive Bidding Differs From Premium Support

In our approach, competitive bidding would set rates paid to MA plans without involving TM, a fundamental difference from a reform first proposed several decades ago known as "premium support." Originally proposed by economists and involving all Medicare beneficiaries, premium support would use market forces to reveal the prices of TM and private plans, with premiums based on the cost of each option minus the average bid. As proposed, TM became the equivalent of a national MA plan, with per beneficiary spending constituting its implicit bid.

Biased selection, coding differences between MA and TM, and limitations in MA utilization data would fundamentally distort comparisons between county-level TM and MA spending. As a consequence, premium support would substantially increase premiums for TM beneficiaries with an unknown but important share of the differences in per beneficiary costs being caused by factors unrelated to efficiency in providing benefits that overstate TM and understate MA costs. In contrast, a system of competitive bidding that applied only to MA plans (without involving TM in bidding) would lower Medicare costs for taxpayers and Part B premiums for all beneficiaries.

DETAILS ON COMPETITIVE BIDDING

We suggest basing MA bids on a standard MA plan that includes Part A and Part B benefits, Part D (basic) prescription drug benefits, a limit on maximum permissible out-of-pocket costs, and a modest further increase in the average annual value for a TM beneficiary with a risk score of 1.0 of $13,261.20 in 2024.[21] We also envision enhancing competition and the ability of beneficiaries to make informed choices by strictly limiting the number of MA plans an insurer may offer in a market and requiring CMS to make available markedly better information comparing plans.

Standardizing Benefits and Limiting the Number of Plans

We suggest that the standard MA plan include Part A and Part B benefits, Part D (basic) prescription drug benefits, and a limit on maximum out-of-pocket costs, as well as including specified additional benefits beyond TM. As an illustration, policymakers might choose an enhanced actuarial value in the range of 104% to 108% of Part A and B benefits. Establishing the actuarial value of additional benefits would be a critical policy choice that could be calibrated to the average generosity of MA extra benefits, potentially after phasing-in adjustments over time to remove or limit extra revenues driven by favorable selection and upcoding.

Expanding the standard MA benefit to include the Part D benefit reflects both the core role that prescription drugs play in the delivery of effective healthcare and the fact 91.6% of MA beneficiaries currently choose MA/PD plans.[f] Policy options could range from fully specifying additional benefits (without plan flexibility) to permitting flexibility for plans to customize added benefits and vary cost-sharing and deductibles, with permissible variations limited by actuarial value or benefit type.[18]

Choosing the actuarial value of the standardized benefit will require considerable judgment by Congress. Many MA plans achieve lower costs compared to TM by relying on utilization-management techniques (such as prior authorization), narrow networks of contracted providers, other managed care tools and, in some instances, capitated payment of providers.

Under current rules, MA plans must include the actuarial equivalent of TM benefits and cost-sharing but may modify specific parameters to offer more generous benefits. The other MA benefit requirement is a catastrophic limit on a beneficiary's maximum annual out-of-pocket cost for covered services. Plans have the option to provide a more generous catastrophic benefit than what CMS requires (by lowering the threshold) and, within broad parameters, may offer additional benefits or offset some or all of the premium associated with Part B or D benefits. Reflecting the availability of a $0 premium plan in counties where 99% of Medicare beneficiaries live, about 75% of MA enrollees in 2024 pay no premium for their MA/PD plan while also receiving additional benefits; in addition, 12% of beneficiaries in conventional MA plans receive a reduction in some of the cost of Part B premiums.[2]

f. Rules for setting the MA/PD benchmark would have to account for Medicare paying 100% of the MA benchmark but only 74.5% of the average of Part D bids.

Competitive bidding changes competition from maximizing benefits to lowering costs, since plans would all bid on standard benefits. Low-bidding plans would reward enrollees by offering reduced monthly premiums, with the potential that rebates may be sufficiently large to not only eliminate the MA premium but also lower their Part B premiums or pay them cash.[g] Conversely, high-bidding plans will have to charge enrollees monthly premiums in addition to what they are paying for Part B. The generosity of the standard benefit that CMS sets, along with the variation in plan bids, will determine whether beneficiaries experience a more or less generous benefit than a plan currently offers, as well as the premiums or cash rebates they receive. Competitive bidding would press plans to maximize efficiency, with resulting savings potentially offsetting reductions in benefit generosity. Meaningful quality measures, enhanced beneficiary information and a limited number of choices involving standardized benefits (significantly reduced from the current average of 43 plans that need not meaningfully differ) would alter the ability of beneficiaries to make informed choices that maximize their preferences.

Calibrating the actuarial value of standard benefits to the most generous plan currently offered would avoid reducing benefits but would likely increase the generosity of MA benefits for most enrollees, which would be costly to taxpayers and beneficiaries paying Part B premiums. Adopting an actuarial value at the average amount for existing plans could somewhat mitigate the cost to Medicare if competitive bidding causes plans to submit more efficient bids, but savings from reduced benefits for enrollees in plans with above-average enhanced benefits would be offset by increased costs for enrollees in plans with below-average enhanced benefits. Maintaining the average value of benefits would also retain a level of generosity built on the 22% overpayment driven by upcoding and favorable selection.

To the extent that beneficiaries receive lower actuarial value (including any premium effects) than is available currently, some may return to TM. As a result, the actuarial value chosen for the standard benefit likely will influence the percentage of Medicare beneficiaries enrolling in MA. This trade-off might be improved if, in addition to the standard plan, MAOs are permitted to offer a limited number—one or possibly two—of "enhanced" plans that would add benefits or lower cost-sharing further. The federal subsidy would equal the subsidy paid for a standard MA plan, and enrollee premiums would reflect the premium associated with the MAO's standard plan plus the actuarial value of the plan enhancements. Beneficiaries could apply rebates arising from below-benchmark bids of efficient plans to pay for enhanced plans.

Importantly, CMS should prohibit excessive variations in benefits and cost-sharing that complicate beneficiary choice. In addition, CMS could decide the extent of the variation allowed for "plan enhancements" not covered in TM, although some express concern that limiting plan flexibility would stifle innovative benefit designs.

Some ACA Marketplaces have adopted further requirements to enhance competition and support informed choice by beneficiaries. For example, Covered California has fully specified the benefit design that plans must offer, making it easier for beneficiaries to compare plans—they can focus on differences in premiums, network breadth, use of prior authorization and customer service. In an aggressive innovation, Covered California limits the number of plans that can be offered in each market; plans submit proposals to the agency to compete for these slots. This approach not only implements findings from behavioral economics to enhance informed beneficiary choice but also has intensified competition and likely lowered prices.

Uniformity in benefit design would reduce adverse selection, limiting the effects of beneficiaries using information about their perceived healthcare needs to select plans based on their anticipated utilization (along with their preferences regarding risk). However, as an example illustrating how the complexity of healthcare can lead to unintended consequences, providing beneficiaries with better information about plans' use of prior authorization, while desirable overall, could lead to more adverse selection. Beneficiaries with low expected utilization might prefer plans that more rigorously manage utilization to lower premiums, while beneficiaries with above-average expected utilization might be attracted to plans that impose fewer prior authorization requirements.

Converting Competitive Bids to MA Rates and Plan Premiums

Several approaches can be used to convert plan bids into the benchmark for each market. Objectives would include maintaining a stable market, preventing dominant plans from exerting undue influence on market premiums and minimizing barriers to new plan entrants. A constant across different approaches to competitive bidding would be rewarding plans, dollar for dollar, with rebates equal to the amount they bid below the benchmark. Beneficiaries would be charged (or rebated) an amount equal to the difference between each plan's bid and the benchmark.

The Part D approach to competitive bidding uses the bids of all plans, weighted by their enrollment, to set the benchmark at the resulting mean amount. While this methodology

g. Because Medicare beneficiaries typically have their Part B premium automatically deducted from their Social Security benefits, offsetting the Part B premium might not be very visible to enrollees, causing plans to opt instead to pay rebates directly to their enrollees.

can promote stability, it has the disadvantage of potentially allowing the bid from a dominant plan to effectively set the benchmark, reducing competition. ACA Marketplaces have modified the Part D approach to bidding by pegging premium subsidies to the premium of the second-lowest (Silver) plan in a market. By using the second-lowest bid rather than the mean, the ACA approach may increase pressure for plans to lower their bids.

Methods calibrated to generate lower benchmarks might reduce Medicare costs but could lead to fewer participating plans in a market; having too few plans runs the risk of limiting competition and increasing costs over the longer term. For example, inappropriate benchmarks could result if a single plan dominates the market or if the two plans with the lowest bids command a very small market share or have characteristics that make their bids unrepresentative of the overall market. Such market distortions could eventually destabilize the program.

The ACA approach could be modified by adding a criterion requiring a minimum combined market share (e.g., 20%) for low-bidding plans, which might shift the benchmark bid from the second-lowest plan to the bid from the third-lowest plan (or the fourth, if needed). Alternatively, the benchmark could be linked to a specified percentile of enrollment-weighted bids, such as the 25th or 35th percentile.

Enhancing Competition With Easy-to-Use Information to Compare Plans

Plan Finder at Medicare.gov contains useful information but falls far short of providing comprehensive, easy-to-use information that facilitates comparing plans, despite years of reports and a comprehensive 2019 proposal from MedPAC to restructure MA quality measurement.[22] Plans may fail to keep their provider directories current, may not indicate whether a provider is accepting new patients, and may not clearly explain their specialty referral and prior authorization policies, issues which CMS addresses in a recent Medicaid final rule for Managed Care Organizations (MCOs).[23] Even with a limited number of standardized plans, CMS should test its enhanced beneficiary information to ensure that it communicates effectively with participants.

The CMS Plan Finder relies on Star Ratings as a flawed proxy for evaluating plan quality; because higher Star Ratings increase revenues for plans that bid below MA rates, plans with four to five stars enrolled 74% of enrollees in 2024.[24] Computer-literate beneficiaries can use Plan Finder to identify available plans in an area and, for each MA plan, the CMS website lists benefits, out-of-pocket costs by type of service and extra benefits, as well as relatively granular information on prescription drug costs. In addition to lacking information on in-network providers, availability of appointments and other restrictions on access to care such as prior authorization requirements, Plan Finder generally does not synthesize information for seniors in a way that would facilitate comparing plans and making informed choices.[25]

Unlike what's available to the over 60 million Medicare beneficiaries, the more than 8 million employees, annuitants and dependents participating in the Federal Employee Health Benefit program have access to more extensive, user-friendly information that facilitates informed choice.[26] The "Guide to Health Plans for Federal Employees" published annually by the nonprofit Consumers' Checkbook illustrates the kind of comprehensive information that helps inform beneficiary choice by summarizing benefits, ranking plans and comparing expected costs under a variety of different utilization-driven scenarios.[27] Some state exchanges under the ACA have contracted with Consumers' Checkbook to develop guides for eligible individuals. To quickly improve the ability of Medicare beneficiaries to make better choices and increase competition among MA plans, a first step could entail CMS initially contracting with a nonprofit such as Consumers' Checkbook that has demonstrated the expertise to develop a comparable guide for MA.

Coding and Selection Under Competitive Bidding

This paper began by explaining how MA rates based on TM costs that are inflated by upcoding and favorable selection will overpay MA plans by $83 billion in 2024. The combination of competitive bidding, standardized benefits, a more manageable number of plans and enhanced information facilitating beneficiary choice would delink MA payments from TM costs, lower MA bids and significantly reduce Medicare costs. Competitive bidding would largely transform the problem of increased federal costs to a distributional challenge in which insurers that upcode less or have more limited favorable selection are disadvantaged relative to more aggressive competing plans. Shifting upcoding and favorable selection from increasing aggregate Medicare payments to redistributing funds among plans might make insurers more receptive to reforms, such as those being advanced by MedPAC and independent analysts.

Potential MA Reforms Beyond the Scope of This Paper

A number of policy choices would significantly enhance MA competition under either competitive bidding or administratively set benchmarks, but are beyond the scope of this paper. MedPAC has long recommended that payment areas for local MA plans in Metropolitan Statistical Areas (MSA) should include "collections of counties that are

located in the same state and the same MSA. For payment areas outside of MSAs, payment areas should be collections of counties in the same state that are accurate reflections of health care market areas, such as health service areas."[28] Other promising reforms include enhancing data reported by plans to facilitate improved CMS oversight (e.g., of disenrollments, timely access to appointments, provider network adequacy and accuracy of provider listings), revising risk adjustment, and changing the rules and rate-setting for employer-sponsored MA plans.[29]

Using Transition Rules to Minimize Disruption When Converting to New MA Rules

The magnitude of extra benefits of MA plans varies across counties and reflects differences in spending in TM and the degree of competition in the MA market. This variation would likely be reduced under competitive bidding with a standardized benefit. However, beneficiaries in counties with high current levels of extra benefits would experience a reduction in the generosity of benefits under most scenarios, although enhanced competition could offset some or all of the cost of enhanced benefits.

Under competitive bidding, enrollees are likely to see changes in the benefits that plans offer because the standard benefit would prioritize enhanced insurance benefits (e.g., lowering the maximum out-of-pocket threshold significantly below the current requirement) over nonmedical benefits (e.g., gym memberships or limited vision benefits). Standardized benefits might also lead plans to offer less generous benefits in counties where current MA rates exceed competitively bid benchmarks. Policymakers could consider phasing in the new benefit requirements over a multiyear period to smooth the transition.

As one alternative during a transition period, plans could be required to submit bids based on the standard benefit but be permitted to offer a hybrid benefit that blends their existing benefits with the new standard benefit, with the plan-specific benefits phased out over time. Another alternative in counties where current MA rates are more generous than the competitively bid benchmark would have plans offer the standard benefit plus extra benefits, with annually diminishing amounts available to finance extra benefits. Longer transition periods or less prescriptive rules would ease changes for beneficiaries but could increase Medicare costs and/or delay the full advantages of standardized benefits. The high degree of MA profitability reported by insurers and the level of overpayments from upcoding and favorable selection suggest focusing transition provisions to limit disruption for beneficiaries rather than minimizing it for plans.

CONCLUSION

Reducing the $83 billion in annual overpayments will necessarily involve fundamental changes in how MA operates, and our recommended changes would focus plans on competing based on efficiency and quality rather than through using upcoding to maximize revenue or benefiting from favorable selection. The reforms and transition options we've outlined are intended to minimize disruption for beneficiaries, enhance competition and choice, reduce taxpayer costs and lower Part B Medicare premiums. Although the demonstration authority delegated to the Center for Medicare and Medicaid Innovation provides a possible pathway for CMS to pursue MA reform without legislation, the history of Congress blocking two prior competitive-bidding demonstrations but enacting major reforms in hospital and physician payment in the absence of demonstrations suggests that enacting reforms and subsequently refining them is the only realistic path in a system where Congress often micromanages the Medicare program.[h,30]

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