CHAPTER 1

Synchronizing Medicare policy across payment models

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Chapter summary

Historically, Medicare has had two payment models: traditional fee-for-service (FFS) and Medicare Advantage (MA). Traditional FFS pays per service for services covered under Part A and Part B, according to rates established by the program. In contrast, MA pays private plans a per person, or capitated, rate to provide Part A and Part B services. Starting in 2012, Medicare introduced a new payment model, the accountable care organization (ACO), under which a group of providers can share savings (or in some cases incur losses) if the spending and quality of care for a defined beneficiary population attributed to them meets (or fails to meet) defined targets. The goal of the ACO program is to give groups of FFS providers incentives to reduce Medicare spending and improve quality, similar to the incentives for MA plans.

Currently, Medicare has different rules for each payment model, creating payment inequities and inefficiencies for beneficiaries and taxpayers. Setting consistent rules across the three payment models could promote competition among MA plans, ACOs, and FFS, potentially generating several benefits. Because of that potential, the Commission studied three questions that could help inform the process of synchronization (that is, the process of setting payment rules, quality measures, and incentives that are consistent across all three models): (1) which payment model has the lowest program spending in markets where all three models have a significant number of beneficiaries, (2) how beneficiary premiums and the federal contribution could vary in each

In this chapter

market for each model under different premium designs, and (3) how differences in providers' strategies for "coding" claims (i.e., the reporting of a beneficiary's diagnoses at each encounter) affect payments for services, MA plans' bids, and the measurement of quality.

The Commission found that each of the three models is the least costly in some set of markets and all serve a function in the current system. MA plans have the potential to reduce excessive use in many high-service-use markets, provide greater care coordination, and provide supplemental benefits or premium reductions. ACOs have modestly reduced costs in markets with high service use and provide beneficiaries a choice of providers. FFS continues to be the low-cost option in many low-service-use areas and gives a choice of providers. In addition, FFS hospital prices serve as a reference point for the prices MA plans pay hospitals.

With respect to premium design, Medicare should seek to encourage beneficiaries to choose the most efficient option for receiving Medicare benefits while maintaining equity for beneficiaries across markets. To examine the potential effect of premium design on beneficiary choice, the Commission constructed three illustrative premium designs and studied their potential to encourage beneficiaries to choose the more efficient delivery model. (Because beneficiaries in ACOs are part of FFS Medicare, only two of Medicare's payment models—FFS and MA—were relevant to the analysis of premiums.) The designs the Commission constructed included the following:

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

Under each design, beneficiaries can choose either FFS or MA, but the premium they pay differs. In addition, the federal contribution is financially neutral across payment models—that is, equal for FFS and MA in each market. An analysis of the designs raised two important issues: how potential savings in program spending from beneficiaries choosing the lower cost model could be shared and how the financial risk of variation in Medicare spending across markets could be shared.

Medicare's coding system for reporting patients' diagnoses also plays an important role in efforts to synchronize policy because Medicare links MA payments to patients' reported diagnoses. Owing to discretion in coding, providers' coding practices differ between MA and FFS and among MA plans. The difference can result in disparate payments for patients of roughly the same health status. In the

effort to equalize payments across models, issues that center on FFS and MA providers' coding strategies need to be addressed since coding affects not only payments but also MA plans' bids and quality measurement in each model. Steps that could be taken to ensure more equitable coding across payment models could include making coding adjustments plan-specific and tightening rules for acceptable coding.

Synchronization raises important issues of equity and implementation that need to be resolved to maximize the value of the Medicare program to its beneficiaries and taxpayers. We need to determine how to set payment rules that reward the most efficient model of care in a market, how to encourage beneficiaries to be in that model, and how to provide the information they need to make informed decisions. ■

Introduction

Under the current Medicare program, there are three payment models: traditional fee-for-service (FFS), Medicare Advantage (MA), and accountable care organizations (ACOs). Traditional FFS pays providers for individual services (or in some cases for a set of services, e.g., an inpatient hospital stay), according to the payment rates established by the program. By contrast, under MA, Medicare pays private plans a risk-adjusted per person (capitated) payment rate to provide the Part A and Part B benefit package to plan enrollees.[1] Starting in 2012, Medicare introduced a third payment model: the ACO. Under the ACO model, a group of providers is accountable for the spending and quality of care for a group of beneficiaries attributed to them. The goal of the ACO program is to give groups of FFS providers incentives to reduce Medicare spending and improve quality, similar to the incentives for MA plans. However, currently, only some ACOs bear risk; most share only savings, not losses.

In the traditional FFS Medicare and ACO models, beneficiaries essentially have no restrictions on choice of provider. In the MA model, the MA plan can restrict choice to a specified network of providers; beneficiaries receiving care from providers outside the network pay more. In this respect, MA plans are more like commercial plans commonly available to the working-age population.

Under current law, Medicare's payment rules, quality improvement measures, and incentives are different and inconsistent across the three payment models (see text boxes on the MA payment model and the ACO payment models, p. 8 and p. 9). There are various approaches to achieving consistency. In its June 2014 report, the Commission focused on setting a common spending benchmark for MA plans and ACOs based on local FFS spending. That report's focus on equal benchmarks as a key element of synchronizing Medicare policy across payment models represented a refinement of the principle of financial neutrality between FFS and MA. In this chapter, we further refine our concept of payment neutrality to be equal federal contributions across payment models in a local market. We find this redefinition necessary because, in the beneficiary-premium discussion, we look at examples in which the lower of local FFS spending or MA plan bids determines the reference point for the federal contribution and beneficiary premium.

Several benefits could arise from competition among MA plans, ACOs, and FFS if payment rules, quality measures, and incentives were synchronized. First, beneficiaries could choose a system of care delivery and providers that match their preferences. Second, competition between the models could expose inefficiencies and drive market share away from the inefficient models. For example, if the traditional FFS system has had difficulty controlling utilization in some markets, MA plans may be able to out-compete traditional FFS. Similarly, if FFS has lower costs than MA plans in some markets, they will be able to take market share from higher cost MA plans (or plans may exit the market). If ACOs can generate better care coordination than FFS and have lower overhead than MA plans, then their physicians may be able to offer a level of service that attracts patients away from MA and traditional FFS physicians. By having all models compete, beneficiaries in each market can choose which model provides them the best value.

The Commission has for many years supported giving Medicare beneficiaries a choice between traditional FFS and private plans under MA. The original goals for private plans in Medicare were to provide a mechanism for introducing innovation into the program while constraining Medicare spending. Private plans have greater flexibility to develop innovative approaches to care and can more readily use care-management tools and techniques than CMS. Those abilities could enable private plans to reduce spending and improve the quality of health care services. In turn, Medicare beneficiaries' ability to choose between traditional FFS and MA plans could lead to greater efficiency for the program if Medicare payments to plans were reduced to capture some of those gains. However, as the Medicare program adopted the goal of making MA plans available to all beneficiaries—even in markets where plans are not able to effectively compete with FFS based on cost—plan payments were increased above FFS levels, not reduced. Higher payments resulted in higher MA enrollment, but with some plans bringing higher costs and little or no innovation to the program.

As MA benchmarks are transitioning to levels that are closer to FFS as required by the Patient Protection and Affordable Care Act of 2010 (PPACA), plans have reduced their bids relative to FFS. But on average, taxpayers and beneficiaries continue to subsidize the

The Medicare Advantage payment model

Under current law, Medicare Advantage (MA) plans are required to cover all Medicare Part A and Part B benefits except hospice. With some exceptions, all MA plans must also offer an option that includes the Part D drug benefit, although payments for the Part D benefit are handled separately. Plans may supplement Medicare benefits by reducing cost-sharing requirements, providing coverage of non-Medicare benefits, enhancing the Part D drug benefit, or providing a rebate for all or part of the Part B or Part D premium.

For each county, CMS sets the MA benchmark. An MA plan's payment from Medicare is based on how its bid compares with the local MA benchmark, which represents the maximum amount Medicare will pay to a plan per MA enrollee in a given area. The plan's bid reflects its costs to cover the Part A and Part B benefit package for a beneficiary of average health status and includes plan administrative costs and profit. The local MA benchmark represents a bidding target and is set using statutory formulas that start with local FFS spending and make certain adjustments that increase benchmarks in low-spending areas and reduce them in high-spending areas. In addition, benchmarks are adjusted upward if the plan has a high quality ranking. If a plan's bid is above the benchmark, then the plan receives a payment equal to the benchmark, and enrollees in that plan have to pay a base plan premium—in addition to the Part B premium—that equals the difference between the bid and the benchmark. If a plan's bid is at the benchmark, then the payment equals the benchmark. If a plan bid is below the benchmark, then the plan receives a payment equal to its bid plus a "rebate." The rebate is a fixed percentage—50 percent, 65 percent, or 70 percent, depending on a plan's quality ranking—of the difference between the plan's risk-adjusted bid and risk-adjusted benchmark, with risk adjustment reflecting the expected spending of the plan's projected enrollment. Once the rebate dollars are determined, the plan must return the rebate to its enrollees in the form of supplemental benefits or lower premiums. A more detailed description of the MA payment system can be found at http://medpac.gov/documents/payment-basics/medicare-advantage-program-payment-system-14.pdf?sfvrsn=0. ■

MA program through higher taxes and higher Part B premiums. In its March 2015 report to the Congress, the Commission estimated that MA plans currently cost the Medicare program, on average, 105 percent of FFS program costs. (The relative costliness of MA and FFS varies substantially across local markets.)

In this chapter, we first extend our examination, begun in previous reports, of which payment model has the lowest program spending in different markets across the country. Next, with the goal of encouraging Medicare beneficiaries to choose the model with the highest value, we look at how beneficiary premiums and federal contributions might vary in each market for each model under different approaches to calculating premiums. Third, we consider how "coding" (i.e., the reporting of a beneficiary's diagnoses at each encounter) could affect payment, bidding, and quality measurement.

Comparing FFS, ACO, and MA spending within markets

To compare Medicare-program spending across FFS, ACOs, and MA plans, we examined data for 78 markets (defined as core-based statistical areas (CBSAs) within a state) that each have more than 5,000 beneficiaries enrolled in MA plans and more than 5,000 beneficiaries attributed to ACOs. Our beneficiary sample consisted of 5.5 million beneficiaries in MA plans and 1.7 million beneficiaries in ACOs (accounting for about 70 percent of Medicare's ACO beneficiaries as of January 2013).

We compared the relative program spending on Medicare MA plans and FFS Medicare using MA benchmark data, MA bid data, and expected FFS spending data from the MA plans' 2015 bids. We aggregated these data by county in the 78 markets. We expressed the average MA program

The accountable care organization payment models

There are two models of accountable care organizations (ACOs): the Pioneer ACO and the Medicare Shared Savings Program (MSSP) ACO. (A third model, the Next Generation ACO model demonstration, is scheduled to begin January 1, 2016.)

The mechanics of how ACOs are compensated differ from MA plans. MA plans enroll beneficiaries and receive monthly capitated payments based on their benchmark and bids. The MA plans pay providers and retain the difference between payments from the Medicare program and their payments to providers (or the plans bear a loss if health care costs exceed the Medicare capitation). For ACOs, the Medicare program directly pays providers fee-for-service (FFS) rates. The ACO is paid shared savings based on the difference between what the program paid to providers and the ACO's benchmark (if actual program payments are below the ACO's benchmark and quality targets are met). In the end, the MA plans and ACOs at risk both face similar financial incentives. However, ACOs avoid the extra cost of enrolling beneficiaries and paying claims, while MA plans face these extra overhead costs. Although there is a cost to enrollment and paying claims, the MA plans can undertake utilization management activities such as requiring prior authorization for some services. MA plans also have the flexibility to pay for innovative care delivery models that do not fit Medicare FFS regulations (e.g., home health for non-homebound individuals, a skilled nursing facility stay without a prior three-day hospital stay) and can restrict beneficiaries to a limited network of providers. CMS has waived some of these rules, such as the three-day rule, for Pioneer ACOs and recently discussed waiving some for MSSP ACOs that take two-sided risk (Centers for Medicare & Medicaid Services 2014). By expanding the tools that ACOs can use to control spending and improve coordination, the hope is they can generate value for beneficiaries and taxpayers.

Unlike MA benchmarks, ACO benchmarks reflect historical FFS spending incurred by beneficiaries treated by the ACOs' physicians. In 2015, the benchmark for ACOs roughly represents the expected spending level to be incurred by the ACO's beneficiaries, above which penalties are applied (in a model with two-sided risk) and below which savings are accrued and shared among the ACO's providers. An ACO's target spending, or benchmark, is calculated as follows. First, a subset of FFS beneficiaries is attributed to the ACO, based on its three years' claims history. (Unlike in MA plans, beneficiaries do not enroll in ACOs.) Second, an ACO's baseline spending is set equal to a weighted average of FFS spending for those beneficiaries over three years. Finally, the baseline spending is trended forward based on national trends in spending growth.

At the end of each year, an ACO's actual spending is calculated as the sum of all FFS spending for the ACO's beneficiaries for the year, even if some of those beneficiaries get their care from non-ACO providers during the year. If the actual spending for the ACO's beneficiaries is below the benchmark (and in some cases exceeds a minimum difference), the difference is divided between the ACO and the Medicare program as shared savings. (The percentage of shared savings that accrues to the ACO ranges from 50 percent to 75 percent.) Most ACOs do not bear any downside risk. ■

spending (including the cost of extra benefits) as a share of FFS program spending (i.e., MA program spending / expected FFS spending). We used MA plans' 2015 bid data to have the most recent information for MA and FFS.

The most recent ACO data we have from CMS is for 2013. We compute a measure of "savings" as the difference between expected FFS spending for the ACO beneficiaries and the sum of actual FFS spending and bonuses paid to the ACOs in the fiscal year.[2] We expressed the average ACO-program spending as a share of expected FFS program spending (i.e., ACO program spending / expected FFS spending for the ACO's beneficiaries).

For this analysis, we estimated the relative costliness of the three payment models by comparing the relative savings from ACOs with the relative savings from MA plans in those markets.[3] We considered ACOs with larger savings compared with MA plans in the same market to be that market's low-cost model. Similarly, we considered

The markets we examined

The 78 markets we examined have 21 million Medicare beneficiaries, representing 40 percent of all beneficiaries. After excluding individuals in employer-sponsored MA plans, MA special needs plans, and MA cost plans to allow for greater comparability between ACOs and typical MA plans, 19 million beneficiaries remained in our sample of 78 markets. The markets were distributed geographically across the United States and included areas with high and low levels of service use per beneficiary. Average service use in the 78 markets equaled the national average; service use ranged from 83 percent to 139 percent of the national average, similar to the national distribution. The 78 markets included all markets in which MA plans generated savings of more than 5 percent, with the exception of Miami-Dade, which was excluded because it had fewer than 5,000 ACO beneficiaries in 2013.

MA penetration in the 78 markets was similar to the national average. ACO penetration in the markets averaged 9 percent. ACO penetration has since increased beyond 9 percent because additional ACOs joined the program in 2013, 2014, and 2015. In general, the 78 markets in this study were representative of urban markets in the United States. However, our sample included few rural beneficiaries since rural areas were less likely to have at least 5,000 MA and 5,000 ACO beneficiaries. ■

MA plans with larger savings compared with ACOs in a market to be that market's low-cost model. If a market's MA plans and ACOs both failed to show savings, we considered traditional FFS to be the market's low-cost model. We compared ACOs' savings from 2013 and MA plans' expected savings from 2015 because these are the most recent data for the payment models and the MA bids reflect benchmarks that are closer to FFS spending than benchmarks were in 2013. To the extent that ACO performance improves from 2013 to 2015, future relative savings from ACOs may be somewhat underestimated.

ACO and MA savings were concentrated in high-service-use markets

In comparing markets' expected FFS spending with their MA plans' and ACOs' spending, we found that savings were concentrated in high-service-use markets (Table 1-1).[4] ACOs did not generate material savings for the Medicare program in 2013 after we accounted for bonuses paid to the ACOs that generated savings. Likewise, MA plans—on average—did not generate savings for the program after we accounted for the payments to MA plans to fund supplemental benefits and the effect of quality bonuses on benchmarks. In fact, MA plans were 5 percent more costly on average than FFS.

A primary function of ACOs and MA plans is to improve coordination of care and eliminate unnecessary service use. Our hypothesis is that those actions are easier to take in markets with high levels of FFS service use. We measured service use across all Medicare Part A and Part B services (e.g., hospital, physician, and post-acute care services and durable medical equipment) and divided the 78 markets into service-use quartiles as measured by FFS utilization (Table 1-1). In low-service-use markets, ACO and MA spending were 1 percent and 13 percent, respectively, above expected FFS spending. The higher MA spending reflects payment benchmarks in 2015 that were well above FFS, allowing bids and payments above FFS. In the 19 markets with the highest service use, ACOs and MA plans both generated savings averaging 2 percent. In the case of ACOs, savings were sufficient to pay ACOs their performance bonuses (which may be used in part to fund the ACO's care coordination costs) and save the program 2 percent. In the case of MA plans, savings were sufficient to fund some of the MA plans' supplemental benefits and yield 2 percent savings for the Medicare program.

While the MA savings for the Medicare program were modest in most markets, in 10 of the markets, MA plans generated net savings for the Medicare program of over 5 percent (the maximum was 8 percent). In many of these high-service-use markets, MA plans were able to generate program savings and provide substantial extra benefits for Medicare beneficiaries—for instance, reduced cost sharing or lower premiums for Part D drug coverage. In their bids,

TABLE 1–1

MA and ACO program savings are concentrated in the highest FFS service-use markets and remain modest

		ACO			MA		
Markets, by level of FFS service use	Number of markets	Mean level of ACO program spending relative to FFS spending	Number of ACO beneficiaries	ACO market share	Mean level of MA program spending relative to FFS spending*	Number of MA beneficiaries	MA market share**
All markets	78	100%	1.7 million	9%	105%	5.5 million	29%
Service-use quartiles							
Lowest quartile	20	101	250,000	11	113	650,000	30
Second quartile	19	100	650,000	11	105	1,530,000	25
Third quartile	20	101	450,000	8	103	1,790,000	34
Highest quartile	19	98	390,000	7	98	1,500,000	27

Note: MA (Medicare Advantage), ACO (accountable care organization), FFS (fee-for-service). "Savings" are program savings and are computed net of any funds provided to MA plans to provide extra benefits and net of any bonuses paid to ACOs, which can also be used for certain extra benefits, including care coordinators. We adjusted MA costs by 3 percent to reflect insufficient adjustments for coding made by CMS. Without the additional 3 percent MA adjustment, the relative savings from MA would have been estimated as 3 percent higher. For mean level of ACO and MA program spending relative to FFS spending, markets are weighted equally. Employer MA plans and special needs plans are excluded from the comparison because they are not in competition with ACOs or other MA plans. The number of beneficiaries in all markets is 19 million.
*"MA program spending" refers to all program spending, including spending on supplemental benefits based on 2015 benchmarks and bids.
**"MA market share" refers to the share of beneficiaries in typical MA plans, excluding employer plans and special needs plans. The total MA market share including these types of MA plans would be larger.

Source: MedPAC analysis of Medicare FFS claims data, ACO performance data from CMS, and 2015 MA bid data.

the MA plans in the 78 markets estimated the cost of the extra benefits (including profit and overhead) at about $65 per member per month, equal to 8 percent of average FFS spending. In the four quartiles of FFS service use (from lowest to highest), the value placed on the extra benefits was 8 percent, 6 percent, 9 percent, and 10 percent of FFS spending, respectively, with the extra benefits tending to be slightly higher in high-service-use markets.

ACOs serving elderly dually eligible beneficiaries tended to generate more savings

In other analyses, we have found that both MA plans and ACOs have shown some ability to bring costs below the expected traditional FFS cost for elderly Medicare–Medicaid dually eligible beneficiaries (beneficiaries with Medicare premiums and, in some cases, cost sharing paid through Medicaid or Medicare Savings Programs for individuals with low income). In our analysis of ACO shared savings, we found a statistically significant relationship between the share of elderly dual-eligible beneficiaries in an ACO and the amount of shared savings. A simple linear regression of ACO savings on service use and share of aged dual-eligible beneficiaries indicates that for every 10 percent increase in the share of aged dual-eligible beneficiaries, shared savings increases by an average of 1 percent ($p < .01$).[5] ACOs with high shares of dual-eligible beneficiaries do not have low costs per beneficiary; the data show only that these ACOs tended to restrain costs below the relatively high expected level of spending per elderly dual-eligible beneficiary. This finding is consistent with data from MA plans, showing that dual-eligible special needs plans (SNPs) tend to have higher profit margins (Medicare Payment Advisory Commission 2015). In 2012, SNPs specializing in dual-eligible beneficiaries had an average profit margin of 8.1 percent compared with 4.5 percent for other MA plans.

No one model was uniformly the least costly

From a program-spending perspective, our analysis comparing spending across payment models in each of the 78 markets found that that no one model was lowest cost across all markets. FFS was the low-cost option in 28 markets, ACOs in 31 markets, and MA plans in 19 markets. (However, differences in many markets were small, particularly between ACOs and FFS, as would

be expected given that ACO spending was close to 100 percent of FFS in three of the service-use quartiles, as shown in Table 1-1, p. 11.) MA plans were the least likely to generate savings in low-service-use markets and the most likely to generate savings in high-service-use markets. MA plans were expected to be the high-cost model in low FFS cost areas because MA plans have benchmarks above FFS in low-service-use areas and have higher levels of overhead (which is difficult to overcome in low-service-use markets). In contrast, MA plans were expected to be the lowest cost model in high-service-use markets because they have more tools than traditional FFS and ACOs to reduce service use.

How could relative costliness change over time?

As a result of PPACA, the MA benchmarks are moving closer to FFS spending on average over time. Therefore, some improvement could occur in MA plans' relative costliness if MA plan bids are reduced to align with the lower benchmarks. However, because benchmarks in low-spending markets will continue to be 115 percent of FFS (or more with quality bonuses), we expect MA plans' program spending will still be above FFS in these markets when the new benchmarks are fully implemented in 2017.

ACO program savings could also change over time. As ACOs gain experience and less successful ACOs drop out of the program, the average savings generated for the program by the remaining ACOs could increase. In addition, for ACOs in two-sided risk models (in which providers are not only rewarded for positive performance but also penalized for poor performance), CMS discussed waiving certain restrictions such as the three-day inpatient hospital stay requirement to receive Medicare coverage for skilled nursing facility care (which it already does for Pioneer ACOs) and the homebound requirement for home health. By giving ACOs that accept two-sided risk these extra tools to manage care, we may see improved ACO performance in the future.

Effect of MA plans and ACOs on quality of care and beneficiary satisfaction

The models should not be judged based only on cost. Beneficiaries may vary in their preferences, with some preferring the care coordination and supplemental benefits provided by MA plans. Others may prefer the flexibility of FFS. For those in the FFS system, some may choose an ACO clinician with a reputation for timely coordinated care. Quality of care will also have to be compared. To facilitate quality comparisons, there should be common quality metrics across models and similar paths for rewarding quality, as we discussed in our June 2014 report (Medicare Payment Advisory Commission 2014b).

Currently, we have little information on which to base a comparison of MA and ACO quality indicators with the quality of care in FFS Medicare. The studies comparing quality and patient satisfaction between MA plans and the FFS program provide mixed results, with MA plans doing comparatively well on preventive care services but less well on patient satisfaction (Gold and Casillas 2014). In theory, the greater coordination of care within an MA plan or an ACO could improve care coordination and adherence to guidelines. However, data comparing ACOs and FFS is very limited. McWilliams and colleagues (2014) examined how patient satisfaction changed from 2010 to 2013, once physicians joined ACOs; they found that patient satisfaction with timely access to care and communication among providers improved more for the ACO patients than for other patients.[6] In addition, among patients with multiple chronic conditions, overall ratings of care improved more for the ACO group than for the FFS control group. While the McWilliams findings are positive for ACOs, more studies evaluating quality and patient satisfaction across payment models will be needed before any definitive conclusions can be made.

Interdependence of MA, FFS, and ACO payment models

The ACO program is a subset of the FFS program. It relies on the FFS system of setting prices and paying claims. Essentially, physicians in ACOs can manage the patients, but the government runs the program's administrative functions. Without FFS, there is no ACO program.

It is also true, though less clear, that the MA program is dependent on the FFS program. First, the MA benchmarks are set based on FFS spending. Without that benchmarking capability, the benchmarks would have to be set through a bidding process. The bidding process may not be an effective mechanism to constrain MA bids or prices paid to providers in markets with one dominant insurer or one dominant provider group.

The MA model is also somewhat dependent on the FFS program for setting MA prices for hospital services. The Medicare statute allows MA plans to pay hospitals the FFS rates (as opposed to hospital charges or prevailing commercial rates) for hospital care in cases where they are obligated to pay the hospital but do not have a contractually negotiated rate (e.g., if a plan's enrollee receives emergency

care at a hospital not in the plan's provider network). The net result is that, on average, MA plans pay hospitals a rate that is virtually the same as the FFS rate. This tie to Medicare FFS prices is important for the affordability of MA plans. MA bids show that hospital costs on average account for over 40 percent of all MA plan costs. Data from the American Hospital Association and other sources suggest that average commercial rates are about 50 percent above costs and more than 50 percent above Medicare FFS rates (California Department of Insurance 2014a, California Department of Insurance 2014b, Ginsburg 2011, Medicare Payment Advisory Commission 2014a, White et al. 2013). If MA plans paid hospitals at 50 percent above Medicare rates, the plans' costs would increase by over 20 percent (40 percent × 50 percent). While plans could negotiate some discounts, the magnitude of these discounts would likely be small relative to the discount they get under rates based on FFS administratively set prices. Experience from PPACA's state exchanges indicates that negotiated rates for exchange products are often not significantly below commercial rates (Mathews and Kamp 2013). Given the dramatic difference between hospital prices paid by MA plans and other commercial insurers, traditional FFS needs to continue to exist, among other reasons, to anchor the rates MA prices pay hospitals and keep MA plans affordable.

Determining beneficiary premiums

Under the current system, beneficiaries choose between FFS and MA plans to receive Medicare benefits. (Beneficiaries in ACOs are part of FFS.) The two models can look very different in terms of premiums, benefit design, and choice of providers. To encourage beneficiaries to choose the model that gives them the highest value in terms of cost and quality, the Commission believes that the Medicare program should not subsidize one choice more than another. In other words, the federal contribution toward the cost of Medicare benefits should be equal for FFS and MA in each market.

To examine how different approaches to calculating beneficiary premiums could influence a beneficiary's choice between FFS and MA, we considered different ways to set beneficiary premiums using projected FFS spending data and MA plan bids for 2015.[7] In our analysis, we defined a market area, calculated each market's projected FFS spending, and recalculated each market's MA plan bids from service-area bids. For simplicity, all FFS spending and MA plan bids in our analysis were expressed as per beneficiary per month amounts and standardized for a beneficiary of average health status. Moreover, we assumed that quality was constant across models.[8]

Definition of market areas

For our analysis, we wanted to define market areas that best matched insurance markets served by private plans. Using market areas that are too small can result in many areas with a small number of FFS beneficiaries, and there can be instances of adjacent areas with very different levels of FFS spending. However, if a market area is too large, the cost of serving beneficiaries can vary widely within the area. Accordingly, we adopted a definition of market areas that is larger than the county definition currently used in the MA program.[9]

- In urban areas, we used collections of counties located in the same state and the same CBSA, which is a collective term for metropolitan (50,000 or more in population) and micropolitan (10,000 to 49,999 in population) areas. (Each area consists of one or more counties and includes the counties containing the core urban areas as well as any adjacent counties that have a high degree of social and economic integration with the urban core.)
- Among counties outside CBSAs, we used health service areas (HSAs) as defined by the National Center for Health Statistics. (HSAs consist of collections of counties where most of the short-term hospital care received by beneficiaries living in those counties occurs in hospitals in the same collection of counties.)

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

Average FFS spending per beneficiary in market areas

To calculate a beneficiary premium for FFS Medicare in a given market area, we determined the equivalent of an FFS "bid" based on the area's FFS spending. To calculate FFS spending that is comparable with MA plan bids for 2015, we used the projected average monthly FFS spending per beneficiary for 2015, excluding hospice, direct graduate medical education, and indirect medical education payments.[10] The calculation was standardized for a beneficiary of average health status. Market-area average spending was calculated from county-level FFS spending weighted by the area's number of FFS beneficiaries as of January 2015.

TABLE 1–2

Distribution of market areas by average monthly FFS spending per beneficiary, 2015

Average monthly FFS spending per beneficiary	Number of market areas	Share of beneficiaries
$537–$600	32	2.3%
$600–$700	462	23.3
$700–$800	524	44.7
$800–$900	183	25.9
$900–$1,151	30	3.8
Overall average ($752)	1,231	100

Note: FFS (fee-for-service). FFS spending for 2015 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments. FFS spending is per month per beneficiary and standardized for a beneficiary of average health status. Market areas consist of core-based statistical areas and health service areas in 50 states and the District of Columbia. Number of Medicare beneficiaries is as of January 2015.

Source: MedPAC analysis of Medicare Advantage (MA) plan bids for 2015 and MA enrollment data for January 2015.

Table 1-2 shows the distribution of market areas by average monthly FFS spending per beneficiary for 2015, ranging from $537 to $1,151. About a quarter of beneficiaries lived in areas with FFS spending below $700 a month; about 45 percent in areas with spending between $700 and $800 a month; and about 30 percent of beneficiaries in areas with FFS spending above $800. Across the market areas in our analysis, the average monthly FFS spending was $752.

Adjusting MA plan bids for market areas

Under current law, MA plans are required to cover all Medicare Part A and Part B benefits except hospice (see text box on the MA payment model, p. 8).[11] For each county, CMS sets the MA benchmark. This local MA benchmark represents a bidding target and is set using statutory formulas and adjusted for the plan's quality ranking. Because under current law MA benchmarks are increased relative to local FFS spending in low-spending areas and decreased in high-spending areas, there is less variation in MA benchmarks than in FFS spending across areas. Furthermore, current MA plan bids are clustered around MA benchmarks, and as a result, there is less variation in MA plan bids than in FFS spending across areas.

Given the local MA benchmark, each MA plan selects counties that make up its service area and submits a bid for the service area.[12] The plan's bid reflects its costs to provide the Part A and Part B benefit package for a beneficiary of average health status and includes plan administrative cost and profit.[13] In our analysis, MA plan bids are monthly amounts for the Part A and Part B benefit portion only and are standardized for a beneficiary of average health status. Because the current MA plan bids are for plan-defined service areas, we made the following assumptions in our analysis in converting plans bids at the service-area level to plan bids at the market-area level.

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

The number of MA plan bids varied across market areas in our analysis (Table 1-3). About 8 percent of beneficiaries had only one or two MA plans available to them. However, the vast majority of beneficiaries had at least 3 MA plans available in their market areas, and more than 20 percent had more than 20 MA plans available.

Illustrative examples for calculating beneficiary premiums

Under current law, there is no premium for Part A for beneficiaries entitled to Medicare who receive Social Security or Railroad Retirement Board benefits or are entitled to Medicare because they have end-stage renal disease.[14] All beneficiaries who elect Part B pay a base premium for that coverage, set at about 25 percent of Part B national average benefit costs per beneficiary; conversely, the government's subsidy equals 75 percent of

TABLE 1–3 **Distribution of market areas by number of MA plan bids in market area, 2015**

Number of plan bids in market area	Number of market areas	Share of beneficiaries	Average FFS spending per beneficiary	Average MA penetration rate (in percent)
1 to 2	294	8.0%	$748	15.3%
3 to 5	358	15.1	722	21.1
6 to 10	204	21.2	730	29.4
11 to 20	114	31.1	750	33.7
More than 20	30	21.8	813	43.0

Note: MA (Medicare Advantage), FFS (fee-for-service). FFS spending for 2015 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments. FFS spending and MA plan bids are per month per beneficiary and standardized for a beneficiary of average health status. Market areas consist of core-based statistical areas and health service areas in 50 states and the District of Columbia. Number of Medicare beneficiaries and MA enrollees are as of January 2015. "Share of beneficiaries" does not sum to 100 percent because, out of 1,231 market areas in our dataset, 231 market areas have no plan bids due to exclusions of certain MA plans.

Source: MedPAC analysis of MA plan bids for 2015 and MA enrollment data for January 2015.

the Part B costs. The base Part B premium is set nationally and does not vary across areas.[15]

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

Applying the current-law method for calculating the base Part B premium to our data—25 percent of Part B spending per beneficiary—results in a base FFS premium of $101 per month. This amount represents about 13.4 percent of average combined Part A and Part B FFS spending per beneficiary—and an implied government subsidy rate of 86.6 percent of combined Part A and Part B spending.[16] Our calculated base premium of $101 per month is lower than the actual Part B premium for 2015 of $104.90 per month, but this difference is to be expected given the adjustments we made in calculating FFS spending in our data.

We examined other ways to calculate beneficiary premiums in the context of synchronizing Medicare policy. For illustrative purposes, we considered three approaches that differed in (1) the base premium charged, and (2) which Medicare option the beneficiary can buy for the base premium. Under all three examples, beneficiaries may choose an option other than the one the base premium pays for. In that case, individual beneficiaries' total premiums equal the base premium plus the difference between the option they choose and the option the base premium pays for. Two of the following designs had a base premium set as a share of national average FFS spending and one had a base premium set as a share of local average FFS spending:

- ***Example 1:*** The base premium is set at 13.4 percent of the *national* average FFS spending and pays for FFS Medicare in every market. Under this approach, the premium for beneficiaries choosing an MA plan in their market area equals the base premium plus the difference between the plan bid and their market area's average FFS spending.
- ***Example 2:*** The base premium is also set at 13.4 percent of the *national* average FFS spending but then pays for *either* FFS Medicare or the reference MA plan—whichever costs less—in each market. Under this approach, if FFS spending is lower than the MA bid, the base premium pays for FFS Medicare. But if FFS is higher than MA, the base premium pays for MA, meaning that the Medicare option the base premium pays for would vary across market areas, depending on how FFS spending compares with MA.
- ***Example 3:*** The base premium is set at 13.4 percent of the *local* average FFS spending and pays for *either* FFS Medicare or the reference MA plan—whichever

TABLE 1–4 **Three illustrative examples for calculating beneficiary premiums**

Illustrative example	Base premium	What base premium pays for
Example 1 **National** base premium pays for FFS in every market	13.4% of national FFS	FFS Medicare in every market area
Example 2 **National** base premium pays for lower of local FFS or reference MA bid in each market	13.4% of national FFS	FFS Medicare or reference MA plan, whichever costs less
Example 3 **Local** base premium pays for lower of local FFS or reference MA bid in each market	13.4% of local FFS	FFS Medicare or reference MA plan, whichever costs less

Note: FFS (fee-for-service), MA (Medicare Advantage). In our three examples, we assume that the base premium is set to 13.4 percent of the Medicare Part A and Part B benefit cost, which represents 25 percent of the overall Part B share of the benefit cost. The government subsidy is then 86.6 percent of the benefit cost.

costs less—in each market. Under this approach, in markets where the local FFS spending is lower than the national average FFS spending, the base premium would be lower than the nationally set base premium, whereas in markets where local FFS spending is higher than the national average FFS spending, the opposite would be true. Table 1-4 summarizes these examples.

The examples differ from current law in several aspects. For instance, MA benchmarks would no longer be set administratively. Instead, FFS spending and MA plan bids would determine the reference point for the federal contribution and beneficiary premium.

TABLE 1–5 **Per beneficiary FFS spending and plan bids in selected market areas, 2015**

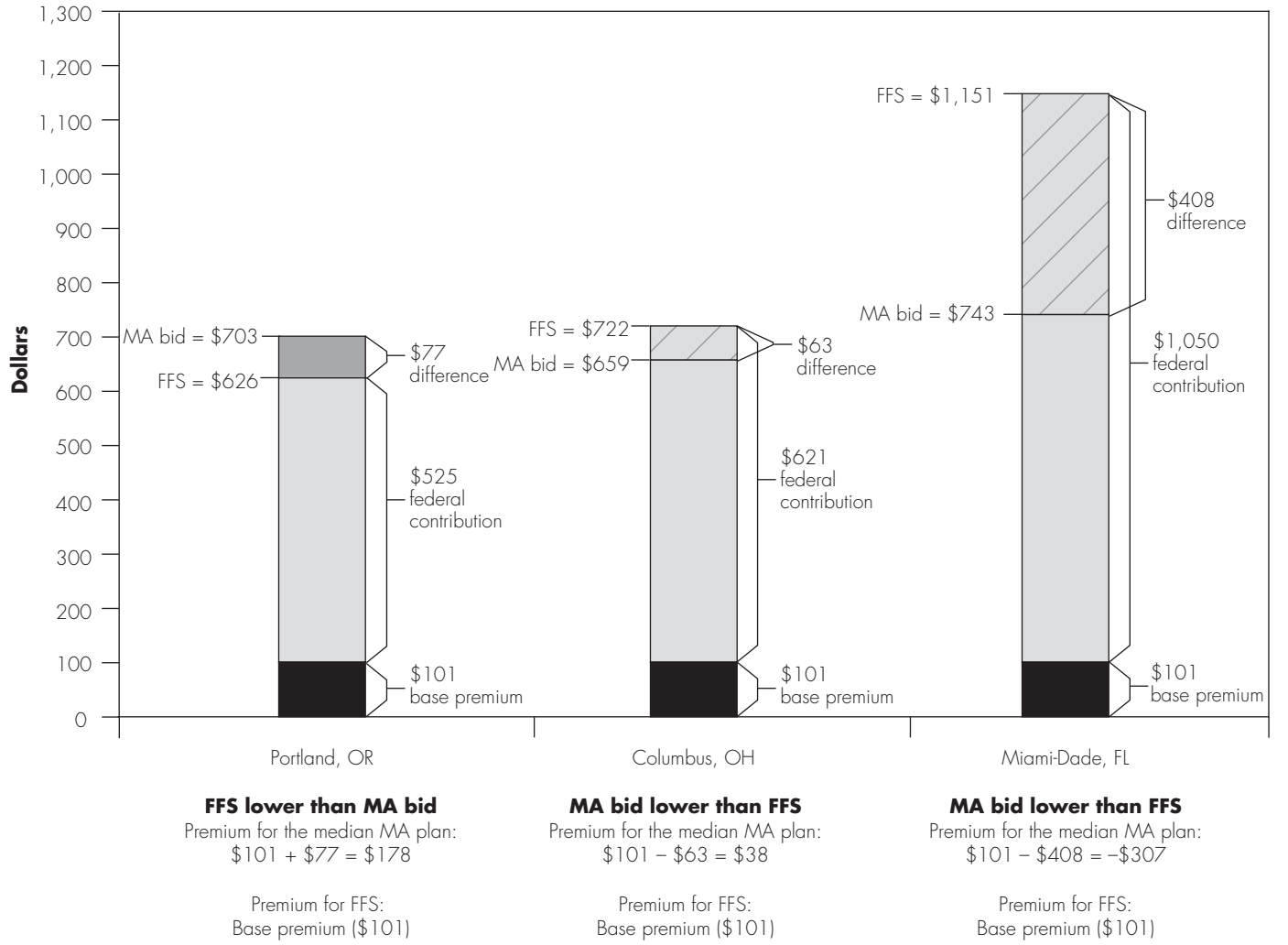
	Market area		
	Portland, OR	**Columbus, OH**	**Miami-Dade, FL**
Number of Medicare beneficiaries (in thousands)	283	287	419
Average monthly FFS spending	**$626**	**$722**	**$1,151**
Number of MA plan bids	23	16	27
MA penetration rate	57%	46%	62%
Range of MA plan bids			
Lowest bid	$607	$614	$572
25th percentile bid	688	659	697
Median bid	**703**	**659**	**743**
75th percentile bid	736	713	816
Highest bid	783	874	956
Number of counties in area	5	10	1

Note: FFS (fee-for-service), MA (Medicare Advantage). FFS spending for 2015 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments. FFS spending and MA plan bids are per month per beneficiary and standardized for a beneficiary of average health status. Market areas consist of core-based statistical areas and health service areas in 50 states and the District of Columbia. Number of Medicare beneficiaries and MA enrollees are as of January 2015.

Source: MedPAC analysis of MA plan bids for 2015 and MA enrollment data for January 2015.

FIGURE 1–1

Example 1: Nationally set base premium pays for FFS in every market



Note: FFS (fee-for-service), MA (Medicare Advantage). FFS spending for 2015 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments. FFS spending and MA plan bids are per month per beneficiary and standardized for a beneficiary of average health status. Market areas consist of core-based statistical areas and health service areas in 50 states and the District of Columbia. Number of Medicare beneficiaries and MA enrollees are as of January 2015. In our examples, we assume the median MA plan bid as the reference MA plan bid. "Difference" is between the median MA plan bid and average FFS spending. For simplicity, a negative premium can be thought of as a reduction of the entire premium plus a cash payment.

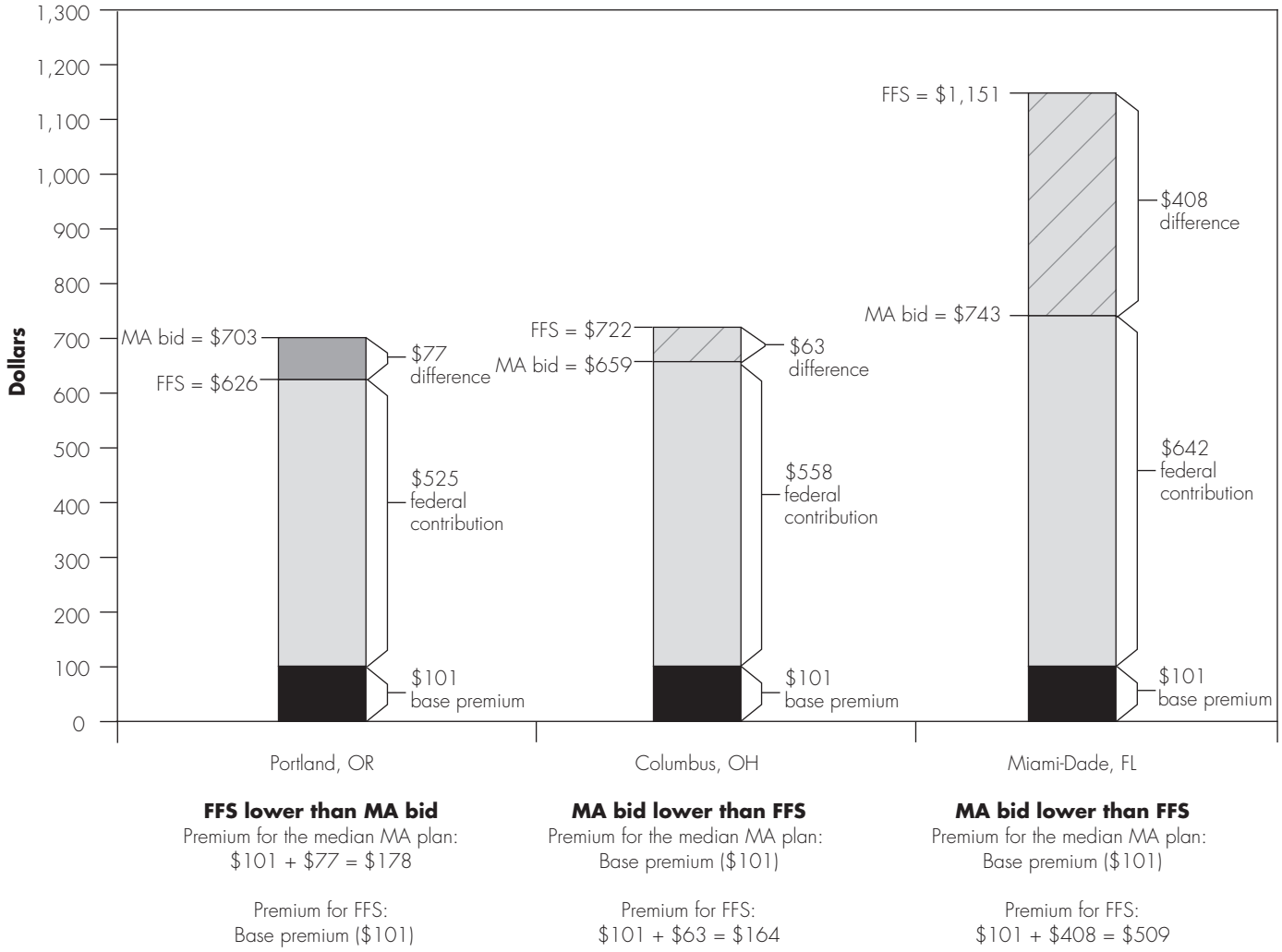
Source: MedPAC analysis of MA plan bids for 2015 and MA enrollment data for January 2015.

To illustrate what premiums would look like in dollar terms under these examples, we applied them to three market areas—Portland, OR; Columbus, OH; and Miami-Dade, FL. As shown in Table 1-5, the three areas have different levels of per beneficiary FFS spending, ranging from Portland's $626 to Miami-Dade's $1,151; Columbus's $722 is a little below the national average of $752. They all have many MA plans and high MA penetration (i.e., at least 46 percent of Medicare beneficiaries in each area are in MA plans). In all three examples, we used the median MA plan bid as the reference MA plan bid. Defining the reference MA plan bid is also a design choice. For example, it could be the lowest bid, the second lowest bid, a weighted average bid, etc. The median plan bid in these three markets varies less than the FFS spending in those markets, in part because the MA benchmarks in 2015 for those markets also vary less than average FFS spending.

Using the data from these three markets, Figure 1-1 illustrates the first example for calculating beneficiary premiums. The base premium is $101, or 13.4 percent

FIGURE 1–2

Example 2: Nationally set base premium pays for either FFS or MA, whichever costs less, in each market



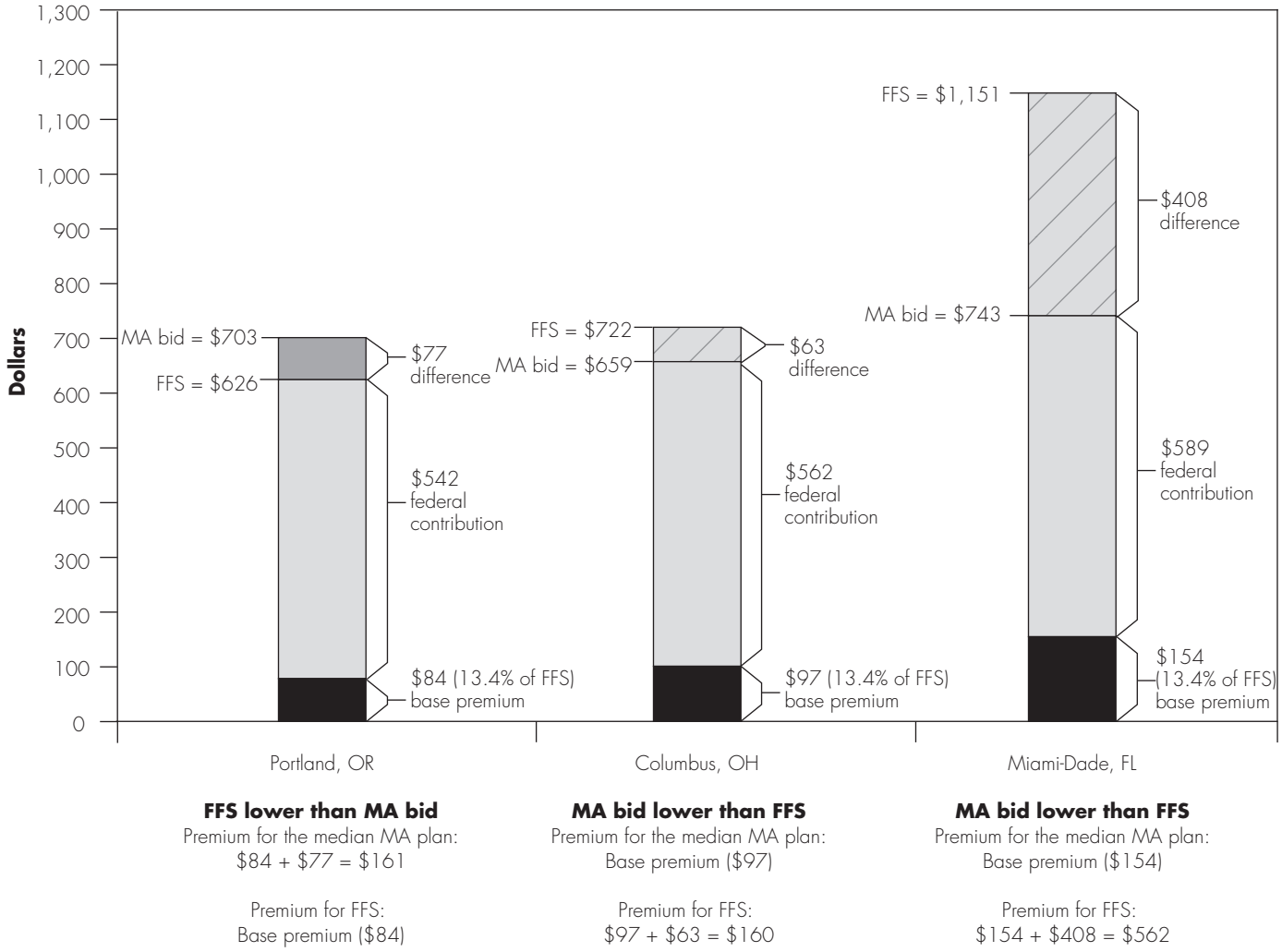
Note: FFS (fee-for-service), MA (Medicare Advantage). FFS spending for 2015 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments. FFS spending and MA plan bids are per month per beneficiary and standardized for a beneficiary of average health status. Market areas consist of core-based statistical areas and health service areas in 50 states and the District of Columbia. Number of Medicare beneficiaries and MA enrollees are as of January 2015. In our examples, we assume the median MA plan bid as the reference MA plan bid. "Difference" is between the median MA plan bid and average FFS spending.

Source: MedPAC analysis of MA plan bids for 2015 and MA enrollment data for January 2015.

of the national average FFS spending ($752) in all three market areas. In Portland, the reference MA bid is higher than local average FFS, and the difference between MA and FFS equals $77 ($703 minus $626). Therefore, if the beneficiary chooses MA, the premium for the median plan equals the base premium ($101) plus the difference ($77), or $178. (Premiums for MA plans whose bids are lower than $703 would be less than $178.) In contrast, in Columbus and Miami-Dade, the median MA plan bid is lower than local average FFS spending—by $63 and $408, respectively. Therefore, the premium in Columbus for the median MA plan, which equals the base premium plus the difference, is $38 ($101 minus $63) and in Miami-Dade is –$307 ($101 minus $408). For simplicity, a negative premium can be thought of as a reduction of the entire premium plus a cash payment. In this example, we assumed that the beneficiary receives the entire difference between FFS and MA. However, how to share this difference between the beneficiary and the program

FIGURE 1–3

Example 3: Locally set base premium pays for either FFS or MA, whichever costs less, in each market



Note: FFS (fee-for-service), MA (Medicare Advantage). FFS spending for 2015 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments. FFS spending and MA plan bids are per month per beneficiary and standardized for a beneficiary of average health status. Market areas consist of core-based statistical areas and health service areas in 50 states and the District of Columbia. Number of Medicare beneficiaries and MA enrollees are as of January 2015. In our examples, we assume the median MA plan bid as the reference MA plan bid. "Difference" is between the median MA plan bid and average FFS spending.

Source: MedPAC analysis of MA plan bids for 2015 and MA enrollment data for January 2015.

is a policy decision. For instance, under current rules, if MA plans bid below the benchmark, the program retains a share of the difference and the balance is commonly returned to the beneficiary in the form of extra benefits.

In the second example, the base premium of $101 no longer pays for FFS Medicare in every market (Figure 1-2). Instead, it pays for either FFS or MA—whichever costs less—in each market. Therefore, in Portland, where FFS is lower than MA, the base premium pays for FFS, whereas in Columbus and Miami-Dade, where MA is lower than FFS, the base premium pays for MA. The difference between FFS and MA is added to the beneficiary premium of the higher cost option in each market. In other words, while the beneficiary pays the base premium of $101 for FFS in Portland and for MA in Columbus and Miami-Dade, beneficiaries pay a higher premium if they choose MA in Portland and FFS in Columbus and Miami-Dade.

Finally, under the third example, the base premium is set to 13.4 percent of the local FFS spending: $84 in Portland, $97 in Columbus, and $154 in Miami-Dade (Figure 1-3).

TABLE 1–6 **Summary of illustrative examples for calculating beneficiary premiums**

	Market area		
	Portland, OR	**Columbus, OH**	**Miami-Dade, FL**
Median MA plan bid	$703	$659	$743
Average monthly FFS spending	626	722	1,151
Difference between MA and FFS	77	–63	–408
Example 1: Nationally set base premium pays for FFS Medicare in every market			
FFS premium	101	101	101
MA premium	178	38	–307
Federal contribution	525	621	1,050
Example 2: Nationally set base premium pays for either FFS Medicare or reference MA plan, whichever costs less, in each market			
FFS premium	101	164	509
MA premium	178	101	101
Federal contribution	525	558	642
Example 3: Locally set base premium pays for either FFS Medicare or reference MA plan, whichever costs less, in each market			
FFS premium	84	160	562
MA premium	161	97	154
Federal contribution	542	562	589

Note: MA (Medicare Advantage), FFS (fee-for-service). FFS spending for 2015 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments. FFS spending and MA plan bids are per month per beneficiary and standardized for a beneficiary of average health status. Market areas consist of core-based statistical areas and health service areas in 50 states and the District of Columbia. Number of Medicare beneficiaries and MA enrollees are as of January 2015. In our examples, we assume the median MA plan bid as the reference MA plan bid. "Difference" is between the median MA plan bid and average FFS spending. For simplicity, a negative premium can be thought of as a reduction of the entire premium plus a cash payment.

Source: MedPAC analysis of MA plan bids for 2015 and MA enrollment data for January 2015.

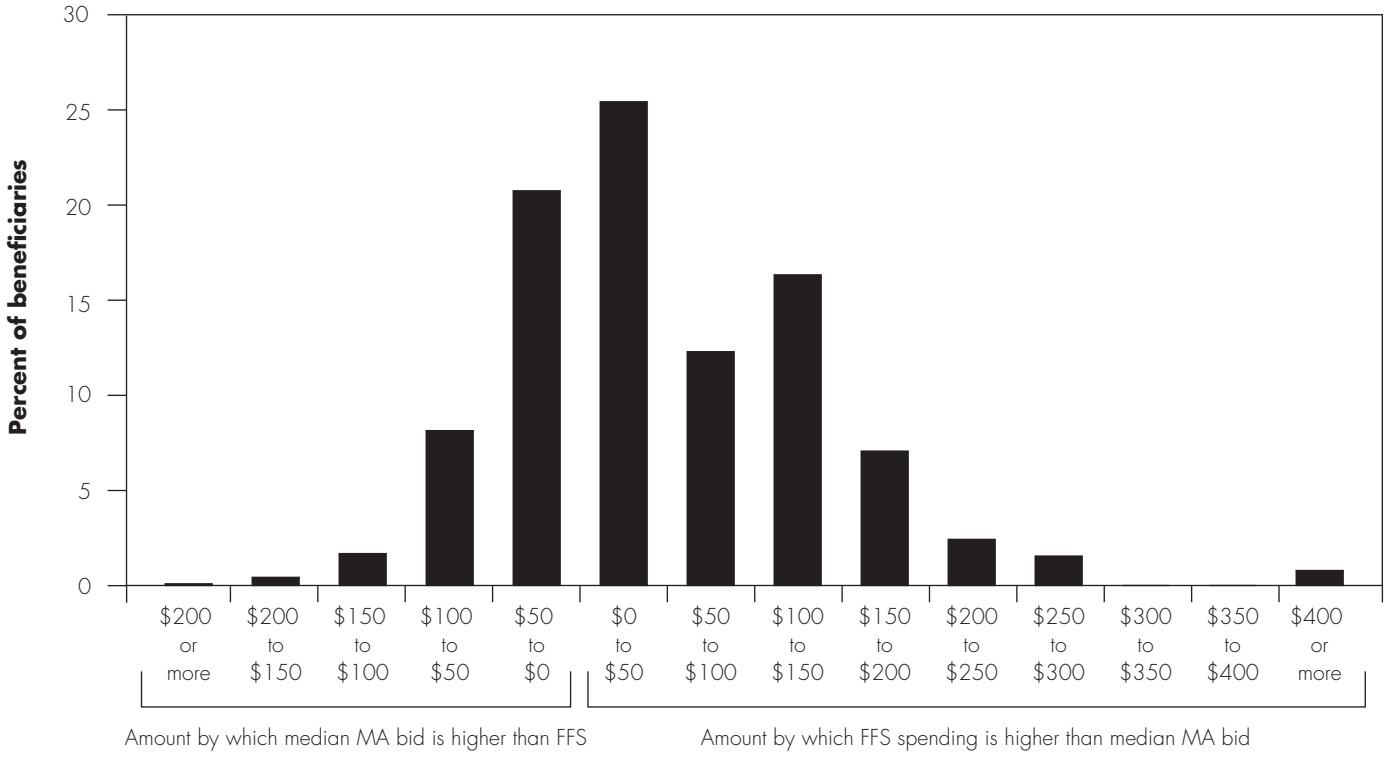
These changes in the base premium, compared with those under the second example, reflect the beneficiary facing the geographic variation in FFS spending across market areas. As in the second example, the base premium pays for either FFS or MA—whichever costs less—in each area. In other words, while beneficiaries pay the base premium for FFS in Portland and for MA in Columbus and Miami-Dade, they pay a higher premium if they choose MA in Portland or FFS in Columbus and Miami.

The first and second examples for calculating beneficiary premiums highlight how the difference in the average monthly cost of the Medicare benefit under FFS and MA within each market area can be shared between the program and the beneficiary. Differences in the reference MA bid relative to FFS in each market are summarized in Table 1-6: $77 in Portland; –$63 in Columbus; and –$408 in Miami-Dade. Under the first example, the beneficiary who chooses MA pays the entire difference only if MA is higher cost than FFS and gets the entire difference if MA is less than FFS. In contrast, in the second example, the beneficiary who chooses the higher cost option pays the entire difference regardless of which option—either FFS or MA—is higher cost, and the federal contribution is less than in Example 1 if FFS is higher cost.

The contrast between the second and third examples for calculating beneficiary premiums raises the question

FIGURE 1–4

Distribution of the difference between average FFS spending and the median MA plan bid, 2015



Note: FFS (fee-for-service), MA (Medicare Advantage). FFS spending for 2015 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments. FFS spending and MA plan bids are per month per beneficiary and standardized for a beneficiary of average health status. Market areas consist of core-based statistical areas and health service areas in 50 states and the District of Columbia. Number of Medicare beneficiaries and MA enrollees are as of January 2015. Out of 1,231 market areas in our dataset, 231 market areas have no plan bids due to exclusions of certain MA plans.

Source: MedPAC analysis of MA plan bids for 2015 and MA enrollment data for January 2015.

of who should pay for or benefit from the geographic variation in FFS spending. Because these amounts are all risk adjusted, geographic variation arising from differences in health status or dual-eligible status are already accounted for. The remaining differences represent differences in local input prices and service use. In the second example, the base premium does not vary across areas, whereas in the third example, the base premium adjusts proportionately to local FFS spending. Is it fair for beneficiaries in high-spending areas to pay higher premiums for the same basic benefit? Alternatively, is it fair for beneficiaries in low-spending areas to cross-subsidize beneficiaries in high-spending areas? More broadly, how should the program and the beneficiary share the geographic variation in program spending?

There are potential savings in program spending in each of the examples if beneficiaries choose the lower cost model more often. A key policy question is how those potential savings could be shared between the beneficiary and the program.

In all three illustrative examples, the difference between the average FFS spending and the reference MA bid is a key variable in calculating beneficiary premiums. Especially in the second and third examples, this difference is the additional premium beneficiaries would pay if they chose the higher cost option between FFS and the reference MA plan. Figure 1-4 summarizes the distribution of the differences between FFS and MA for all market areas. Almost half of beneficiaries are in market areas where the difference is less than $50. About 2 percent of beneficiaries are in market areas where the median MA bid is higher than FFS spending by $100 or more. In contrast, about 28 percent of beneficiaries are

How the beneficiary premium is calculated under Part D

Under Part D, stand-alone prescription drug plans and Medicare Advantage (MA) drug plan sponsors bid to provide an outpatient prescription drug benefit to enrollees. Each plan serves enrollees who live within 1 of 34 Part D regions, which are made up of either 1 state or multiple states. The law provides for a defined basic benefit, but, within limits, plan sponsors can offer different benefit designs that have the same actuarial value as the defined benefit. Sponsors can offer enhanced benefits if they also offer a plan with basic benefits in the same region.

For each enrollee, Medicare provides plans with a subsidy that averages 74.5 percent of basic benefits. That subsidy takes two forms: a direct subsidy (monthly capitated payment) that lowers premiums for all enrollees and individual reinsurance that pays for 80 percent of enrollee spending above Part D's catastrophic threshold.

Enrollee premiums are the direct result of Part D's bidding process. Plans submit bids that reflect their expected benefit payments plus administrative expenses after deducting expected reinsurance subsidies. CMS takes standardized bid amounts for basic benefits and calculates an average, weighted by each plan's enrollment in the previous year. The base beneficiary premium equals 25.5 percent of the national average benefit costs. Because the base premium and direct subsidy are set nationally, those amounts do not vary across plans or by geographic region.

However, enrollees pay different premium amounts depending on the plan they select. Each plan's premium is set as the base premium plus any difference between the plan's bid and the national average bid. Enrollees choosing a plan that is costlier than the average pay a higher premium—the full difference between the plan's bid and the nationwide average. If they select a plan that has a lower than average bid, their premium is lower by that difference. If enrollees pick a plan that includes supplemental coverage, they must pay the full price for the additional benefits.

Part D ensures that beneficiaries eligible for the low-income [drug] subsidy (LIS) have premium-free plans available to them. Part D's bidding process determines a maximum amount that Medicare will pay for premiums on behalf of LIS enrollees in each of the country's 34 Part D regions. It is based on an average of premiums for plans with basic benefits, weighted by each plan's LIS enrollment in the previous year, and it ensures that at least one stand-alone prescription drug plan is available at no premium. Plans with premiums up to this regional threshold are premium free for LIS beneficiaries. As a result, LIS beneficiaries have access to at least one premium-free stand-alone drug plan, even in regions where the average bid is higher than the national average. ■

in market areas where FFS spending is higher than the median MA bid by $100 or more. Figure 1-4 (p. 21) also shows that even among market areas where FFS is higher by a large difference, Miami-Dade remains an outlier, with a difference of $408. In all other markets, the difference between FFS and MA is less than $300.

Limitations of our analysis

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

Second, our analysis uses plan bids under the current MA program as a proxy for the total cost of providing the Medicare benefits through private plans because they are the best measure we have. However, these bids are the plans' responses to current rules, which are different from all three illustrative examples. Under different rules, MA plans are likely to bid differently. For example, current MA bids are highly correlated with

current MA benchmarks, which range from 95 percent to over 125 percent of FFS spending in 2015. Without those administratively set benchmarks, as in our analysis of Example 2 and Example 3, plans would likely change their bids. Additionally, plan bids would be different if the program defined a market area, as under our illustrative examples, compared with if MA plans defined their own service area, as under current law. Moreover, under different rules for calculating beneficiary premiums and the federal contribution, MA plans would likely make different decisions regarding whether to enter or exit a particular market area and how much to bid.

Finally, our analysis does not discuss how beneficiaries would respond to changes in their premiums. Our examples show that methods for calculating beneficiary premiums could have a major effect on beneficiaries' costs. But a premium is only one of many factors beneficiaries might care about. In making a choice with the highest value to them, some beneficiaries would need to trade off premiums and other aspects of the benefit package, as well as their perception of the quality of different choices.

This process can be difficult and complex. For example, under current law, choosing traditional Medicare offers no restrictions on providers but may require additional choices among Medicare supplemental plans and among Part D plans. Choosing an MA plan may simplify the process by offering all Medicare benefits—Part A, Part B, Part D, and supplemental coverage—in a single plan, but would necessitate receiving care from a limited network of providers. When choices require considering multiple dimensions simultaneously, beneficiaries' ability to compare and make trade-offs among a large set of options would likely be limited (see text box on factors affecting beneficiaries' decision making, p. 24). Moreover, if the difference in premiums among choices is too high, the choice that the beneficiary would otherwise consider most attractive might be prohibitively expensive and therefore not a realistically viable choice. These issues are additional policy considerations that must be factored into designing beneficiaries' financial incentives.

The effect of coding on payments, bids, and quality

Coding (i.e., the reporting of a beneficiary's diagnoses at each encounter) affects payment, bids, and quality measurement. Coding can directly influence payment. In MA, for example, a beneficiary's risk score (which incorporates selected diagnoses as well as some additional factors) is multiplied by a base payment rate to determine a plan's payment. When an MA plan bids to provide the Medicare benefit in a market, that bid is for a person of average risk, which is defined as a person having a risk score of 1.0 using CMS's hierarchical condition categories (CMS–HCC) risk model. Because a beneficiary's health status, based on diagnosis codes, determines the beneficiary's risk score, coding is also crucial to bidding. Finally, for risk-adjusted quality outcomes such as readmissions, coding is important because it can affect the risk adjustment for a beneficiary and the resulting quality score. Thus, uniformity in coding is a crucial consideration when attempting to synchronize policy across the three payment models.

Coding practices and the determination of bids and payments

A key feature of MA's bidding system is that a bid is for a person of average risk (or a 1.0 risk score). Risk adjustment is designed to neutralize cost differences that are due solely to the health status of beneficiaries within each plan. Without adequate risk adjustment, a plan that had sicker enrollees would be more costly than other plans (all else being equal) and its bid would be higher. We do not want to penalize such plans, and we do not want incentives for plans or ACOs to avoid sicker beneficiaries. With adequate risk adjustment, differences in bids would reflect varying levels of resource use driven by a plan's utilization management practices, providers' practice styles, beneficiary preferences for care, and the mix of services used. Differences in cost based on such factors are the cost differences that should be reflected in plan bids.

MA plans encourage more intensive coding than is the practice among FFS providers because it increases their payments from Medicare. For example, a plan may ensure that the physician includes a diagnosis for diabetes each time a diabetic patient has an office visit to make sure that diagnosis is included in the risk-adjustment model. While the diagnosis is appropriate, a physician in FFS may not include that diagnosis if the patient is visiting for some other reason—resulting in inconsistency between the coding practices of each sector. Another source of more-intensive coding in MA plans is the inclusion of diagnoses from home assessment visits, which are initiated by MA plans but may not involve interaction with a beneficiary's primary care provider. Such visits are not a common

Factors affecting beneficiaries' decision making

A policy designed to create financial incentives for beneficiaries anticipates certain behavioral responses from them (for example, reducing their use of services in response to higher cost sharing or changing their Medicare coverage in response to changes in premiums). To meet the intended goals, designing such a policy would need to take into consideration how beneficiaries make decisions and respond to incentives. In particular, it would need to take into account that beneficiaries' ability to compare and make trade-offs among a large set of options may be limited.

People's ability to understand and use health insurance—Medicare included—may be limited simply because health insurance is inherently complex. It requires the consideration of multiple dimensions simultaneously, is filled with unfamiliar terminology, and requires a high level of numeracy to make informed judgments. Moreover, people have different preferences and needs for health care, which can be uncertain and unpredictable. As a result, people often stick with the same insurance coverage year after year even when better options are available, seek advice from family or friends, and choose highly advertised plans or those from a well-known brand. (Health insurance is not unique in this way. People show similar shopping behavior in other complex financial decisions, such as mortgage shopping.)

The psychology literature suggests that the number of options people face may affect their choice (Iyengar and Kamenica 2010, Schwartz 2004). The choice overload hypothesis states that an increase in the number of options to choose from may lead to adverse consequences, such as decreased motivation to choose or less satisfaction with the option chosen. A meta-analysis of choice overload studies shows differences in the study results (Scheibehenne et al. 2010). Although the literature does not have clear answers on when and why choice overload may occur, it suggests that choice overload is more likely under certain circumstances. Choosing is more difficult when available options are similar, no clearly superior option exists among several attractive options, or decision makers have no well-defined preferences before choosing. In these situations, individuals typically use decision heuristics to simplify or limit the amount of information that must be processed to make the decision. These short cuts are not always benign. For instance, variables that are easily measured, like cost, are often subconsciously given more weight than variables that are more subjective, like quality. Ultimately, the process may arbitrarily eliminate potentially relevant details from consideration and overstate the importance of other information. Beyond the number of options available, therefore, making it easier for beneficiaries to navigate the set of available options and reducing the time and cognitive burden required to make a choice would improve the decision-making process.

Moreover, the nature of how choices are presented, described, and framed can affect people's decision making. Because people are prone to systematic biases, their decisions are sensitive to the context in which they make them (Kahneman 2011). For example, people's decisions can change depending on the order in which choices are arrayed and the words used to describe and frame them. But because these biases are predictable, they also present an opportunity to influence people's decisions in the direction policymakers desire. For example, the initial set of options influences how consumers view and interpret subsequent information and the decisions they ultimately make. Therefore, determining the default setting for sorting and displaying options has a big effect on what consumers see as their choices. ■

occurrence in FFS Medicare. Because the CMS–HCC model is calibrated using only FFS data, the inclusion of diagnoses from health assessments done in the home is problematic.

Recognizing the issue of more-intensive coding in MA plans, the Medicare statute currently requires a coding adjustment to address differences in coding practices between MA plans and FFS providers so that MA payments are accurately risk adjusted. For 2015, that adjustment was a risk score reduction of 5.16 percent. However, the Commission has found that the statutory coding adjustment does not fully adjust for the differences

TABLE 1–7 **Effect on MA plan bids from a 3 percent reduction in plans' risk scores**

	Market area	
	Portland, OR	**Miami-Dade, FL**
Median bid (risk score not reduced)		
Median bid before risk adjustment to 1.0	$668	$1,025
Weighted average risk score from 2015 bids	0.95	1.38
Median bid after risk adjustment	$703	$743
Median bid (risk score reduced by 3%)		
Median bid before risk adjustment to 1.0	$668	$1,025
Weighted average risk score from 2015 bids, reduced by 3%	0.92	1.34
Median bid after risk adjustment	$725	$766
Difference in median bids after risk adjustment	$22	$23

Note: MA (Medicare Advantage). The risk scores are determined for plans other than employer group plans and special needs plans.

Source: MedPAC analysis of Medicare Advantage plan bids for 2015.

between MA and FFS and that MA risk scores should be further reduced by about 3 percent (Medicare Payment Advisory Commission 2015).

For purposes of synchronizing policies, one approach to addressing the observed coding differences is to use the current approach of an across-the-board reduction in the risk scores that MA plans report. (A similar approach could be applied to ACOs to the extent that more-intensive coding occurs among ACO providers and it has an effect on the computation of costs and savings.) The example described earlier of how to determine MA premiums and the cost to beneficiaries of FFS in the different markets already reflects the current statutory adjustment. Table 1-7 illustrates how a further adjustment of 3 percent would affect that analysis. A reduction in plan risk scores of 3 percent to adjust for more-intensive coding would raise plan bids because they would be divided by the new, lower risk score to compute a 1.0 bid. That would narrow the difference between FFS and MA in Miami-Dade, where FFS is the more costly option, and widen the difference in Portland, where MA is the more costly option.

For example, the median bid before risk adjustment in Miami-Dade was $1,025. This amount, divided by the risk score from the 2015 bids (1.38) yields a 1.0 bid of $743, which is what we used in our analysis (e.g., see Table 1-6 (p. 20) and Figure 1-1 (p. 17)). If the risk score were reduced by 3 percent, the risk score becomes 1.34. Dividing $1,025 by that risk score yields $766 as the new 1.0 bid. As shown in Table 1-7, the median bid increases from $743 to $766 in Miami-Dade, and from $703 to $725 in the Portland, OR, metropolitan statistical area (MSA). If in Miami-Dade, beneficiaries choosing the FFS option are expected to pay the full difference between the average FFS cost and the median MA bid (as would be the case in the second and third premium design examples), the beneficiary's financial obligation is reduced by $23 per month with the coding adjustment. Table 1-7 also demonstrates that, although median MA bids in Miami-Dade and Portland are close to each other after risk adjustment ($766 and $725, respectively), there would continue to be large geographic variation in actual payments to MA plans. The MA payment rate is over 50 percent higher in Miami-Dade for the median bid ($1,025 versus $668 in Portland) because of the difference in risk scores of the beneficiaries enrolling in MA. The difference in risk scores between the two areas is also apparent in the FFS population of Miami-Dade and Portland. CMS data show that in 2012 the Miami-Dade risk score was 1.31, while in the Portland MSA it was 0.92 (Centers for Medicare & Medicaid Services 2015b).

There may be reasons to use a coding adjustment that is not an across-the-board adjustment. Currently, plans are, in effect, disadvantaged if they code less intensively

than other MA plans because the adjustment is the same for all plans. Kronick and Welch (2014) have shown that coding practices are not uniform across MA plans. An alternative to an across-the-board coding adjustment—particularly if premiums are determined at the local market level—is to have plan-specific coding adjustments (which could also apply to ACOs with more-intensive coding). This adjustment would be more difficult to determine, but it would remove some of the incentive for plans to increase coding intensity. Another approach might be to tighten the rules for acceptable coding so that MA coding more closely mirrors the coding in FFS. For example, CMS could use MA encounter data for risk-adjustment purposes, but accept only those encounters that have an analogue in FFS Medicare.[17]

A further complication is that coding also varies by geographic area in the FFS sector beyond what would be expected based solely on health status. Song and colleagues (2010) found that areas of higher utilization have more-intensive coding with "substantial differences in diagnostic practices that are unlikely to be related to patient characteristics." This finding raises questions such as whether the FFS risk scores should be reduced with a geographic-area specific coding adjustment. Should the coding adjustment for MA plans in a high-service-use area like Miami-Dade be in relation to the Miami "community standard" of coding in FFS rather than a national average? If the premiums for FFS will vary by market area in a synchronization model, should Miami-Dade FFS costs have a coding adjustment different from a low-service-use area like Portland?

Coding practices and other issues in the assessment of quality

Another aspect of synchronization across payment systems is the concept of having payment differentials based on the quality of care. The Commission has considered an approach that would give additional quality-based payments to MA plans and ACOs if their quality is better than that of FFS in their market (and lower payments if their quality is worse). This approach is predicated on the fact that MA plans and ACOs have agreed to be accountable for a population of beneficiaries and on the availability of population-based outcome measures. (See Chapter 3 of the Commission's June 2014 report for a full discussion of this approach (Medicare Payment Advisory Commission 2014b).) Currently, our ability to measure such outcomes is limited, and some of the limitations arise from differences in coding practices.

The effect of coding on quality measurement

Coding can play a part in determining a plan's performance on quality measures. A case in point is hospital inpatient readmission measures, one of which is a Healthcare Effectiveness Data and Information Set® (HEDIS®) measure used in the MA star system of quality measurement. A readmission measure also is one of the outcome measures that the Commission has suggested for population-based quality measurement.

The HEDIS readmission measure compares a plan's actual readmission rate with an expected readmission rate based on patients' demographics and diagnoses. All other things being equal, if more intensive coding results in a greater number of diagnoses in one plan compared with another, the plan with more intensive coding will show better performance on the readmission measure because its expected readmission rate will be higher.

Measures that are not risk adjusted can also be affected by coding practices. For example, many of the current HEDIS measures are for the treatment of diabetics. If MA plans are able to identify all their enrollees who have diabetes, including those in the early stages of the disease, while in FFS the diagnosis is more likely to appear in later stages (when comorbidities are more likely to be present), the MA plan's share of diabetics who control their blood sugar, cholesterol, and blood pressure may be higher than in FFS because the FFS beneficiaries diagnosed with later-stage diabetes are a more complicated set of patients.

Other issues in synchronizing quality measurement

There are many other issues in synchronizing quality measurement and assessment across the three payment models. One notable difference is that higher quality is rewarded with extra payment in the MA model, whereas in the ACO model, unless quality meets a specified threshold, shared savings payments are reduced. This difference would be resolved under our approach—rewards for both ACOs and MA plans with better quality than FFS and penalties if lower. In addition to this issue, other, more technical issues would need to be resolved. Some examples are discussed below.

The Commission's March 2010 report included a congressionally mandated study of methods to compare quality in FFS Medicare with the quality of care rendered by MA plans. The observations made in that report and its recommendations are applicable in our discussion of ensuring a level playing field in measuring quality

across the three payment models. Some of the report's recommendations have been implemented, but others have not. For example, performance of MA plans in the star rating system continues to be measured at the contract level, even though a single contract can stretch across a wide geographic area—as in the case of the first health plan listed in public use files of HEDIS data, which is "CHA HMO (Hawaii/Iowa)," with about half of the plan's enrollment in Hawaii and half in Iowa. The Commission recommended that quality reporting should be done at a smaller geographic level, using areas that correspond more closely with health care markets.

With regard to the patient experience measures collected through the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) survey, the phrasing of the questions differs between, for example, the ACO CAHPS survey and the MA CAHPS survey. In addition, the case-mix adjustment for response bias differs. In MA, Medicare–Medicaid dual-eligibility status is a factor in assessing case mix, while in the CAHPS Clinician & Group Surveys (used for ACOs), it is not. These differences in the mechanics of quality measurement need to be addressed before we can be confident that we can judge and compare quality in the different payment models.

Conclusion

We have reviewed three aspects of synchronizing Medicare payment models in this chapter: which model has the lowest program spending in select markets, ways of designing the beneficiary premium to encourage beneficiaries to choose the lower cost model, and how coding needs to be accounted for to assure fair comparisons across models. Each of these issues can be quite complex, but there are some unifying principles for evaluating them that stem from considering the goal of synchronizing Medicare payment policy: maximizing the value of the Medicare program to beneficiaries and taxpayers. We need to determine how to set payment rules that reward the most efficient model of care in a market, how to encourage beneficiaries to be in that model, and how to provide the information they need to make informed decisions. If more beneficiaries were in the most efficient model, savings could be generated that could then be shared between the program and beneficiaries.

By the most efficient payment model in each market, we mean the model that has the lowest program spending and provides high-quality care. In this chapter, we have focused on lower program spending and found that each of the three models has the lowest program spending in some markets and all serve a function in the current system. In our June 2014 report, we focused on quality and described a system in which MA plans and ACOs would be judged relative to the ambient level of FFS quality in each market and be rewarded (or penalized) if their quality was above (or below) that of FFS (Medicare Payment Advisory Commission 2014b). Spending and quality considerations would need to be combined to encourage providers in all markets to improve quality, control program spending, and be part of the most efficient model of care in their market.

Encouraging beneficiaries to be in the most efficient model is the next step. In this chapter, we have looked at three ways of setting beneficiaries' premiums.[18] In each illustrative example, the federal contribution is equal for FFS and MA in each market, no matter which option the beneficiary chooses. That is, in all three examples the federal contribution in a market is financially neutral between models. The examples assumed that quality was equal across models, which would be unlikely, and as discussed above, payments to each MA plan and ACO should be modified to account for quality. If MA were the lower cost model and the beneficiary premium was set to cover the cost of being in MA, the beneficiary would have to be guaranteed access to an MA plan with quality at least equal to the ambient level of FFS quality in the market. For example, only bids from plans with quality equal to or above FFS could be counted when establishing the reference bid.

Putting synchronization into practice—redesigning payments, beneficiary premiums, and benefit design—will be a complex task and will require balancing the interests of beneficiaries, taxpayers, and providers. One crucial part of the task will be defining what is equitable. There are three aspects of this definition that are of particular importance:

- ***Equity for beneficiaries across the country.*** As we have shown in previous work, the cost of Medicare varies widely across the country because of differences in input prices, health status, and use of Medicare services. Currently, beneficiaries' premiums for FFS reflect none of these factors, and one could argue that beneficiaries in low-cost markets are subsidizing beneficiaries in high-cost markets. Should beneficiary premiums reflect the difference between prices and service use in the local market and the

national average, or should beneficiaries be insulated from some or all of these differences? Should beneficiaries pay more or less depending on regional spending over which they have little influence?

- ***Equity for beneficiaries within a market.*** Beneficiaries within a market may now have the choice of many MA plans or staying in FFS Medicare. Should the government make equal contributions for all plans in a market—as we have illustrated in our examples—even if that means a beneficiary may have to pay more to remain in FFS in some markets? If there are savings, should they accrue entirely to the beneficiary, to the Medicare program, or a combination?

- ***Equity across generations.*** One aspect of equity we have not investigated is that of equity across generations. Under current law, taxpayers—who are increasingly in limited-network plans with high premiums, deductibles, and cost sharing—essentially guarantee Medicare beneficiaries access to any Medicare provider of their choice for a set premium across the country. At its inception in 1965, Medicare was modeled on the insurance design then prevalent in the market for those under age 65, premised on the idea that those over age 65 should have access to health insurance on similar terms. As insurance design changes, should Medicare return to that principle and reflect current insurance design, which often does not guarantee access to all providers but only those in a defined network? If Medicare is not redesigned, should other taxpayers be asked to subsidize a benefit design that is more generous than what is becoming standard in the industry? Or should the government contribution be set to give Medicare beneficiaries an incentive similar to those with commercial insurance to pick the lower cost option?

No matter how policymakers resolve these issues of equity, other issues will need to be addressed. We have mentioned quality and risk adjustment. In addition, there will be complications in regard to how to design a synchronization policy for low-income beneficiaries, how to ensure capacity in the efficient model (that is, how would Medicare ensure that MA plans had the capacity to handle all comers if MA were the low-cost model in a market), and whether Medicare would have to change from an opt-out of FFS design to an opt-out of the more efficient model design if premiums were based on the low-cost alternative. It will be difficult to achieve consensus on these issues and others that will arise. However, the goal is one that is essential to achieve if we want the Medicare program to be affordable and maintain sufficient support from both its beneficiaries and the taxpayers who fund a large share of the program's cost. ■

Endnotes

1 The Part A and Part B benefit package in MA excludes hospice. In our March 2014 report, the Commission recommended including the Medicare hospice benefit in the MA benefit package beginning in 2016 (Medicare Payment Advisory Commission 2014c).

2 Our set of ACOs includes Pioneer ACOs with a fiscal year that started in January 2013, MSSP ACOs with a fiscal year that started in April 2012, and MSSP ACOs with a fiscal year that started in July 2012. For simplicity, we use "2013 ACO performance" for all ACOs.

3 By comparing the savings relative to a market's FFS spending, we could use data from different years without having to account for price changes over time, which allowed us to use the most recent data available for the ACO comparisons with FFS and the MA comparisons with FFS.

4 We measured service use from 2006 to 2008 based on the data from our earlier work (Medicare Payment Advisory Commission 2011). Because the ACO benchmarks were computed using data from 2009 onward, it is advantageous to measure service use with data before 2009 to avoid random variation affecting both the ACO benchmarks and the relative service-use computations.

5 The dependent variable in the regression was ACO savings in the ACO's fiscal year (2012/2013). The independent variables were the historical service use in that CBSA (2006 to 2008), the share of ACO beneficiaries who were dual eligible and over 65, the share who were disabled, and the share who had end-stage renal disease. The objective was to see whether it was more or less difficult to generate savings when serving dual-eligible beneficiaries. The coefficient on dual-eligible status was significant ($p < 0.01$) and negative, which suggests that the ACOs have been more successful bringing dual-eligible beneficiaries' spending down than the spending on other beneficiaries. The coefficient on service use was also significant ($p < 0.001$), but the share who were disabled and the share who had end-stage renal disease did not significantly affect shared shavings. The dual-eligible finding needs to be examined further. In past research, we have found that there may be a need for separate risk adjusters for fully dual-eligible beneficiaries and partial dual-eligible beneficiaries who have slightly higher incomes. We will be testing the data in the future to see whether these findings hold true for both partial and fully dual-eligible beneficiaries.

6 ACOs have an incentive to keep patients satisfied so they do not seek care outside of the ACO. When we talked to ACO physicians, they have said that they have taken measures such as setting up new agreements with specialists to allow for more-timely appointments to improve patient satisfaction. This one study suggests Medicare beneficiaries aligned with the ACO may be benefiting from ACO physicians' concerns about leakage.

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

8 Quality is an important aspect of synchronization. However, we could consider using quality as a payment adjustment that would take place outside of the determination of benchmarks or premiums. This approach is consistent with the Commission's approach to quality discussed in our June 2014 report (Medicare Payment Advisory Commission 2014b).

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

10 FFS spending data are from the MA rate calculation data for 2015 (Centers for Medicare & Medicaid Services 2015b).

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

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

13 We use current MA plan bids for 2015 because they represent the latest data available. As discussed, county benchmarks under the current MA program can differ significantly from county FFS spending, and plan bids tend to be correlated with benchmarks, not FFS spending. Therefore, MA plan bids would likely change if benchmarks and rules changed.

14 For individuals who are not eligible for premium-free Part A and have 30 to 39 quarters of Medicare-covered employment, the premium is $224 per month in 2015. For individuals who are not eligible for premium-free Part A and have fewer than

30 quarters of Medicare-covered employment, the premium is $407 per month. There are very few individuals in these two categories.

15 Higher income beneficiaries pay higher monthly premiums (as high as $336 a month in 2015) based on their modified adjusted gross income.

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

17 In determining FFS and MA risk scores, the current risk-adjustment system uses diagnoses from only certain sites of service and from certain providers. For example, diagnoses from skilled nursing facility or durable medical equipment claims are not used. Diagnoses arising from a home assessment are included for risk adjustment if a health professional is billing for a Medicare-covered service. However, the claims arising from a home assessment in MA (usually billed by nurse practitioners) are very infrequent in FFS and can be thought of as not truly having an analogue in FFS. In the Final Notice of MA rates for 2016, CMS noted that "the encounter data system accepts diagnoses obtained through chart review," which also represents a difference between the diagnoses that would be present in FFS claims and diagnoses in plans' encounter data (Centers for Medicare & Medicaid Services 2015a).

18 In the chapter, we have not specified how the beneficiary premium would be collected. Currently the only mechanism is the Part B premium, which is now used to collect additional amounts for income-related premiums.

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