

**WHEN IS COMPETITION NOT COMPETITION: THE CURIOUS  
CASE OF MEDICARE ADVANTAGE**

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ABSTRACT

*Policymakers routinely assume that Medicare Advantage plans and the traditional Medicare program compete for beneficiaries. Yet the District of Columbia federal district court blocked the proposed Aetna and Humana merger, finding that for purposes of antitrust analysis Medicare Advantage plans and traditional Medicare are effectively in different product markets. That is, they do not compete. This article reviews the basis for the court decision, which relied to a large extent on information that Medicare beneficiaries select their insurance coverage based on durable preferences either for the Medicare Advantage or the traditional Medicare option.*

*The article explores whether the apparently durable beneficiary preferences are based on intrinsically different attributes of Medicare Advantage plans and traditional Medicare or, rather, importantly dependent on regulatory policies that with change would likely alter beneficiaries' selections. The policies considered include: the maintenance of an archaic benefits structure in traditional Medicare, rules that limit access to supplemental Medigap insurance to wrap-around traditional Medicare, and the relative generosity of payments to Medicare Advantage plans.*

*The article next considers approaches to explicitly promoting competition between the Medicare Advantage sector and traditional Medicare, finding the premium support approach that many market-oriented economists and policy analysts tout as a way to promote efficiency-producing plan competition in Medicare would likely reduce the insurance plan choices available to most beneficiaries. Further, although premium support proponents typically tout the virtues to unfettered market competition, only by adopting regulatory policies that constrain market forces would such an approach actually reduce spending.*

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## I. BACKGROUND

“[Medicare Advantage] insurers compete not only with each other but also with [traditional Medicare] through the terms of the contracts or insurance plans that they offer beneficiaries.”<sup>1</sup>

“The central market definition question in this case is about the nature and extent of any competition between Original Medicare options and Medicare Advantage.”<sup>2</sup>

These quotes selected above represent a typical viewpoint of policy analysts about the competition between traditional Medicare (TM)<sup>3</sup> and various private health insurance plans now labeled as Medicare Advantage (MA) plans in the MA program.<sup>4</sup> The issue of whether MA plans compete in the same or a different product market as the TM program was central to a District of Columbia federal district court’s decision to block the proposed thirty-seven billion dollar merger of Aetna and Humana because of what it judged as its anti-competitive effects in violation of federal antitrust laws.<sup>5</sup> A reason for the focus on MA was that Aetna and Humana have very high MA market shares in 364 counties across twenty-one states with questionable countervailing competitive forces.<sup>6</sup> The two companies’ combined market share in the 364 counties ranges “from 1 to 34% of all Medicare enrollees, but 33 to 100% of Medicare Advantage enrollees,” pointing to the importance of determining whether TM is in the same product market as MA plans.<sup>7</sup>

1. Joseph P. Newhouse et al., *How Much Favorable Selection Is Left in Medicare Advantage?*, AM. J. HEALTH ECON. 2015, at 1, 3.

2. *United States v. Aetna Inc.*, 240 F. Supp. 3d 1, 21 (D.D.C. 2017).

3. This article will refer to the government-managed Medicare program that has been in place since 1965 as the traditional Medicare (TM) program. Others have referred to it as Original Medicare and fee-for-service Medicare. *What is Original Medicare?: Original Medicare Defined*, MEDICARE INTERACTIVE, <https://www.medicareinteractive.org/get-answers/how-original-medicare-works/original-medicare-defined/what-is-original-medicare> (last visited Oct. 13, 2017).

4. See Paul Wong & Subramiam Ramanarayan, *Reduced-Form Versus Structural Econometric Methods in Market Definition: Lessons from Aetna-Humana*, ANTITRUST HEALTH CARE CHRON., June 2017, at 18, 18, 20. The labels come from the Medicare Modernization Act of 2003. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, 117 Stat. 2066; see also *Medicare Advantage*, KAISER FAM. FOUND. (Oct. 2017), <http://files.kff.org/attachment/Fact-Sheet-Medicare-Advantage>.

5. Abbe R. Gluck & Thomas Greaney, *Court Blocks Aetna-Humana Deal: The Mega-Mergers Meet the Trump Administration Next*, HEALTH AFF. BLOG (Jan. 30, 2017), <http://healthaffairs.org/blog/2017/01/30/court-blocks-aetna-humana-deal-the-mega-mergers-meet-the-trump-administration-next/> (last visited Oct. 13, 2017). In addition to the central issue of anti-competitive effects in Medicare, the court also focused on “individual insurance sold on the ACA’s exchanges in 17 counties in three states where the overlap between the companies was significant.” *Id.*

6. *Id.*

7. Leemore S. Dafny, *Good Riddance to Big Insurance Mergers*, 376 N. ENG. J. MED. 1804, 1804 (2017).

In operational terms, the court asked whether “a hypothetical monopolist of all the Medicare Advantage plans in a particular county could profitably impose a small but significant non-transitory increase in price on those plans—or whether substitution by seniors to Original Medicare options would make any attempted price increase unprofitable.”<sup>8</sup> “Analyzed under antitrust law precedents, evidence that a segment of customers has a ‘durable preference’ for a product, such that other products would not constrain the exercise of market power by the merging parties, is usually dispositive.”<sup>9</sup>

The court relied on two complementary sources of information presented in testimony by the parties in determining that MA operates in a different product market from TM.<sup>10</sup> The “most persuasive” evidence the court found was the switching data, “that is, data about how often seniors leave Medicare Advantage plans and where they go when they do.”<sup>11</sup> The court concluded that the switching data presents a “clear picture: Medicare Advantage enrollees rarely switch plans, but when they do, they overwhelmingly stay within Medicare Advantage.”<sup>12</sup> In addition to the persuasive switching data, the court also relied on business documents that “make plain that, rather than focusing their efforts on competition with Original Medicare, Aetna and Humana focus on competition with other Medicare Advantage organizations.”<sup>13</sup>

In the opinion, Judge Bates also relied on studies showing that those who developed a durable preference for MA plans likely prefer particular attributes MA plans have that TM lacks, including lower costs produced through a limited network, a cap on out-of-network spending, care coordination, and supplemental benefits like prescription drug coverage.<sup>14</sup> The court did not hold that TM and MA did not compete at all, acknowledging that there is “a degree of competition,” as seniors chose between TM and MA plans, and noting that TM serves as a “starting point for Medicare Advantage plan design.”<sup>15</sup> Nevertheless, the court held that such limited competition does not mean that TM and MA should be included in the same antitrust product market.<sup>16</sup>

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8. *United States v. Aetna Inc.*, F. Supp. 3d 1, 21 (D.D.C. 2017).

9. *Gluck & Greaney*, *supra* note 5.

10. *Aetna Inc.*, 240 F. Supp. 3d, at 9.

11. *Id.* at 27.

12. *Id.* The court concluded that the lack of switching between the two sectors makes it “unlikely that competition from Original Medicare options will suffice to discipline Medicare Advantage pricing.” *Id.* at 42.

13. *Id.* at 41–42. Also, the court concluded that MA plans “compile impressive amounts of local, plan-specific competitive intelligence about Medicare Advantage offerings . . . across the country” but rarely compile similar information about TM or Medicare supplemental insurance plans. *Id.* at 42.

14. *Id.* at 41.

15. *Aetna Inc.*, 240 F. Supp. 3d, at 22–23.

16. *See id.* at 23.

In the view of antitrust law professors, the court's decision that MA plans and TM do not engage in meaningful competition was well reasoned and persuasive.<sup>17</sup> Yet it begs the question of why a broad range of policy analysts consider that MA plans do—and should—actively compete with TM. In essence, how can MA plans not compete with TM for purposes of antitrust analysis yet be viewed as actively competing for purposes of general health policy analysis, as indicated in the selected quotes presented at the beginning of this article?<sup>18</sup>

For decades, the option of private plan contracting in Medicare has pursued two goals, which sometimes come into conflict.<sup>19</sup> The first is to expand Medicare beneficiaries' choices to include private plans, which have different attributes from the TM insurance program.<sup>20</sup> The second is to take advantage of potentially lower costs produced by managed care to reduce Medicare spending.<sup>21</sup> Through most of its history, the first goal of increasing private plan options has been attained by paying more to health plans so they can provide extra benefits to attract beneficiaries to preferentially select private plans, now called MA plans.<sup>22</sup> The information the court had in determining that beneficiaries had distinct and durable preferences for either MA or TM came at a time of overly generous, but declining, extra payments to MA plans.<sup>23</sup> At other times, more emphasis on cost containment changed the relative attractiveness of MA plans compared to TM,<sup>24</sup> which in turn alters beneficiaries' preferences.

This article explores why policy analysts routinely assume that private plans in Medicare compete with the TM program, whereas antitrust analysis has concluded that they do not compete sufficiently to place MA plans and TM in the same product market. This article explores various aspects of this seeming paradox.

The article starts by clarifying the differences in general policy versus antitrust analysis of the competitive issues at play, making clear that a central policy focus has been on seeking to balance the two goals of beneficiary choice and cost containment by creating "level-playing field" competition between

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17. See Gluck & Greaney, *supra* note 5. Health law professors Gluck and Greaney called the court's decision "extremely thorough and grounded in a strong factual record" and delivered at "warp speed by major antitrust litigation standards." *Id.*

18. See *supra* text accompanying notes 1–2.

19. Thomas G. McGuire et al., *An Economic History of Medicare Part C*, 89 MILBANK Q. 289, 290–91 (2011).

20. *Id.* at 290.

21. *Id.* It is not clear whether MA or TM can become more successful at reducing the growth rate of Medicare spending. Having a vibrant MA program competing with TM is one way to let the market decide while responding to beneficiary preferences.

22. *Id.* at 291.

23. *United States v. Aetna Inc.*, 240 F. Supp. 3d 1, 32–37 (D.D.C. 2017); see also McGuire et al., *supra* note 19, at 292.

24. See McGuire et al., *supra* note 19, at 291–92.

private plans and TM. Next, the article explores the topic of what characteristics of private plans and TM seem intrinsic to the particular option and which seem dependent on extrinsic policies that can alter beneficiaries' decisions if not their underlying preferences. It also explores barriers to obtaining Medigap insurance and the differences in the benefits the different plans are allowed to offer as reasons why MA plans are relatively attractive to beneficiaries, pointing out that policy changes could alter these apparent beneficiary preferences.

Next, the article explores policies that promote competition between private plans and TM, making the case that without these policy interventions, most beneficiaries would not have the choice between MA plans and TM that they currently enjoy in most geographic areas. These regulatory policies, some of which were adopted for reasons other than to promote competition, actually enable competition between private Medicare plans and TM, and permit beneficiaries to exercise their preferences between the insurance approaches. These regulatory policies include the prohibition on provider billings of beneficiaries that exceed Medicare-allowed amounts and a regime of administered pricing to establish government contributions or benchmarks against which MA plans bid established expressly to permit beneficiaries' choices in many areas that otherwise would see either plans or TM dominate. Finally, the paper explores some of the reasons why premium support, a form of Medicare restructuring that converts Medicare from a defined benefit program to a defined contribution program,<sup>25</sup> could seriously compromise the goal of offering plan choices to beneficiaries because of a dominating interest in cost containment. Policy proposals that require much more direct competition between private plans and traditional Medicare could perversely reduce beneficiary choice, undermining the durable preferences the court concluded that beneficiaries display.

## II. WHEN IS COMPETITION NOT COMPETITION?

The apparent paradox of MA plans and TM actively competing from the perspective of policy analysts and not competing for purposes of antitrust analysis apparently does not represent an exceptional situation. In the *United States v. Aetna, Inc.* decision, Judge Bates noted various interactions between MA and TM, including that “to be viable products, Medicare Advantage plans must control their costs—relative to Original Medicare—enough to offer beneficiaries more benefits or lower out-of-pocket expenses than Original Medicare does.”<sup>26</sup> Yet while acknowledging that “any assessment of the

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25. JOSEPH ANTOS, AM. ENTER. INST., PLAN COMPETITION AND CONSUMER CHOICE IN MEDICARE: THE CASE FOR PREMIUM SUPPORT 3 (Apr. 2013), [http://www.aei.org/wp-content/uploads/2013/04/-plan-competition-and-consumer-choice-in-medicare-the-case-for-premium-support\\_141511443922.pdf](http://www.aei.org/wp-content/uploads/2013/04/-plan-competition-and-consumer-choice-in-medicare-the-case-for-premium-support_141511443922.pdf).

26. *United States v. Aetna Inc.*, 240 F. Supp. 3d 1, 23 (D.D.C. 2017).

competitive conditions facing Medicare Advantage plans must take the role of Original Medicare into account,” Judge Bates found that MA plans competed in a different product market than TM.<sup>27</sup>

Implicitly addressing the apparent paradox, citing *United States v. H & R Block, Inc.*, Judge Bates concluded, “Not every competitor—not even every competitor with a functionally interchangeable product—must be included in the product market.”<sup>28</sup> He continued, “What matters is the extent to which competition from Original Medicare options would constrain the exercise of market power in Medicare Advantage.”<sup>29</sup> In short, antitrust analysis requires a more granular application of the concept of competition, grounded in whether a competitor operationally faces market forces that constrain it from profitably increasing prices to consumers without losing business to competitors.

Policy analysts consider a broad array of competitive issues between MA plans and TM, some of which have little or nothing to do with beneficiaries’ preferences. A dominant policy consideration is whether there is active and fair competition between private plans and TM. The most consistent and strongest articulation of this position has been presented by the Medicare Payment Advisory Commission (MedPAC), which since 2001 has supported the concept of “level playing field” competition between an array of private plan types and TM.<sup>30</sup> MedPAC advocates “financial neutrality” between MA plans and TM to further fair competition and to promote greater equity for beneficiaries living in parts of the country with markedly different per capita Medicare spending.<sup>31</sup> MedPAC has defined financial neutrality as follows: “[T]he Medicare program should pay the same amount, adjusting for the risk status of each beneficiary, regardless of which Medicare option a beneficiary chooses.”<sup>32</sup>

The practical problem in establishing payment neutrality is that “in geographic areas with high levels of service use in FFS Medicare [TM], plans are able to provide a substantial level of extra benefits because they are able to

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27. *Id.* at 23, 27.

28. *Id.* at 23 (citing *United States v. H & R Block, Inc.*, 833 F. Supp. 2d 36, 54 (D.D.C. 2011)).

29. *Id.*

30. MedPAC calls for “payment neutrality” which has been equated with “level playing field” competition. MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 112 (Mar. 2001); Mark Miller, Executive Director, MedPAC, Medicare Advantage Private Fee-for-Service Plans and Employer Groups (Apr. 11, 2008), [https://www.nhpf.org/library/handouts/Miller.slides\\_04-11-08.pdf](https://www.nhpf.org/library/handouts/Miller.slides_04-11-08.pdf) (noting the MedPAC MA “current recommendation, dating from 2001 [is] level playing field (neutrality) between the traditional FFS program and payment for private plans”).

31. MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: ISSUES IN A MODERNIZED MEDICARE PROGRAM 60 (June 2005).

32. MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 24 (Mar. 2007).

reduce service use among their enrollees” as compared to *unmanaged* TM.<sup>33</sup> In other geographical areas, where TM service use is relatively low, plans have not been able to provide as much or, in some cases, any extra benefits because it is more difficult to reduce service use below the TM level.<sup>34</sup> These differences are often perceived as inequitable from a beneficiary perspective because beneficiaries in areas where TM service use has been lower, reflecting more prudent use of resources, were less likely to have plans offering extra benefits than plans in high service use areas.<sup>35</sup> From this policy perspective, being able to assure beneficiaries’ preferences for health plans conflicts with beneficiary-related equity considerations.

Conversely, in considering equity, although beneficiaries do not have access to the same level of extra benefits through private plans that other beneficiaries enjoy, they do have access to providers that produce low-cost, high-quality services directly provided via TM.<sup>36</sup> MedPAC observed that the inequities in the TM program are the opposite of those in the private MA plans.<sup>37</sup> In short, preferences for either MA or TM have had a lot to do with the beneficiaries’ place of residence.

However, while MedPAC’s financial neutrality is a useful guiding principle, there are multiple payment approaches that could satisfy it; that is, different methods exist for achieving level playing field competition. MedPAC described the choice concisely in a detailed review in 2009.<sup>38</sup> At that time, the biggest cause of unlevel playing field competition was that MA plans in aggregate received 114% of TM spending, representing about twelve billion dollars more for the beneficiaries enrolled in MA plans than it would be spending if they were in TM,<sup>39</sup> producing a Congressional Budget Office (CBO) estimation of \$150 billion extra spending over ten years.<sup>40</sup>

In analyzing how to pay equitably in an attempt to assure level playing field competition, MedPAC created and analyzed four options Congress might consider for setting MA benchmarks against which MA plans bid to provide the

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33. MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: IMPROVING INCENTIVES IN THE MEDICARE PROGRAM 201 (June 2009). Though administered pricing to hospitals, physicians, and other providers accounts for geographic variations in input prices, extra funding for graduate medical education, disproportionate share hospitals, and other statutory-recognized differences justify varying administered prices, and spending differences across geographic areas mostly represent differences in service use. *See id.* at xi.

34. *Id.* at 201.

35. *Id.*

36. *Id.* Further, at the state level, “[h]igher [service] use is correlated with lower quality” while “quality is higher in lower-service-use areas.” *Id.*

37. *Id.*

38. MEDICARE PAYMENT ADVISORY COMM’N, *supra* note 33, at 201 tbl.7-1.

39. *Id.* at 172.

40. *Id.* at 184.

statutory benefits they are required to provide.<sup>41</sup> MedPAC emphasized that all of the options are financially neutral to TM in the aggregate—and each would have cost the program the same as TM in the first year, saving twelve billion dollars.<sup>42</sup> A main difference between the four options is that two linked benchmarks against which MA plans bid closely to 100% of TM spending in the local payment area.<sup>43</sup> The other two options are linked more closely to expected plan costs, which vary much less than spending does across TM geographic areas.<sup>44</sup> The latter two thus were designed to achieve payment neutrality nationally but not locally.<sup>45</sup> Although the different payment options are financially neutral, the precise way in which payments would be determined would have produced very different distributional effects related to beneficiary out-of-pocket obligations, most importantly strongly influencing how competitive MA plans and TM were at the local level.

In the decision, Judge Bates acknowledged that durable beneficiary preferences for either MA or TM depends importantly on a number of factors, including the extra benefits and the relatively low cost sharing that many MA plans offered.<sup>46</sup> Yet the ability to offer extra benefits and lower cost sharing depends crucially on congressional control over the generosity of MA plan payment, which in turn now depends on the level of cost benchmarks against which plans bid.

Enrollment in MA and its predecessor plans has varied significantly across the country based on how payments to MA plans were determined. Prior to the Balanced Budget Act of 1997 (BBA), so-called “1876 Medicare risk” plans spread unevenly across the country because the plans were paid at ninety-five percent of the actual county-level spending in TM.<sup>47</sup> In areas with high TM spending, private plans could provide the required statutory services for less than TM and therefore were able to attract enrollment by having the margins to offer substantial extra benefits.<sup>48</sup> Conversely, in other geographic areas, private plans

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41. *Id.* at 188.

42. *Id.* at 184.

43. MEDICARE PAYMENT ADVISORY COMM’N, *supra* note 33, at 188.

44. *Id.*

45. *See id.* at 191, 196.

46. *United States v. Aetna Inc.*, 240 F. Supp. 3d 1, 28, 41 (D.D.C. 2017) (“But most MAOs [Medicare Advantage Organizations] do [differentiate themselves from Original Medicare] successfully, and create products different from Original Medicare in a number of important respects: they have a limited network, cap out-of-pocket spending, coordinate care, and generally offer supplemental benefits like prescription drug coverage.”).

47. Robert A. Berenson, *Medicare+Choice: Doubling or Disappearing?*, HEALTH AFF. 65, 65, 67, 68, 71 (Nov. 2001), <http://content.healthaffairs.org/content/early/2001/11/28/hlthaff.w1.65.full.pdf> (noting that although plans were supposed to be paid ninety-five percent of the adjusted average per capita cost, because of a calculation error they were actually paid ninety-eight percent when the BBA was implemented).

48. *See id.* at 73.

could not successfully compete with TM in these lower-cost counties.<sup>49</sup> The BBA and subsequent legislation<sup>50</sup> aimed to provide broader choice for beneficiaries throughout the country, initially by establishing payment “floors” for paying private plans and later, in the Patient Protection and Affordable Care Act (ACA), by varying the benchmarks from 95% to 115% of TM spending to more closely approximate private plan costs.<sup>51</sup>

The specific payment method for MA plans that Congress adopts is meant to affect the take up of MA plans by Medicare beneficiaries across different areas, attempting to balance beneficiary choice, incentives for program savings, and notions of equity for beneficiaries. In the federal district court decision, Judge Bates acknowledged that Aetna and Humana contended the legislative and regulatory changes would likely make MA plans and TM more competitive, but he dismissed their arguments that current preferences depend on specific legislative and regulatory details that can vary, producing different beneficiary preferences.<sup>52</sup> As demonstrated above, the payment designs and payment levels supporting MA have changed a number of times throughout the history of private plans in Medicare. Yet the court found that the need for MA plans to differentiate themselves from TM limits the extent to which either an MA plan or TM is “reasonably interchangeable” with the other.<sup>53</sup>

In listing the attributes of MA plans,<sup>54</sup> the court identified some characteristics of MA plans and of TM that are intrinsic to the model as well as some that are extrinsic and depend importantly on policy decisions that can and do change, just as payment levels change. As noted earlier, the court listed a limited network, a cap on out-of-pocket spending, care coordination, and supplemental benefits, like prescription drug coverage, as distinctive features of MA plans and not part of TM.<sup>55</sup> Arguably, a limited provider network is an intrinsic feature of an MA plan in contrast to the freedom of choice of virtually any licensed provider, which seems intrinsically a characteristic of TM.

MA plans have long provided care coordination as a distinctive difference from TM. However, in recent years, in a number of ways TM has adopted approaches to care coordination so that it may no longer be an intrinsically

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49. *See id.*

50. For a legislative history, see McGuire et al., *supra* note 19.

51. *Id.* at 309, 321. Counties with benchmarks set at 115% of risk-adjusted TM costs have lower TM spending (in absolute dollars) than counties with benchmarks set at 95% of risk-adjusted TM costs. *Id.* However, the approach of varying benchmarks—the government contribution—to more closely approximate MA plan costs rather than county-level spending in TM was designed to promote beneficiary choice of either MA or TM in most parts of the country. *See id.* at 290.

52. *United States v. Aetna Inc.*, 240 F. Supp. 3d 1, 31 (D.D.C. 2017).

53. *Id.* at 41.

54. *Id.*

55. *Id.*

distinctive attribute of MA plans.<sup>56</sup> And neither a cap on out-of-pocket spending nor supplemental benefits are intrinsic to MA. For many years, proponents have advocated for a cap on out-of-pocket spending in the basic Medicare benefit package, sometimes referred to as Part E of Medicare, and to facilitate a comprehensive program that packages what are now separate insurance programs for Part A and B benefits, acute care benefits, Part D drug coverage, and protection against catastrophic expenses and other cost-sharing obligations that Medigap insurance provides.<sup>57</sup> Indeed, even Republican proponents of restructuring Medicare as a premium support program featuring explicit, fair competition between private plans and TM propose such a cap in TM.<sup>58</sup> As noted, the availability of supplemental benefits by MA plans is not an intrinsic feature of all MA plans but rather depends on the level of payment that MA plans receive in relation to their costs, a factor that, in the history of private plans in Medicare, is subject to continuing change.

### III. EXTRINSIC BARRIERS TO BENEFICIARIES EXERCISING THEIR PREFERENCES

A particular extrinsic regulatory factor related to availability of Medigap supplemental insurance may be a reason why there is such limited switching between the MA plan sector and TM. Given gaps in coverage in the basic Medicare benefits and substantial co-insurance for some services, especially the absence of an annual or lifetime limit of out-of-pocket spending on Part A and B services, about twenty percent of Medicare beneficiaries enroll in Medigap plans offered by private insurers.<sup>59</sup> As Tricia Neuman of Kaiser Family Foundation notes:

Under federal law and in many states, [Medigap] insurers are not required to participate in an annual open enrollment period, and are only required to sell a

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56. RACHEL BURTON ET AL., *MEDICARE'S EVOLVING APPROACH TO PAYING FOR PRIMARY CARE* 4–5, 8, 11 (2017), [https://www.urban.org/sites/default/files/publication/95196/2001631\\_medicare\\_s\\_evolution\\_approach\\_to\\_paying\\_for\\_primary\\_care\\_0.pdf](https://www.urban.org/sites/default/files/publication/95196/2001631_medicare_s_evolution_approach_to_paying_for_primary_care_0.pdf).

57. See, e.g., Karen Davis et al., *Medicare Essential: An Option to Promote Better Care and Curb Spending Growth*, 32 *HEALTH AFF.* 825, 900–01 (2013); see also Robert A. Berenson & Melissa A. Goldstein, *Will Medicare Wither on the Vine? How Congress Has Advantaged Medicare Advantage—And What's a Level Playing Field Anyway?* 1 *ST. LOUIS U. J. HEALTH L. & POL'Y* 5, 23–24 (2007).

58. See, e.g., *See a Better Way: Our Vision for a Confident America*, OFFICE OF THE SPEAKER OF THE HOUSE 36 (2016), [abetterway.speaker.gov/\\_assets/pdf/ABetterWay-HealthCare-Snapshot.pdf](http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-Snapshot.pdf).

59. Tricia Neuman & Juliette Cubanski, *The Gap in Medigap*, KAISER FAM. FOUND. (Sept. 27, 2016), <http://www.kff.org/medicare/perspective/the-gap-in-medigap/> (last visited Oct. 13, 2017). In contrast, all MA plans are required by CMS to provide such a limit, which is currently set at \$8250. *CTRS. FOR MEDICARE & MEDICAID SERVS., ANNOUNCEMENT OF CALENDAR YEAR 2017 MEDICARE ADVANTAGE CAPITATION RATES AND MEDICARE ADVANTAGE AND PART D PAYMENT POLICIES AND FINAL CALL LETTER 74* (Apr. 4, 2016), <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf>.

policy under specific circumstances, such as when applicants first enroll in Medicare at age 65 or within a year of trying a Medicare Advantage plan.<sup>60</sup>

Medigap insurers are generally allowed to use medical underwriting to decide whether to accept an application and how much to charge as a premium for the particular Medigap policy a beneficiary selects.<sup>61</sup> If a beneficiary applies for Medigap coverage after the initial open enrollment period or the one-time MA trial, Medigap insurers can impose a six-month non-coverage period for pre-existing conditions and can engage in medical underwriting and experience rating.<sup>62</sup> In short, when trying to reenter TM from an MA plan, the beneficiary may lack both guaranteed issue and community rating, resulting in either denial of coverage for pre-existing conditions for six months or expensive premiums in perpetuity.<sup>63</sup> Importantly, the applicable law does not require Medigap insurers to sell policies to disabled Medicare beneficiaries below the age of sixty-five, unless required to by certain states,<sup>64</sup> such that only two percent of disabled beneficiaries have a Medigap policy.<sup>65</sup>

In relation to beneficiary proclivities related to switching, the consumer protections—including an annual open enrollment period without pre-existing condition exclusions—do not apply to the Medigap market as they do to MA plans.<sup>66</sup> This means that seniors who opt for an MA plan when they first go on to Medicare can effectively be locked out of the Medigap market if they have a persistent pre-existing condition, such as cancer.<sup>67</sup> In short, under current rules, seniors who have once selected an MA plan partly may be able to obtain an out-of-pocket limit to their financial exposure for medical care costs only if they remain in an MA plan.

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60. Tricia Neuman, *Traditional Medicare...Disadvantaged?*, KAISER FAM. FOUND. (Mar. 31, 2016), <http://www.kff.org/medicare/perspective/traditional-medicare-disadvantaged/> (last visited Oct. 14, 2017). If the beneficiary has group health coverage through an employer or union, the Medigap Open Enrollment Period starts when the group insurance is terminated and the beneficiary seeks to join Medicare as a primary insurer. CTRS. FOR MEDICARE & MEDICAID SERVS., *CHOOSING A MEDIGAP POLICY: A GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE 16* (2017), [https://www.medicare.gov/Pubs/pdf/02110-Medicare-Medigap\\_guide.pdf](https://www.medicare.gov/Pubs/pdf/02110-Medicare-Medigap_guide.pdf).

61. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 60, at 16.

62. *Id.* at 16, 33.

63. *Id.* at 14, 19.

64. *Id.* at 39.

65. Neuman & Cubanski, *supra* note 59. Overall, about sixteen percent of Medicare beneficiaries are eligible because of disabilities and eligibility in the end-stage renal disease program. Juliette Cubanski & Christina Swoope, *A Primer on Medicare: Key Facts About the Medicare Program and the People It Covers*, KAISER FAM. FOUND. (Mar. 20, 2015), <http://www.kff.org/report-section/a-primer-on-medicare-who-is-eligible-for-medicare/> (last visited Oct. 13, 2017).

66. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 60, at 14.

67. *See id.* at 16.

Further, the exposure to a Medigap rejection because of pre-existing conditions, common in an elderly population, could influence beneficiary preferences for MA or TM in the first place. As noted, the rules might dissuade MA enrollees from switching back to TM when they get a serious illness or injury and could partly explain why beneficiaries who do switch back to TM commonly switch back again to MA at their first opportunity in an open enrollment period.<sup>68</sup> Others may choose to stay in TM all along because of the potential of not being able to obtain Medigap insurance if they want to return to TM. The difference in beneficiary access to the MA and Medigap markets suggests that durable preferences may be contingent on particular barriers to switching that are not inherent in beneficiaries' actual preferences but are reflected in their pragmatic decisions when faced with statutory or regulatory barriers to the exercise of their preferences.

The Medigap discussion raises an important issue that many observers think strongly affects beneficiary preferences for MA versus TM: the significant benefit gaps in Medicare. In particular, the traditional program has substantial cost sharing in the form of premiums, hospital deductibles, and co-insurance for Part B services, such as physician services, and a lack of coverage that limits beneficiary exposure to "catastrophic" expenses.<sup>69</sup> MA plans bidding below the applicable benchmark that represents the government contribution are able to do better, producing benefits to enrollees by reducing Part A and B cost sharing, reducing Part B and D premiums, enhancing Part D benefits, and providing other benefits, such as vision and hearing services.<sup>70</sup>

Other parties attempt to provide complementary insurance to fill the coverage gaps in TM.<sup>71</sup> The Medicare Modernization Act of 2003 (MMA) "offer[ed] prescription drug coverage only through private plans, either stand-alone private drug insurance plans or Medicare Advantage plans" offering drug benefits.<sup>72</sup> This MMA decision "mark[ed] the first time in [Medicare's] history that a [core] Medicare benefit [was not] available through the basic program."<sup>73</sup> By requiring beneficiaries to receive prescription drug benefits only from a private insurer, the MMA effectively replaced the previous two-stop shopping

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68. See Joseph P. Newhouse et al., *Steps to Reduce Favorable Risk Selection in Medicare Advantage Largely Succeeded, Boding Well for Health Insurance Exchanges*, 31 HEALTH AFF. 2618, 2621 (2012).

69. See *An Overview of Medicare*, KAISER FAM. FOUND. 2–3 (Apr. 2016), <http://files.kff.org/attachment/issue-brief-an-overview-of-medicare>.

70. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: INCREASING THE VALUE OF MEDICARE 208, 208 fig. 9-2 (June 2006), [http://www.medpac.gov/docs/default-source/reports/Jun06\\_EntireReport.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/Jun06_EntireReport.pdf?sfvrsn=0).

71. See KAISER FAM. FOUND., *supra* note 69, at 3.

72. Karen Davis et al., *Medicare Extra: A Comprehensive Benefit Option for Medicare Beneficiaries*, HEALTH AFF. 442 (Oct. 4, 2005), <http://content.healthaffairs.org/content/early/2005/11/15/hlthaff.w5.442.full.pdf+html>; see also Berenson & Goldstein, *supra* note 57.

73. *Id.*

approach—TM and a separate supplemental insurance program—with three-stop shopping for beneficiaries who otherwise are satisfied with staying in TM.<sup>74</sup> In fact, the MMA prevented Medigap plans from offering new prescription drug benefits, only *grandfathering in* established Medigap policies which have drug coverage,<sup>75</sup> producing the three-stop shopping faced by beneficiaries in TM.

Especially since many of the same private plans offering MA plans also offer the stand-alone Part D drug benefit, including Humana and Aetna, some beneficiaries likely find it simpler to just let the same insurer provide all their benefits, including the basic Medicare benefits. In fact, ten years ago Humana developed a near-national strategy for reaching virtually all Medicare beneficiaries with a stand-alone drug plan with a goal “to ultimately migrate those customers’ to their more profitable Medicare Advantage plans,”<sup>76</sup> thereby promoting the relative simplicity of one-stop shopping. In the immediate aftermath of MMA implementation, Humana engaged in marketing abuses in their zeal to migrate beneficiaries from the TM by offering two additional private plans with its MA plan, in some cases giving its agents financial incentives to favor the selling of MA plans rather than Part D.<sup>77</sup> It is interesting that the internal documents that Judge Bates reviewed apparently no longer emphasize Humana’s and other MA plans’ migration strategy, suggesting that the Centers for Medicare and Medicaid Services’ (CMS’) regulatory oversight may have been successful in preventing marketing abuses.

#### IV. MEDICARE POLICIES THAT PROMOTE COMPETITION AND BENEFICIARY CHOICES

MA plans are available to respond to beneficiary preferences only because they take advantage of particular rules in Medicare that permit the plans to pay hospitals and physicians at or near TM program rates, which are much lower than the rates commercial insurance plans pay.<sup>78</sup> It is interesting to note that until

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74. See Robert A. Berenson, *Medicare Disadvantaged and the Search for the Elusive ‘Level Playing Field’*, HEALTH AFF. 576 (Dec. 15, 2004), <http://content.healthaffairs.org/content/early/2004/12/15/hlthaff.w4.572.full.pdf+html>.

75. See 42 U.S.C. § 1395ss(v)(1)(A) (2012).

76. Robert A. Berenson, *Doctoring Healthcare, II*, AM. PROSPECT, (Dec. 17, 2006), <http://prospect.org/article/doctoring-health-care-ii> (last visited Sept. 23, 2017) (quoting Mike McAllister, then Chief Executive Officer of Humana).

77. See *Plan A: Hook Them with Part D*, BLOOMBERG BUS. WK. (Jan. 29, 2006, 11:00 PM), <https://www.bloomberg.com/news/articles/2006-01-29/plan-a-hook-them-with-part-d> (last visited Nov. 24, 2017).

78. See Thomas M. Selden et al., *The Growing Difference Between Public and Private Payment Rates for Inpatient Hospital Care* 34 HEALTH AFF. 2147, 2148–49 (2015) (noting the gap between TM payments and commercial health plan payments to hospitals has consistently increased, with commercial plans paying about ten percent more than TM in the late 1990s and seventy-five percent more in 2012). A recent analysis by the Congressional Budget Office (CBO) finds an even larger differential. Jared Lane Maeda & Lyle Nelson, *An Analysis of Private-Sector*

relatively recently, MA policy experts and relevant government agencies had simply assumed that MA plans pay hospitals at higher commercial insurance rates,<sup>79</sup> implicitly assuming that MA plans were very effective at reducing service use to be able to price competitively with TM. It has now been shown that the reason MA plans are able to obtain TM prices is that the Medicare statute does not allow providers to bill patients more than would be allowed for payment in TM; that is, balance billing in excess of Medicare rates is not permitted in MA.<sup>80</sup> Though legislated as a protection for beneficiaries, the limitation of payment to TM rates directly affects negotiating leverage between MA plans and providers.<sup>81</sup> In essence, in the MA program, hospitals can choose to be “in-network” at Medicare rates or “out-of-network” at the same rates.<sup>82</sup> Such hospitals lack leverage to demand the higher commercial rates that most hospitals use their negotiating leverage to achieve.

If MA plans had to pay at or near their negotiated commercial rates, they would not be competitive with TM virtually anywhere in the country. No amount of care management to reduce service use would overcome the pricing differential for hospital care or physician care;<sup>83</sup> thus, they would be priced out of the market. Yet many proponents of the premium support approach to fundamental Medicare restructuring envision that market competition alone—with a reduced government role in setting fees through administered pricing<sup>84</sup>—

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*Prices for Hospital Admissions* 26 (Cong. Budget Office, Working Paper, 2017), <https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/52567-hospitalprices.pdf>. Reviewing 2013 claims from three large national insurers, the CBO found that commercial insurance rates for inpatient hospital services were eighty-nine percent higher than TM rates, but MA plan rates for inpatient services were roughly equal to TM’s rates, with no differences based on market characteristics such as MA penetration. *Id.*

79. CONG. BUDGET OFFICE, DESIGNING A PREMIUM SUPPORT SYSTEM FOR MEDICARE 13 (Dec. 2006), <https://www.cbo.gov/sites/default/files/109th-congress-2005-2006/reports/12-08-medicare.pdf>; Berenson & Goldstein, *supra* note 57, at 16; *see also* Joseph R. Antos, *The Wyden-Ryan Proposal—A Foundation for Realistic Medicare Reform*, 366 NEW ENG. J. MED. 879, 880 (2012); McGuire et al., *supra* note 19, at 310; MEDICARE PAYMENT ADVISORY COMM’N, *supra* note 33, at 201.

80. Social Security Act § 1866, 42 U.S.C. § 1395cc (2012); 42 C.F.R. § 422.214 (2017).

81. Robert A. Berenson et al., *Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices*, 34 HEALTH AFF. 1289, 1293 (2015).

82. *Id.* at 1292.

83. *See* Robert A. Berenson, *Addressing Pricing Power in Integrated Delivery: The Limits of Antitrust*, 40 J. HEALTH POL. POL’Y & L. 711, 716–18 (2015).

84. Administered or administrative pricing determines the price of health coverage, such as the capitation rates that set the benchmarks for MA plans, from administrative records such as prior years’ health claims in the TM program. *See* Roger Feldman et al., *A Competitive Bidding Approach to Medicare Reform*, AM. ENTER. INST. 6 (Apr. 2013), <https://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf405538>.

would reduce Medicare spending.<sup>85</sup> For example, prominent conservative policy analysts while recommending adoption of premium support as a core part of their Medicare Reform Agenda, never mention the need for this form of price regulation—a ban on balance billing to Medicare beneficiaries—and specifically criticize TM’s use of administered pricing, the very prices MA plans use to be able to compete with TM and each other.<sup>86</sup> Former Secretary of the U.S. Department of Health and Human Services (HHS) Tom Price, a longtime proponent of premium support, went further, when as a member of the House of Representatives, introducing legislation that would allow physicians to bill beneficiaries for charges that exceed Medicare allowed amounts.<sup>87</sup> As HHS Secretary, Secretary Price continued to support such legislation, which would undermine the direct link between TM rates and the negotiated MA rates that allow MA plans to compete effectively with TM.<sup>88</sup>

#### V. MEDICARE RESTRUCTURING TO INCREASE COMPETITION COULD DECREASE BENEFICIARIES’ PREFERENCES

Premium support<sup>89</sup> proponents typically criticize the current MA program policy of varying the benchmarks against which MA plans bid, arguing that it is

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85. See CONG. BUDGET OFFICE, PUB. NO. 4655, A PREMIUM SUPPORT SYSTEM FOR MEDICARE: ANALYSIS OF ILLUSTRATIVE OPTIONS 3 (Sept. 2013). Under the premium support approach, the federal government would contribute the same risk-adjusted amount toward coverage for each beneficiary in a region. *Id.* People who choose a plan (or TM) that costs more than the federal contribution would generally have to pay higher premiums, and those who choose less costly options could pay lower premiums or receive cash rebates or extra services. *Id.* at 2. Premium support proponents argue that the heightened competition created by requiring beneficiaries to use their own funds, dollar for dollar, to pay for plans more costly than the fixed contribution would reduce costs and produce savings for the government. *Id.* at 3.

86. See Joseph Antos et al., *Improving Health and Health Care: An Agenda for Reform*, AM. ENTER. INST. 43, 45 (Apr. 2015), <https://www.aei.org/wp-content/uploads/2015/12/Improving-Health-and-Health-Care-online.pdf>. A former Bush Administration CMS Administrator called CMS in their management of TM a “dumb price fixer.” Uwe E. Reinhardt, *The Medicare World from Both Sides: A Conversation with Tom Scully*, 22 HEALTH AFF. 167, 167 (2003).

87. See Medicare Patient Empowerment Act, H.R. 1700, 112th Cong. § 1802(b)(4) (2011).

88. See Virgil Dickson, *MH Exclusive: Price Backs Balance Billing for Medicare Patients*, MOD. HEALTHCARE (Mar. 9, 2017), <http://www.modernhealthcare.com/article/20170309/NEWS/170309880> (last visited Sept. 15, 2017).

89. Premium support is the term used to encompass restructuring Medicare from a defined benefit to a defined contribution program. ANTOS, *supra* note 25, at 8. Under the current Medicare structure of a defined benefits program, beneficiaries are entitled to all needed, covered services from TM (although without an out-of-pocket limit of their cost-sharing obligations); whereas under defined contribution, beneficiaries are given a fixed dollar amount to be used to purchase a private plan or TM in the marketplace. *Id.* at 3. With defined benefits, Medicare provides services; with defined contributions, Medicare provides a fixed amount of funding toward the purchase or services. See *id.* Proponents of premium support argue that in contrast to defined contribution, a defined benefit approach pays for services without limiting total spending, which is a unique approach to addressing Medicare’s spending growth. *Id.* at 3, 8. However, that is not really true.

wrong that the government would pay extra to private plans in areas where TM provides lower-cost coverage and equally wrong when it overpays TM in areas where approved plans offer *equivalent care* at lower cost.<sup>90</sup> They argue, “There is no policy justification for selectively offering free, government-financed supplementary benefits to beneficiaries in one geographic region but not another.”<sup>91</sup> In short, in the choice between the two goals of beneficiary choice and cost containment presented at the beginning of the article, these policy analysts come down clearly in favor of cost containment. They do not give any weight to a policy justification promoting beneficiary choice of insurance plan or program in order to empower beneficiaries to exercise their durable preferences for either MA or TM.

A recently published paper has explored the reasons why the premium support approach, developed to promote market competition primarily to reduce Medicare spending, could severely reduce beneficiaries’ choices and, by doing

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The ACA established the Independent Payment Advisory Board (IPAB) as a mechanism to limit total Medicare spending if it was triggered by spending that exceeded a specified threshold, a mechanism that conservatives commonly criticize. *2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, THE BDS. OF TRS., FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TR. FUNDS 178 (2017), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2017.pdf>; Editorial, *Destructive Health Care Proposals*, N.Y. TIMES (June 18, 2015), <https://www.nytimes.com/2015/06/18/opinion/destructive-health-care-proposals.html> (last visited Nov. 24, 2017) (“The [IPAB] has been vilified by conservative critics with outlandish charges that it will ration care, tell patients what treatments they can receive and disrupt doctor-patient relationships.”). Since passage of the ACA, Medicare spending increases have been below the threshold at which spending reductions need to be imposed. THE BDS. OF TRS., FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TR. FUNDS, *supra*, at 178. The difference between the two approaches to limiting total spending then is premium support supposedly relies on market mechanisms (although as discussed earlier this marketplace would only work well by adopting price regulations and administered pricing currently in MA). ANTOS, *supra* note 24, at 19. The IPAB approach, however, more directly regulates spending. See THE BDS. OF TRS., FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TR. FUNDS, *supra*, at 178.

90. *Bipartisan Policy Center Debt Reduction Task Force: Hearing Before the Joint Select Committee on Deficit Reduction*, 112th Cong. 7 (2011) (testimony by Sen. Pete Domenici & Dr. Alice Rivlin, Co-Chairs, Bipartisan Policy Center Debt Reduction Task Force).

91. *Id.* at 8. Note that this policy position seems to equate equivalent care with equivalent benefits. See *id.* Presumably, beneficiaries with preferences for either an MA plan or TM are expressing judgment about differences in how their care is being provided, for example, whether they prefer care from a narrow, perhaps carefully selected provider network emphasizing care coordination and utilization management, or from a broad choice of virtually any licensed provider less subject to insurer oversight. Feldman et al., *supra* note 84, at 10. Another formulation of the same principle stated that “setting the government contribution to premiums at any amount greater than the competitively determined price of the entitlement benefits wastes money.” *Id.* at 6.

so, reduce the prospects for evenly achieving spending reductions.<sup>92</sup> The following section briefly discuss some of the problems current versions of premium support—promoted as facilitating beneficiaries’ choices to discipline market competition<sup>93</sup>—have failed to appreciate.

Because there is substantially more geographic variation in spending in TM compared to MA, following this policy principle of not paying extra to support beneficiary preferences, a principle that is assumed in most premium support proposals,<sup>94</sup> TM would likely have a decisive price advantage in some regions, whereas private plans would surely dominate in other areas.<sup>95</sup> Beneficiary choices would be diminished in both situations. Under current versions of premium support, relatively few geographic areas would have a level playing field for plan competition in which beneficiaries face comparably-priced premiums for private plans and TM, and could choose their preferred approach to providing insurance.<sup>96</sup>

Another issue that premium support proponents neglect relates to risk adjustment. Risk adjustment is necessary to alter payment amounts based on the

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92. ROBERT A. BERENSON ET AL., THE URBAN INST., RESTRUCTURING MEDICARE: THE FALSE PROMISE OF PREMIUM SUPPORT 9–13 (Oct. 2017), [https://www.urban.org/sites/default/files/publication/93801/aarp\\_24oct2017\\_1.pdf](https://www.urban.org/sites/default/files/publication/93801/aarp_24oct2017_1.pdf).

93. See, e.g., *See a Better Way*, *supra* note 58. Paul Ryan labels premium support a “consumer-directed” approach, *id.* at 13, yet most versions of premium support being proposed reduce consumer choices.

94. See CONG. BUDGET OFFICE, *supra* note 85, at 9, 23 (discussing design features of premium support approaches); see also Paul N. Van de Water, *Converting Medicare to Premium Support Would Likely Lead to Two-Tier Health Care System*, CTR. ON BUDGET & POLICY PRIORITIES (Sept. 26, 2011), <https://www.cbpp.org/research/converting-medicare-to-premium-support-would-likely-lead-to-two-tier-health-care-system>.

95. See MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM 102–04 (June 2017). MedPAC shows how MA plan bids and TM spending compares across the country, *id.* at 102, and in the lowest spending TM quartile, the median for MA plan bids to provide statutory benefits for a beneficiary of average health status compared to TM spending in the same area is 1.06, *id.* at 104. At the other extreme, in counties with the highest TM spending the median MA plan bid is 0.73. *Id.* MedPAC’s analysis does not address current flaws in the risk-adjustment system that systematically overpays MA plans, an issue this paper addresses later in this section.

96. See MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 353–57 (Mar. 2017). MA is currently able to offer a wide array of private plans alongside TM in almost all parts of the country—an average of ten plans per county—precisely because the MA benchmarks reflect the greater geographic variation of spending in TM, compared with spending in MA plans. *Id.* at 353. In the MA program, the government contribution varies from 95% of the costs of TM to 115%. *Id.* at 357. The 20% spread, which is an artifact of administered pricing, facilitates competition and contributes to the presence of MA plans and TM in virtually all counties, whereas premium support generically would rely on actual private plan bids and TM costs to determine the government contribution, without adjustment to reflect the reality that TM costs vary much more geographically than do MA plan costs. See BERENSON ET AL., *supra* note 92, at 9–10.

fact that health care needs vary substantially across the Medicare population. MA plans bid to provide the services for the beneficiary of average health status but receives payments that are adjusted for actual health risks as measured by the diagnoses reported to CMS as documented in claims for payment or comparable encounter forms received from providers, especially physicians.<sup>97</sup> MedPAC has recently focused on the problem of MA plans' aggressive approach to diagnosis coding, which raises the diagnosis-based "risk score" that is used to alter their average payment.<sup>98</sup> The Commission found that Medicare Adjustment risk score growth through 2016 produced almost ten percent extra payments, about half of which were subject to reduction because of an administrative adjustment for the rise in coding intensity.<sup>99</sup> These analyses are supported by recent attention to whistleblower suits against UnitedHealth Group Inc., the largest MA insurer,<sup>100</sup> and other MA insurers that allege fraudulent inflation of risk scores.<sup>101</sup>

In addition, independent of the plans' ability to produce higher risk scores by aggressively *finding* diagnoses, studies continue to find that plans enjoy favorable selection when assessed through ways other than reported diagnoses to measure health status based spending differences.<sup>102</sup> In the current MA program, such under-adjustment of risk selection is to the advantage of MA plans and the beneficiaries who select MA plans. However, because of the current defined benefit program structure, TM and the beneficiaries who select it are not disadvantaged; TM does not receive fixed, risk-adjusted contributions as it would under premium support.<sup>103</sup>

However, when in full competition with MA plans under premium support restructuring, the overpayments to MA plans would produce a commensurate underpayment to the TM program, something that does not occur today under the defined benefit nature of TM. Furthermore, whereas MA plan managers are working hard to maximize plan risk scores, no one in TM is authorized to

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97. MEDICARE PAYMENT ADVISORY COMM'N, *supra* note 96, at xxii.

98. *Id.*

99. *Id.*

100. *Id.* at 354 tbl.13-3.

101. See, e.g., Mary Williams Walsh, *A Whistle-Blower Tells of Health Insurers Bilking Medicare*, N.Y. TIMES (May 15, 2017), <https://www.nytimes.com/2017/05/15/business/dealbook/a-whistle-blower-tells-of-health-insurers-bilking-medicare.html> (last visited Oct. 15, 2017); see also, e.g., Mary Williams Walsh, *UnitedHealth Overbilled Medicare by Billions, U.S. Sues in Suit*, N.Y. TIMES (May 19, 2017), <https://www.nytimes.com/2017/05/19/business/dealbook/united-health-sued-medicare-overbilling.html> (last visited Oct. 15, 2017).

102. See, e.g., Newhouse et al., *supra* note 1, at 2; see also, e.g., Brown et al., *How Does Risk Selection Respond to Risk Adjustment? New Evidence from the Medicare Advantage Program*, 104 AM. ECON. REV. 3335, 3362 (2014).

103. See BERENSON ET AL., *supra* note 92, at 1.

maximize TM's risk scores,<sup>104</sup> and no proponent of premium support has pointed to the imbalance in active management among MA plans and passive management to determine the bid of TM. This imbalance could produce systematic underpayment of TM relative to enrollee risk, causing the TM costs—and bid premiums—to rise each year to compensate for the shortfall. In some places, this likely would lead to a “death spiral” of TM and reduce the ability of beneficiaries to exercise their preferences for either an MA plan or TM when the latter is not available in their market.<sup>105</sup>

Consistent with the spirit of the court's decision in the Aetna-Humana merger case, others would disagree with this premium support policy prescription, noting that beneficiaries would not consider that private health plans and TM offer equivalent care, as premium support proponents assert.<sup>106</sup> Rather, as a policy prescription, one could argue that there is little policy justification for a premium support model that would deny the following benefits: care coordination, high performance networks, among other attributes of well-run private insurance plans to large parts of the country, the broad choice of providers, and less bureaucratic intrusion that TM offers in other areas.

## VI. CONCLUSION

For much of the past decade, Medicare per-beneficiary spending increases have been quite modest, lower than in any decade since Medicare's inception in 1965.<sup>107</sup> This is in no small part due to measures adopted in the ACA and subsequent legislation. The rise in Medicare spending is not the result of a particularly inefficient government program that permits “out-of-control” spending but rather the result of caring for a rapidly growing Medicare beneficiary population that began in 2011 with the aging in of the baby boom generation.<sup>108</sup> Given the reality of what is causing Medicare spending growth, fundamental restructuring of Medicare to provide defined contributions in the form of premium support is unwarranted. Rather, policy can continue the search for level playing field competition between the two sectors of private plans and the Medicare program to support what the court found were beneficiaries' preferences for either MA plans or TM. Moreover, this article described removal

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104. Erin Goetsch, Milliman, *Principal & Consulting Actuary, Risk Adjustment and Its Use Within the Medicare Advantage Program* (Oct. 11, 2012), at Slide 7, [www.fchp.org/~media/Files/General/BRRGoetsch.ashx](http://www.fchp.org/~media/Files/General/BRRGoetsch.ashx).

105. BERENSON ET AL., *supra* note 92, at 13–14.

106. *See supra* notes 90–91 and accompanying text.

107. *See generally* THE BDS. OF TRS., FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TR. FUNDS, *supra* note 89, at 196–98.

108. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: CONTEXT FOR MEDICARE PAYMENT POLICY 38 (Mar. 2017). Beginning in 2011, about 10,000 people age into the Medicare program every day. *Id.* at 32. Further, “Medicare enrollment is projected to grow by nearly 50 percent by 2030.” *Id.*

options for extrinsic barriers that interfere with both level playing field competition among plans and durable preferences for beneficiaries. The complementary goals of offering beneficiaries broad choices of health plan and TM options while reducing the trajectory of Medicare spending can both be achieved within the current structure of Medicare.