Economic Principles for Medicare Reform

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In this article, we develop an economic framework for Medicare reform that highlights trade-offs that reform proposals should grapple with, but often ignore. Central to our argument is a tension in administratively set prices, which may improve short-term efficiency but do so at the expense of dynamic efficiency (slowing innovations in new treatments). The smaller the Medicare program is relative to the commercial market, the less important this is; but in a world where there are no market prices or the private sector is very small, the task of setting prices that are dynamically correct becomes more complex. Reforming Medicare should focus on greater incentives to increase competition between Medicare Advantage plans, which necessitates a role for government in ensuring competition; premium support; less use of regulated prices; and less appetite for countless "pay for performance" schemes. We apply this framework to evaluate Medicare for All proposals.

Keywords: Medicare; value-based care; health care reform; markets in health care

While the U.S. health care sector is often described as a private, market-based system, the government now controls more than 60 percent of spending (Martin et al. 2018). Public insurers provide insurance to several groups, including the elderly, the indigent, and

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the disabled. Of all insurers in the United States, Medicare—which provides health insurance for the elderly and a subset of the disabled population—is the largest in terms of spending and is expected to grow even more in coming years as a result of changing demographics. Given this breadth of coverage, Medicare's current coverage decisions and operations, as well as reforms to the program's structure, will likely have meaningful market-wide effects.

Medicare reform is important for a number of reasons. First, the demographics of the baby-boomers means Medicare enrollment is growing rapidly. This enrollment growth is important as we consider reform, because it creates a political constituency that will both demand improvements to the existing program and push back against any reforms that are seen to decrease the generosity of existing benefits—even if those reforms increase net social benefits (the net benefit to patients and producers of health care, including the net benefit to taxpayers).[1]

Second, even after the implementation of the Affordable Care Act (ACA), a meaningful fraction of the U.S. population remains without health insurance coverage (at the time of this writing, the percentage of uninsured hovers at 13 percent of the population, up from 10.9 percent in November 2016 [Witters 2019]). In addition, health care costs for even those who are insured are quite high, and many individuals are in plans with high cost sharing relative to their income, which leaves them underinsured to the financial risk of a health shock. Many see the relative success of the existing Medicare program in providing broad coverage to the elderly and want to expand it to others. Often described as "Medicare for All," these various policy proposals range from allowing progressively younger individuals to purchase Medicare coverage to the expansion of the existing Medicare program to serve as a single-payer system for the entirety of the U.S. population.[2] These proposals are popular, but popularity does not mean that the hard work of grappling with the underlying trade-offs has been started, let alone achieved.

Third, despite the ostensible "dual mandate" of the ACA to both increase coverage and control costs, health care costs in the United States continue to grow, albeit at a slower rate than in the past (Chandra, Holmes, and Skinner 2013). Concerns about rising costs and a lack of universal coverage has pushed policy-makers to call for an expanded role for the Medicare system because of the belief that a government-run program can be more administratively efficient than a complex web of private firms offering coverage. In addition, some supporters of such reforms believe a system of administratively set prices will be less expensive, because these prices will be below those determined by a market transaction. Other constituents, who are interested in the debt and tax ramifications of such a large health care program financed by the federal government, want to reform the program accordingly. Still other reformers do not want to shrink Medicare per se but believe it can be made more efficient—which increases its sustainability and reduces the extent to which this program may be crowding out other public spending priorities.

Finally, the last major changes to Medicare occurred in 2003 with the Medicare Modernization Act (which introduced Medicare Advantage [MA]) and

in 2006 with the introduction of the prescription drug benefit (Medicare Part D). Medicare Part D, now nearly 15 years old, was effectively created from scratch and has allowed us to learn many things about the structure of the program over time. In addition, neither of the most recent reforms addressed fundamental challenges to the design and financing of the Medicare medical benefit, so even in the absence of the political and economic imperatives noted above, some amount of Medicare reform is long overdue.

Given the importance of Medicare today and its potential for serving as a centerpiece for even further health care reforms, our aim is to provide an economic framework for considering reforms to the existing Medicare program. Such a framework highlights the trade-offs with which all proposals—including those originating from purely normative or polling perspectives—must grapple. Our approach is distinct from the several excellent proposals by the Medicare Payment Advisory Commission (MedPAC) and many think tanks. Many of those proposals provide specific modifications to the existing program but are piecemeal—such as reforming the way physicians are paid for prescribing infusion therapies. In a desire for specificity, those proposals often ignore larger dynamic forces such as innovation and spillovers, whose long-term policy effects are often not empirically certain. But the lack of existing empirical evidence or the difficulty of persuading voters to understand these long-run forces does not mean that they are quantitatively small. There are potentially massive implications of changes to the Medicare program, and therefore it is incumbent on reform proposals to grapple with their long-run implications for societal well-being.

With the fundamentals of this framework in mind, we then propose a series of broad and specific reforms intended to provide structure for more competition in the existing program. One objective of this mutually reinforcing package of reforms is to provide the existing Medicare program with incentives for improving innovation in cost containment beyond the use of administrative rate setting. We view administrative rate setting as having two limitations: the process is routinely captured by provider groups, as demonstrated by how physicians determine their relative fees and how hospitals have lobbied Congress for ad hoc additional payments (Chan and Dickstein 2019). The process also requires the government to determine prices—this is not only hard without an external benchmark, but such prices are unlikely to reflect socially optimal compensation as government's size in health care approaches that of a monopsonist (i.e., a single buyer). Our second objective is to emphasize that the goal of Medicare reform must extend beyond simply reducing spending growth. Such a goal runs the danger of creating a fiscally sustainable program that does not offer sufficient insurance value. In our view, a more laudable goal is building a program that increases (or at a minimum maintains) the value of health insurance over time, which means designing a program where growing per capita Medicare spending is justifiable if it increases societal benefits more than its spending.

We believe that the innovations necessary to achieve these goals over the long term come through a greater reliance on market forces and market competition, which also necessitates a role for government in ensuring such competition, but a different role than government setting prices or expanding "pay for performance"

schemes. This tension between administratively set prices, which may improve efficiency in a static (short-run) sense, but at the expense of dynamic efficiency (slowing innovations in the set of treatments available to patients), has been largely ignored in most previous Medicare reform proposals and by all Medicare for All proposals. The smaller the Medicare program is relative to the commercial market, the less important this omission is; but in a world where there are no market prices or the private sector is very small, the task of setting prices that are dynamically correct becomes vastly more complex. The reality that markets are beneficial even in health care is supported by the increasing reliance on competition even in one of the most notable government-run health care systems, Britain's National Health Service, which has undertaken several recent experiments with private markets and providers (Gaynor, Moreno-Serra, and Propper 2013; Propper and Van Reenen 2010). The British experience with introducing competition and incentives means market forces can be combined with government-run and -financed health care systems. In addition, to the extent that Medicare becomes a vehicle for a universal health insurance program, this second goal would moderate some of the potential negative consequences of an expanded use of buyer power.

A Primer on Medicare's Structure and Problems

Structure of Medicare

Medicare is the largest social-insurance program in the world, with spending continuing to increase over time. Medicare payments were $702 billion in 2017, up from $502 billion in 2007 (in 2017 dollars). This funding comes from several parts of Medicare. Part A provides insurance for hospital services and is available to everyone over age 65. Part B provides coverage for physician services and has a premium that is moderately adjusted by income. Part D provides coverage for prescription drugs. Unlike Parts A and B, which are entirely run by the government, Part D is subsidized by the government, but the plans are administered by private insurers, and individual enrollees are responsible for some portion of the premium. Within this time period, the share of total payments for Part A, Part B, and Part D has shifted, with spending on the latter two components increasing (from 41 to 44 percent and 11 percent to 14 percent, respectively), and the former decreasing (from 47 to 42 percent).

A final component of Medicare is Part C, often described as MA. This was introduced in the 1970s as a voluntary managed care version of Medicare, where private firms receive a risk-adjusted, capitated payment from the government and are financially responsible for medical expenses of all enrollees. Spending on the MA program also increased from 2007 to 2017, rising from 18 percent of total Medicare benefit spending to 30 percent ($210 billion).[3] About a third of Medicare beneficiaries are in MA plans, but there is geographic variation in its penetration. About 9.2 million Medicare beneficiaries are also eligible for Medicaid, which covers premiums for Part A; Part B; and a variety of

copayments, coinsurance, and deductibles. Eligibility depends on income and the state of residence.

In dollar terms over the past decade, Medicare Part A spending has grown by just less than $100 billion to $300 billion, Part B spending increased by $150 billion to just over $300 billion, and Part D spending grew by $50 billion. In the same time, payments to MA grew by approximately $150 billion to a total of just over $200 billion. The entire program grew by over $407 billion in the past decade, and the size of the current program is now $700 billion, which is about 15 percent of the federal budget (Cubanski and Neuman 2018). In recent years, Medicare spending has grown more slowly than it had in previous years. Between 2010 and 2017, average annual growth in Medicare spending per beneficiary was 1.5 percent, compared to 7.3 percent between 2000 and 2010. Despite the slowing growth rate of per beneficiary spending in the recent past, changing population demographics in part point to the idea that overall spending will start to increase again in the coming years. In addition to the aging of the population, increased use of services, increased intensity of care, and new technologies have led actuaries to project that future spending growth will increase at a faster rate than in the recent past; projected net outlays are expected to increase from $583 billion in 2018 to $1.26 trillion in 2028. Average annual growth is expected to be higher between 2017 to 2027 (7.5 percent) than it was between 2010 and 2017 (4.5 percent). Per beneficiary spending is also expected to grow at a fast rate between 2017 and 2027 (4.6 percent) compared to 2010 to 2017 (1.5 percent). Over the long term, the Congressional Budget Office (CBO) predicts that net Medicare spending will grow from 2.9 percent of gross domestic product (GDP) in 2018 to 6.1 percent of GDP in 2047 (Cubanski and Neuman 2018). The CBO predicts that "excess" health care cost growth—defined as the extent to which the growth of health care costs per beneficiary, adjusted for demographic changes, exceeds the per person growth of potential (the maximum sustainable output of the economy)—will account for 60 percent of spending for Medicare, Medicaid, and subsidies for ACA Marketplace coverage, while the aging of the population will account for 40 percent of this spending.

The unique financing structure of Medicare also leads the program to use more resources than other government-funded programs. Other public payers such as Medicaid are constrained by the inability of state governments to run budget deficits. In contrast, Medicare is primarily funded from general revenues, payroll taxes, and beneficiary premiums (41 percent, 37 percent, and 14 percent, respectively), though it is also funded in small part by transfers from states, taxation of Social Security benefits, and interest. There is no hard budget constraint on many of these components. Part A, Part B, and Part D are funded by different levels of each of these sources of funding. One way of better understanding the current state of Medicare funding is to look at the solvency projections of the Medicare Hospital Insurance trust fund, from which Part A benefits are paid. Part A funding largely comes from payroll taxes. Actuarial analysis of the state of the trust fund posits that the Part A trust fund will be depleted by 2026 (leaving Medicare to be able to cover only 91 percent of Part A costs from payroll tax revenue). While Part B and Part D spending comes from beneficiary premiums

and general revenues, which are set annually based on spending, increased future spending will require higher general revenue funding and higher beneficiary premiums (Cubanski and Neuman 2018). These demands mean higher taxes and higher beneficiary premiums for the elderly, most of whom are entirely dependent on Social Security income.

Problems confronting Medicare

Medicare's peculiar financing structure, whereby spending can be perpetually deficit financed, creates a number of problems. The first is that Medicare does not rely on cost-effectiveness in its coverage decisions (Chandra, Jena, and Skinner 2011). This means that a number of dubious medical therapies are routinely covered, including therapies that may work for some patients in some settings but may be overused in others. For example, proton beam therapy is an expensive new technology that has demonstrated valuable benefits for pediatric cancers, but it is routinely used for other cancers where the value is far less clear yet where the technology is no less expensive. These policies also induce innovation in wasteful therapies (Weisbrod 1991). Relatedly, Medicare does not use narrow networks to restrict access to lower-quality providers, which reduces the economic penalty associated with being a lower-quality provider and decreases the incentives to improve. Given Medicare's size, these effects spill onto other payers, while continuing to increase the debt-to-GDP ratio (CBO 2019).

Second, Medicare operates on a chassis of fee-for-service (FFS) payments, which means that care can be fragmented (for some conditions, hospitals are paid prospectively but the physicians in these hospitals are still paid FFS) because payments are also not coordinated across different types of care—hospitals, physicians, and pharmaceutical companies are paid separately, even though there may be complex spillovers from their treatment decisions. Beneficiaries in traditional Medicare (so about two-thirds of beneficiaries) have wraparound supplemental coverage (Medigap, employer-sponsored retiree benefits, or Medicaid) and a separate Part D prescription drug plan. There is no reason to believe that fragmented insurers, each responsible for a portion of a beneficiary's health in a particular setting, will result in an optimal insurance design from a patient perspective or taxpayer perspective (Chandra, Gruber, and McKnight 2010).

Third, Medicare's FFS rates are also determined by an administrative process, not a market process. This process pays hospitals based on average cost, not marginal cost and is tied to average industry cost, not marginal costs for a specific provider (meaning that payments are likely too generous). Physicians are paid on the basis of the resource-based relative value scale (RBRVS) that ties payment to (average) economy-wide time effort and practice expenses, not outcomes or marginal cost.

Because these prices are set by Congress, there are large incentives for associations to lobby Congress for ad hoc supplements to their payments. For example, Cooper et al. (2019) document how a series of hospitals were able to use political leverage to increase their Medicare reimbursement as a result of their local representative voting in favor of the creation of Medicare Part D. Pushing

in the other direction is that Medicare can always reduce payments if hospitals and physicians reduce their costs—reducing their incentive to reduce cost in the first place. Another example of payment regulation that would not arise from a market process is the constant desire to tie spending to a set function of growth in GDP. The now-defunct Sustainable Growth Rate (SGR), which was repealed by Congress in 2015, highlights this desire. No economic principle would generate this goal—for these principles would tie health care spending to the value of that spending, which depends on the opportunity cost of that spending. This tying is likely to vary across services and specialties, none of which were accounted for in the SGR (Alhassani, Chandra, and Chernew 2012).

Confronted with the challenge of not being able to use cost-effectiveness for its FFS patients, Medicare has experimented with a variety of lackluster "pay for performance" schemes, the most recent one being the accountable care organization (ACO) program, almost all of which have shown anemic results on outcomes and spending. There are three reasons for this: first, performance in the form of concrete health outcomes is hard to measure, so these programs have collapsed into "pay for process." Nor is it clear that Medicare is able to figure out market demand for performance (the "pay" in pay for performance), so the payment for performance improvement may be substantially less than what it actually takes to induce improvement. Many of these proposals are also focused on improving quality and not lowering costs, and they increase costs, as providers are doing more, not less (McWilliams 2016).

Finally, Medicare has low administrative costs, but this is not automatically an asset—fraud detection, quality measurement, and utilization review increase administrative costs; and Medicare does less of these activities, piggybacking on the efforts of private payers.

To be clear, many of these problems do not affect the MA program, which is free to exclude hospitals from its network and pay providers in novel and more integrated ways. We discuss the challenges to MA later in this article.

Other reform proposals

Confronted with these challenges, a number of reform proposals exist for Medicare. We do not review each of them here, but we note that many are focused on specific ideas, like raising the age of eligibility of Medicare. Fifteen proposals, ranging from premium support in Medicare, raising Medicare premiums, and increasing cost sharing, are thoughtfully discussed in a report by the American Association of Retired Persons (AARP; n.d.). MedPAC also provides an excellent, and up-do-date list of proposals to improve Medicare (MedPAC 2019).

These various proposals highlight three features of Medicare reform. First, many reform proposals seek to improve some arbitrary aspect of price regulation, which has undesirable consequences, with another regulation. For example, regulators have figured out that paying physicians 6 percent over the cost of high-priced drugs induces physicians to prescribe high-cost drugs. They respond by lowering this percentage, but the lower percentage is not based on market forces, or research about the optimal percentage, or understanding that some of these

drugs have different levels of spillover effects on hospital spending and so should not be treated like other drugs. This results in a perpetual cycle of regulation, updates, and opportunities for lobbying and rent-seeking. Second, many proposals seek to improve the way Medicare pays off services under the rubric of "payment reform." But payment reforms in Medicare are often still tied to FFS payments. Third, these proposals do not grapple with two key features of Medicare reform: the ability of a monopsonistic buyer to pay subcompetitive prices that will affect the incentives to innovate and the spillovers from Medicare policy onto payers.

Guiding Principles for Medicare Reform

We have discussed a number of challenges facing Medicare—principally cost growth that results from its peculiar financing and payment models. We begin by discussing economic principles for Medicare policy reform. Enumerating these principles is key to understanding our policy proposals. Our principles are grounded in economics, and so reflect knowledge of incentives and trade-offs. Consequently, they are unlikely to deliver political expediency or achieve ad hoc budget targets. The guiding principles are as follows:

One: The goal of any reform to Medicare is not simply to reduce spending but to increase the societal benefits of the program (i.e., its holistic value to society). It is true that policy solutions that supplant the market in favor of administrative prices decrease budgetary costs. However, the economic efficiency costs of such a decision are far less clear and could decrease the value of the insurance product over the long term.

Two: FFS Medicare has no residual claimant ("the insurer") and therefore lacks strong incentives to discourage overuse, decrease fragmentation, or encourage true preventative health care. In such situations, where there is no residual claimant and we lack perfect contracts to motivate public employees, the privatization of government services can enhance social benefits (Shliefer 1998; Hart, Shliefer, and Vishny 1997). Fundamentally, Medicare savings to date have been achieved using regulated prices rather than efficient quantities. The implications of these regulated prices increase as the size of the Medicare program grows. Using market forces in place of administrative rate setting can correct for this disincentive; but in the realm of social insurance, it can create additional problems if quality cannot be easily monitored and contracted. Effectively, Medicare must look for areas where the benefits of the cost incentives of privatization outweigh the potential adverse consequences of lower quality. This may require operation of both public and private versions of the system for different types of patients.

Three: Defining the "correct" price for innovation in a political environment is difficult, and those suffering from lack of treatments often lack a seat at

the proverbial table. Fundamentally, this is a question of the salience of the lack of treatment access. Individuals who cannot purchase an existing drug are clearly observable and identifiable, while those who lack access because a treatment does not exist are more theoretical. After all, we cannot identify exactly which treatments are not emerging because of inefficiently lower prices. This lack of salience means that if prices are subject to the political process, they would undervalue the benefits for individuals who represent smaller constituencies or future constituencies, relative to current constituencies. This is important because medical innovations, preventive and therapeutic, have profound implications for future patients but may not be as beneficial for those who are currently sick.

Four: Medicare is fundamentally engaged with the private market, and Medicare reforms can have very large impacts on the behavior of private firms. Engagement with the private market varies across proposals. FFS Medicare pays private hospitals and providers—this is an example of the most limited engagement. However, Medicare recipients also enroll in plans operated by private insurance firms, including both the prescription drug insurance plans of Medicare Part D and the managed care plans of MA. Spillovers from Medicare can increase or decrease the efficiency of the entire system. For example, the creation of the prospective payment system likely helped to control the growth of hospital spending compared to a counterfactual world where Medicare paid cost-plus to hospitals. In contrast, Medicare's willingness to provide coverage for any treatment regardless of its relative efficacy makes it hard for private insurers to implement stricter utilization management programs to address moral hazard concerns in insurance. These spillover effects magnify the impact of both positive and negative aspects of Medicare's reforms.

Five: Medicare is potentially the best platform for enacting reforms to the health care system, which can have far-reaching implications that affect multiple parties. For example, changes to an insurance product that give providers incentives to provide more efficient care will likely affect all patients and not simply the innovative insurer. Given these investments could be costly for the innovative insurer, there may be concern about the competitive implications of the spillovers benefits to competitors. This could decrease the rate of innovation. Medicare can solve the potential "common agency" problem that exists in U.S. health care, where no single payer in the system is willing to make investments that will change provider behavior in a way that could have spillover benefits for competitors (Frandsen, Powell, and Rebitzer 2019).

Six: As Medicare increases its use of private firms for the provision of insurance, it must focus on creating the structures for these firms to create, rather than simply capture, value. This requires that firms bear risk while ensuring that they do not face incentives to avoid providing services to particular individuals. This means that the economic principal of risk adjustment is central to Medicare reform. Even if Medicare creates a single risk pool and eliminates private insurers completely (which would eliminate

plan incentives to select healthier patients), individual hospitals and physicians still need to be compensated more when they see sicker patients.

Seven: While Medicare would like to ensure that private firms do not capture an inappropriate amount of value, it is important that reforms balance this desire with creating the appropriate incentives for these firms to make value-creating investments in the first place. Firms must remain convinced that the returns from their fixed and sunk investments are not subject to renegotiation in future periods. For example, if firms must make investments to improve efficiency, they must believe that they will be able to reliably benefit from the value created by such investments. Consider the case of bundled payments, ACOs, or MA plans—all involve private firms making investments to reduce unnecessary spending. If firms believe that regulators will observe the reduced spending and subsequently decrease the payments to these private firms, they will underinvest in these value-creating activities in the first place. This is the economic concept of "hold-up," and it is critical as Medicare considers its ongoing interactions with private firms.

Similarly, creating bundled pricing for services creates strong incentives for innovation that reduces costs for a given level of quality across a variety of related services, and, arguably, those incentives have generally been lacking in health care. However, bundles have difficulty providing incentives to develop products and processes that increase quality and charge a commensurately higher price. Unless firms are confident bundles will be updated to include the new technology or process, bundled payment initiatives will discourage investments in value-creating goods and services. Therefore, bundles may be more appropriate in areas of health care where existing treatment options are quite good, and efficiency is more likely to be created by cost savings.

In addition, reforms must consider the alignment of incentives within and across firms. For example, certain types of hospital global budgets cap total hospital spending to reduce the incentives for wasteful practices like duplicative tests and unnecessary treatments. But such budgets also create scope for zero-sum competition within various units of a hospital by eliminating the incentives to attract more patients—for example, a superior cardiology department would attract more cardiology patients, but the budget for their operations will come from the budget of other departments, reducing the incentives for the cardiology department to improve. Aspirational statements about professionalism and diligence in medicine do not substitute for these economic realities.

Eight: As we consider the scope of activities undertaken by the Medicare program, it is important to keep focus on the goal of the program. Medicare is intended to be a social health insurance system and not an income support program. The "social insurance" of Medicare occurs when observably healthy enrollees subsidize observably sicker ones (i.e., both enrollees enter the risk pool when they are already healthy and sick). Such a feature is not likely to

> be accomplished by private insurance markets alone, where products are intended to pool together people with similar health risk or to adjust premiums to account for differential risk. The goals of social insurance are to increase access to health care services, smooth consumption from negative health care shocks, and redistribute resources from the healthy to the sick.[4]

That is not to say that Medicare cannot serve as a means of income support or offer programs like housing or long-term care. However, this must be a conscious decision because the implications of income support programs are quite different from those of health insurance—and muddling that definition can lead to an inefficient expenditure of resources. Moreover, to the extent that insurance requires a residual claimant, and competition between insurers is desirable, the more services that are covered by insurance, the more difficult it becomes to measure plan outcomes or induce plan switching by enrollees.

Opportunities to Improve Medicare

While Medicare recipients have broad access to medical providers, the financial protection provided is more limited than many people likely understand. For example, a 2012 Kaiser Family Foundation study found that the actuarial value of Medicare is less than the average plan offered by large employers.[5] This lower actuarial value should not be surprising. Table 1 shows the various cost-sharing provisions for Medicare Part D, within FFS Medicare.

Concerns about this lack of financial protection can be seen by the emergence of both the Medigap and the MA program—both of which fill in some of the gaps in the traditional FFS program. Under the Medigap program, patients pick between a variety of standardized plans offered by private firms. These supplemental Medigap policies have a benefit design structure that does not take into account spillover effects on the rest of the Medicare program. For example, small increases in copayments for diabetes drugs would reduce their use, saving Medigap plans money, but some beneficiaries are hospitalized as a result, increasing Medicare spending elsewhere (Chandra, Gruber, and McKnight 2010). Conversely, to the extent that the cost sharing for Medicare is efficient, supplemental insurance plans can further increase Medicare spending. Cabral and Mahoney (2019) find that Medigap increase an enrollees Medicare spending by more than 22 percent.

Depending on the generosity of coverage, Medigap enrollees could construct a combination of plans that provide an actuarial value that exceeds the average private market plan. Of course, constructing plans in this way hinders perhaps the only utilization management tool for FFS Medicare. As a result, spending for enrollees in Medigap exceeds that of otherwise similar Medicare enrollees.

Another attempt to improve Medicare coverage is MA. Under MA, plans are administered by private firms that are reimbursed based on a benchmark. If firms submit a bid below the benchmark, they can receive a rebate that they must spend on additional medical services for their enrollees. This often involves services such

TABLE 1
Medicare Part D Standard Benefit Design (2019)

Benefit Phase	Limit	Payer Responsible (percent responsible)
Deductible	Below $415	Enrollee (100%)
Initial coverage period	Below $3,820 and above $415	Enrollee (25%) Plans (75%)
Coverage gap	Below $8,140 and above $3,820	Brand-name drugs: • Manufacturer discount (70%) • Enrollee (25%) • Plans (5%) Generic drugs: • Enrollee (37%) • Plans (63%)
Catastrophic coverage	Above $8,140	Enrollee (5%) Plans (15%) Medicare (80%)

SOURCE: An overview of the Medicare Part D prescription drug benefit. See https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit.

as paying enrollees' premiums for Medicare Part B, Part D, or providing additional coverage for services excluded from the traditional Medicare benefit, such as vision. These additional services are attractive to enrollees and, therefore, plans, which can successfully bid below the benchmark (i.e., those that can maintain a sufficiently low-cost structure) should expect to gain market share. That said, like any privatization system, there are concerns that the cost incentives for the private firms may be too large, resulting in adverse consequences for enrollees. MA attempts to address this through multiple channels. First, there is competition among the privatized firms, which should provide incentives for increased quality to retain enrollees. In addition, the amount of the rebate that firms receive is based on their quality star rating; that is, firms that receive a higher star rating receive a large share of the difference between their bid and the benchmark.

The policy goal of MA is for private firms to respond to competitive pressures to manage the care of Medicare enrollees. After all, firms are the residual claimant on the amount of their bid that is not consumed by enrollee health spending. However, at the time of its creation, policy-makers were cognizant of the fact that this payment structure would dissuade firms from enrolling individuals with conditions that require large amounts of medical spending. At the extreme, policy-makers were worried that firms would design plans to be so sufficiently unattractive to sick individuals that these enrollees would not sign up for coverage in the first place. Therefore, policy-makers created a system of risk adjustment where MA firms receive greater payments from Medicare for individuals with documented medical conditions. Ideally, under such a system, firms are rewarded for managing the spending of sick individuals and not avoiding them

entirely. In practice, there are concerns that firms may be able to game the system by augmenting the codes of individuals to make them appear sicker than they would appear in the FFS data.[6]

MA plans broadly increase the financial protection of Medicare while providing incentives for firms to innovate on plan design. Various features of MA result in these plans effectively adopting the administrative price schedule for Medicare.[7] Multiple studies find that the provider prices paid by MA insurers are quite close to the Medicare price schedule (Curto et al. 2019; Baker et al. 2016). This is quite different from the commercial market, where prices for insurers are meaningfully higher than Medicare (White and Whaley 2019). Given an inability to secure prices below the Medicare schedule, the only means of increasing profits is to find ways to manage the quantity of care—an incentive that is largely absent from FFS Medicare but one that MA plans do extremely well.

A Package of Market-Based Reforms

We propose a series of reforms to Medicare to increase competition and the insurance value of the program. These proposals will increase the economic efficiency of the existing program. In addition, if Medicare serves as the vehicle for either a large expansion of social insurance or, at the extreme, universal health coverage, these reforms will create a program that is more amenable to having a larger (or even dominant) presence in the health care market.

At a high level, these market-based reforms are an attempt to translate our guiding principles into a series of tractable policies that would increase the economic efficiency of the Medicare program. Certainly, for any of these reforms, there are a number of legal and regulatory issues that would need to be addressed before a final policy could be implemented—a task that is beyond the skill set of economists but one that is readily taken on by administrative lawyers. Our goal is primarily to highlight the economic rationales for these various concepts to serve as a starting point for policy development and to emphasize that the Medicare Advantage program could serve as a vehicle for reform efforts.

One: Introduce pricing pressure on Part B (or physician-administered) drugs

Currently, physician-administered drugs under Part B are reimbursed based on a "buy-and-bill" system. Physicians purchase the drugs and, once they are administered, the physicians are paid the average sales price (ASP) of the drug plus a percentage markup (i.e., ASP + 4.3 percent). There are multiple channels through which this system provides incentives for higher spending on drugs. First, physicians have an incentive to prescribe more expensive drugs.

Second, profit-maximizing pharmaceutical manufacturers have the incentive to charge inefficiently high prices in the private market (i.e., profits that are above the profit-maximizing level) because the lost commercial sales can be made up for by higher payments from the public payer. Third, public spending is higher because they are a multiple of the inefficiently high private prices. As a result, the buy-and-bill system results in higher spending for both the public and the private market.

There is widespread agreement among economists that the buy-and-bill system is an inefficient method of procuring these physician-administered products. However, the best replacement program is unclear. Moving to a simple flat fee for administering the drugs would eliminate the incentives for manufacturers to raise prices and for physicians to prescribe higher priced drugs. However, because physicians take ownership of the product (i.e., they must actually purchase the drug), their inventory and capital costs increase as a function of the drug's price. Therefore, simply moving to a flat fee would create a disincentive for physicians to provide more expensive but clinically appropriate drugs. In addition, a flat fee system does not (without other changes to the system) create negotiating pressure on manufacturers.

A second proposal is to move all prescription drugs to the Part D program regardless of where they are administered. This would allow pharmacy benefit managers (PBMs) to negotiate lower prices. However, the cost-sharing provisions of Part D mean that this would expose patients to potentially meaningfully higher costs (the equilibrium impacts for patients could be lower if all our proposed policies are implemented as a package).

Perhaps the best solution for injecting more competition into the pricing of Part B drugs would be to establish a series of vendors that maintain a financial title to the drug and manage the inventory of physician offices. This would be like the goal of the Competitive Acquisition Program (CAP), which was created with the intent of establishing a series of vendors for Part B drugs. Unfortunately, CAP never attracted enough vendors to establish a competitive market, which is a concern for any attempt to reform the Part B market. There are several potential reasons why the CAP program failed to gain traction, and it is important to learn from these concerns as we reform payment for Part B drugs. At a minimum, any vendor program must provide firms with the tools and ability to use utilization management to secure discounts. This must include the ability to exclude products when manufacturers are unwilling to give sufficiently large discounts.

In addition to the direct benefits to Medicare, given the role of Medicare in many of these drug markets, the purchasing decisions of the public payer increases private prices. This is both a direct impact of the fact that manufacturers may find higher private prices optimal to increase public payments and of indirect spillovers, as many private firms pay prices that are effectively just a function of the Medicare price (Duggan and Morton 2006). Thus, to the extent that the Medicare price is too high, these private prices are also inefficient.

Two: Fix incentives for high-priced drugs in Part D

When the Part D program was created, the underlying concept was to use the expertise and incentives of the private market to secure discounts on pharmaceutical products.

However, to entice a sufficiently large number of competitors to this newly emerging market, the program provided a reinsurance program that shielded firms from the costs of very expensive drugs. Specifically, once a patient's annual drug spending exceeds a preset limit ($8,140 in 2019), the government is responsible for 80 percent of additional spending. While this generous reinsurance did attract several firms to the market, it also markedly decreased the incentives for these firms to strongly negotiate with manufacturers for drugs whose annual spending falls into the catastrophic range.

In addition, the existence of catastrophic coverage increases the incentives for Part D firms to prefer drugs that have high list prices because patient cost sharing is tied to list prices. As list prices increase, patient cost sharing increases, which increases total drug spending and the likelihood of a patient reaching the level of catastrophic coverage (where patient cost sharing decreases). These incentives have little to do with improved health care or lowering costs and should be reformed.

The combination of these incentives has made the reinsurance payments under Part D one of the largest budget components of the plan. For example, Figure 1 from MedPAC shows that expected payments from reinsurance are now the largest component of a plans' expected bids (MedPAC 2018).

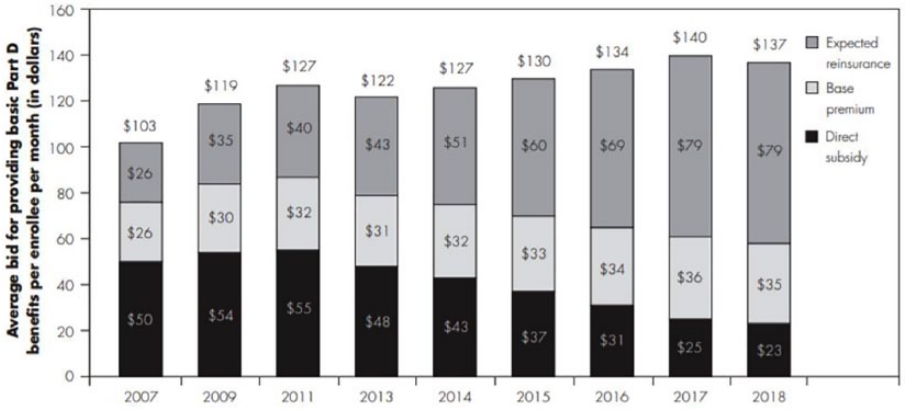
To restore the appropriate incentives to Part D, we propose that a greater share of the responsibility for exceptionally high-cost patients be shouldered by the private firms that are responsible for negotiating prices. These proposals will raise premiums because of lowered cost sharing but will also increase competition between Part D plans, primarily by increasing the incentives to negotiate lower prices for drugs that are currently over the catastrophic threshold.

Three: Eliminate coinsurance for prescription drugs—replace with flat copayments

Enrollees in Medicare Part D are exposed to high levels of cost sharing on the execution of their purchases. This includes both high deductibles and coinsurance (i.e., patients paying a percentage of the price of the medication). This cost sharing is intended to accomplish two goals: decreasing the use of low-value drugs and moving patients toward products that offer a large price discount. However, after patients are exposed to a certain level of cost sharing, the payments are unlikely to affect their choice of products. Therefore, if patients are exposed to high cost-sharing payments without another option in the therapeutic class, these payments unwind the benefits of the insurance product.

Therefore, we propose that the only acceptable form of cost sharing for prescription drugs under the Part D program is flat copayments. Given that firms use high cost sharing to move patients across products, an alternative rule would

FIGURE 1
National Average Plan Bid for Basic Part D Benefits



SOURCE: MedPAC based on data from the Centers for Medicare and Medicaid Services (CMS), available at http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch14_sec.pdf.
NOTE: The averages shown are weighted by the previous year's plan enrollment. Amounts do not net out subsequent reconciliation amounts with CMS. Components may not sum to stored totals due to rounding.

be that firms must provide at least one product in each therapeutic class that has a flat copayment.

An added benefit of this policy change is that it would blunt the distortions created by rebates in the market. Under the current system, rebates are confidential discounts negotiated between manufacturers and PBMs. Economic research shows that confidentiality results in larger discounts. As a result, PBMs require that coinsurance (i.e., percentage-based cost sharing) be based on the list price of the drug. Therefore, patients who pay coinsurance increasingly do not benefit from negotiations in this sector. However, in a world of copayments, this is no longer a problem.

Four: Limit protected classes in Part D

When Medicare Part D was created, there was a concern that firms would create incomplete formularies (i.e., lists of drugs that the insurance plan covers) that did not provide sufficient therapeutic options for patients. As a result, Congress created several restrictions on what must be included in the formulary. These six protected classes include drugs that are anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immunosuppressants. The antineoplastics category includes many oral chemotherapy drugs. Within these classes, Part D plans have to cover "all or substantially all drugs" within each of the classes, but these restrictions also mean that plans cannot build closed

formularies to secure discounts. According to the Centers for Medicare and Medicaid Services (CMS), "typical private market discounts for these drugs are in the 20 to 30 percent range, but the average discount across all protected classes in Part D is just 6 percent" (Azar and Verma 2019). At their core, these classes reflect a preference by society to provide complete access to all products in these categories. However, the trade-off for this access is very high prices in these categories. In addition, these high prices can distort manufacturers' investment decisions away from more competitive categories if capital markets are constrained in some manner, even if those competitive markets need additional treatment options.

CMS has recently proposed a rule allowing plans to exclude protected class drugs with price increases that are greater than inflation from their formularies, as well as certain new drug formulations that are not a significant innovation over the original product. Plans would also be allowed to use prior authorization and step therapy (approving coverage for a more expensive treatment after a cheaper one has failed) for protected class drugs.

We propose that we either eliminate or greatly reduce the restrictions within these protected classes, along the lines that CMS has suggested. If eliminated, these categories would revert to the existing formulary restrictions for other classes. Moreover, the central concern that plans would withhold valuable drugs would be addressed by competition and marketing: at the time of this writing, there are 901 stand-alone Part D plans, and it is difficult to imagine that skimping on valuable drugs would persist in an environment where there is high plan competition and where prescription drug manufacturers can advertise their products. These concerns are probably more likely to be true for therapeutics that target extremely small or rare diseases that are not part of the protected classes to begin with.

Five: Reference pricing for drugs

Reference pricing for drugs is an alternative to using deductibles and copayments and can be deployed well when there are drug classes with therapeutic alternatives that are generally equivalent. The idea is for the plan to label a set of therapies as the reference therapy for a condition or a patient. These would have no cost sharing, but patients who want something other than the reference treatment will pay more for such treatments. The extra payment need not be the full additional cost of the new drug but could be a copayment or coinsurance amount.

The key challenge is determining the reference product: if drugs in a class are genuinely equivalent, then the reference product should be the cheapest product (for example, a generic should clearly be the reference product in a class that includes a brand-name product and its generic competitor). When there is heterogeneity within a class in the form of multiple branded drugs, the reference product could be the most cost-effective one—which creates strong incentives for manufacturers to lower their prices and obtain this designation, as it will beget a large volume of patients. A novel drug that is substantially better than older alternatives could still qualify as the reference product if its outcomes are substantially superior even in comparison to its higher price. One area for

improvement is to rethink the use of "drug classes" as the grouping for reference pricing (these classes are mostly a statement about a drugs mechanism of action) and redefining the grouping as a medical condition (so drugs for congestive heart failure and drugs for heart attacks would be different classes, even though the classes may have overlapping drugs).

In situations where a medical condition can be treated by a generic drug and a branded drug with a different composition, it may be tempting to make the generic drug the reference product because of its substantially lower price. This would not be right if incremental improvements cost proportionately more (e.g., a 10 percent improvement means that prices are higher than 10 percent). In these settings, to ensure that there is a viable market for better drugs, one may want to use the pregeneric entry price for the now generic drug to determine its cost-effectiveness. Such a price more closely reflects willingness to pay for the product.

In principle, the reference product could be defined differently for different patients—a patient with a particular mutation may have a reference product that works on that mutation; patients without this mutation may have another reference product. In this manner, there is no tension between reference pricing and indication-based pricing, where the same drug is sold at different prices based on the drug's efficacy in different conditions (Chandra and Garthwaite 2017). As such, reference pricing does not by itself lower drug spending but provides stronger incentives to demonstrate effectiveness and tie patient cost sharing to the likelihood of moral hazard. We note that reference pricing is not applicable for drugs in classes where there is no competition (e.g., orphan drugs).

Reference pricing for health care is not a new idea. It has been successfully implemented in Germany, a nation in which the government does not determine prices or make coverage decisions (Robinson, Penteli, and Ex 2019). It has also been extensively discussed in policy reports for the United States and developed for the specific context of Medicare (Bagley, Chandra, and Frakt 2015; Pearson and Bach 2010). More recently, an employer alliance implemented a version of reference pricing where enrollees paid the full marginal cost of nonreference drugs (as opposed to a copayment or coinsurance to access these drugs). The program led to a 13.9 percent reduction in price per prescription (Robinson, Whaley, and Brown 2017). This number is a lower bound—to the extent that if all Medicare Part D plans moved to this model, there would be larger equilibrium responses.

Six: Reforms to risk adjustment and reimbursement in MA

As discussed above, a primary goal of the MA program is to provide incentives for firms to develop programs that control the use of medical services by their enrollees while disincentivizing firms to skimp on valuable care for patients. MA plans have an advantage over traditional FFS Medicare in doing this for two reasons. First, they are owned by companies that are residual claimants, as opposed to the federal government, which has no immediate incentive to manage costs given its ability to debt-finance spending (the threat of long-term tax

increases or debtors demanding higher yields is not a proven recipe for cost containment). Second, because MA plans are responsible for all health care spending (as opposed to just pharmaceutical or just medical spending), they face strong incentives to coordinate benefits—for example, by spending more on drugs or physician care now, MA plans reduce a costly hospitalization later.

Successfully operating the MA program requires determining the appropriate compensation for plan sponsors. The appropriate payment provides firms with sufficient returns for investing in efforts to reduce costs without overcompensating them or creating inefficient distortions. In addition, given the goal of MA is for firms to manage the care of enrollees, the system must provide the appropriate incentives for firms to accept and manage risk. At some level, this involves providing larger payments to firms that accept patients who are expected to have higher spending. This is currently done through a risk adjusted benchmark that is intended to reflect FFS spending in that county. However, this system faces two primary challenges: (1) accurately determining the appropriate benchmark for payments and (2) the dynamic incentives created by risk adjustment. We consider each in turn.

Under an MA plan, if a plan's bid to provide services in a county is above the FFS benchmark, it receives a rate from the government that is equal to the benchmark, and enrollees pay a premium that equals the difference. If a plan bid falls below the FFS benchmark, the plan receives a base rate equal to its bid. Therefore, the benchmark is a key determinant in the number of participants in the market and the generosity of benefits that enrollees receive. The key here is that the benchmark is calculated using all FFS enrollees in a county, even those who only enroll in either Medicare Part A or Part B. This is puzzling given that MA plans are required to cover both Part A and Part B services. MedPAC estimates that enrollees who enroll in only Part A have lower spending on average; thus, including them in the benchmark determination likely means that, in general, MA benchmarks are too stingy (MedPAC 2017). This is particularly a problem in counties where a relatively large fraction of FFS enrollees chooses to enroll only in Part A. Given that the MA plan must cover both Part A and Part B services, it attracts part of the population with a preference for both services. Therefore, as MA penetration in a county grows, the share of the population with only Part A *or* Part B increases, and their distortion to determining the benchmark grows.

Medicare acknowledges this concern—for example, the benchmark in Puerto Rico (where half the population does not sign up for both Parts A and B) is determined only using FFS enrollees who are in both plans. Hawaii is currently petitioning for similar treatment. That said, MedPAC identifies that there are a large number of counties with high MA penetration where the resulting FFS benchmark involves a large fraction of enrollees who are only in Part A. At the very least, all MA benchmarks should be set using only FFS patients who are enrolled in both Parts A and B of Medicare FFS. Some may argue that MA firms currently are overpaid or capture too much value from the existing benchmark; we believe that this problem (to the extent it exists) should be dealt with directly. It is hard to imagine that deliberately mismeasuring the benchmark to decrease payments

to MA plans based on how much of their FFS population elects Part B coverage increases efficiency.

This brings us to the second concern with MA: that firms will be able to cream-skim the risk pool such that enrollee expenditures are lower than payments from the government without any effort required of the firm. In addition to concerns about overpaying firms, such cream-skimming may make it difficult for individuals with potentially high spending to secure coverage through MA. We know that MA enrollees are healthier than FFS enrollees, as MA enrollees have about a third fewer chronic conditions than those who enrolled in FFS (Geruso and Layton 2019).

Currently, these goals are accomplished through a system of risk adjustment. MA firms gather information on the acuity of patients based on their various diagnoses. Payments to MA plans are then adjusted by these risk codes based on the use of medical services by individuals in the FFS system with similar risk codes. Unsurprisingly, when profit-maximizing firms are provided strong incentives to document the sickness of individuals, they expend resources to do so. These expenditures can be quite significant, and it is unclear whether they create economic value or are simply inefficient expenditures by firms attempting to capture value.

A further concern is that an individual with a particular risk code gathered based on the incentives of MA may not result in the same expected costs as a patient with a similar risk code that emerged as part of the FFS system. This would result in overpaying MA plans. The potential for this problem is recognized in the current system by the existence of a "coding intensity factor"—a blunt tool whereby payments to MA plans are reduced across the board.

Rather than attempting to reduce the impact of more intensive coding (an activity that represents economic waste in the system), another option would be to base coding on immutable characteristics such as race, gender, and geographic location. However, to the degree that spending is not based on specific illnesses, firms would avoid sick individuals conditional on the immutable characteristics that are used.

Fundamentally, there is no perfect answer to the question of risk adjustment, which ultimately represents a tension of balancing the incentive for gaming with the opportunity for cream-skimming. Ideally, we would want to settle on a metric for risk adjustment that is not gameable but that rewards firms for attracting and managing a sick patient population. We know from economics literature that MA plans engage in particular forms of coding: they are more likely to code at the intensive margin than at the extensive margin, as evidenced by a greater number of patients who are coded with the least severe form of a disease.

To circumvent these incentives, we might consider a risk-adjustment system based on plan-wide characteristics such as Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey scores or other measures that assess the sickness of the population, such as the incidence of conditions (e.g., metastatic cancer, pulmonary embolisms, and heart attacks) for which it is harder to code diagnosis at the intensive. In principle, with the increase in genome sequencing and the growing literature on the high predictiveness of risk scores for many

illnesses, a polygenic risk score could be used for risk adjustment. Our interest in using CAHPS scores, which are patient surveys rating health care experiences, is that CAHPS scores are obtained from patients and not from physicians. The challenge with using them in their current form is that they measure patient experiences, which are an ex-post measure of outcomes. However, they could be modified to include a section on self-reported outcomes, such as the SF-36 survey, which captures information on vitality, physical functioning, bodily pain, mental health, and social functioning. The SF-36 has a median completion time of 8 minutes, with 85 percent of respondents completing it in under 10 minutes.

The key point for patient measures is that we do not need these data for all members to operate plan-level risk adjustment. Data from a random panel of a plan's patients would be enough to fully perform this adjustment. For adequate risk adjustment, however, we should be cognizant that medical spending depends on much more than illness. It also depends on patients' preferences, including their preferences for expensive care and the propensity to engage in moral hazard. These are notoriously hard to measure in claims data, but it is possible that more of these features can be observed in patient surveys.

The two problems with determining optimal MA compensation demonstrate the difficulty of determining efficient administrative prices in health care. Even something as simple as determining the appropriate measure of FFS services is complicated, and implementing simple fixes to the benchmark involves a cumbersome legislative and regulatory process. Note that in 2017, all seventeen MedPAC commissions voted in favor of adjusting the FFS benchmark, and the change has still not been implemented. In addition, the problem of risk adjustment illustrates the dynamic effects of incentives created by regulatory systems. We note that as MA evolves, there will be additional dynamic concerns that grow from basing payments in MA on the administratively determined FFS rates. If those rates are set too low, firms' dynamic incentives to invest in quality and innovation will be hampered.

Seven: Premium support in Medicare

MA has been an extremely popular program for which enrollment has exceeded most expectations. Enrollment in MA has rapidly increased, with more than 20 million Medicare beneficiaries enrolled in the program in 2019. High levels of enrollment generate benefits to enrollees in the form of improved plan design and coordination and to the federal government in the form of large reductions in the quantity of services (but not price reductions for a given service). In a pure FFS system, neither of these benefits is possible, as a lack of competition also means a lack of incentives to improves one's offerings.

These features of MA also allow for cost control on a different dimension, by allowing the federal government to subsidize the premium for one health insurance plan (which could be traditional Medicare or an MA plan) and letting enrollees pick another plan by supplementing this "premium support" with their own dollars. In principle, the premium support for a plan could be tied to an enrollee's income (or Social Security income), which would be a way to reduce

the generosity of the Medicare program for higher-income individuals. The exchanges constructed by the ACA have this design feature, and premiums offer a way to consolidate the "dual-eligibles" (those covered by both Medicare and Medicaid) into one program.

There are three concerns with premium support. The first is how to determine which plan to subsidize. The subsidy could be tied to the lowest plan bid or the average plan bid. The CBO has noted that if the payments to plans were tied to the average plan bid, then beneficiaries' total out-of-pocket costs (including premiums) would decrease while federal payments would increase. If the payments were tied to the second-lowest plan bid, then beneficiaries' total out-of-pocket costs would increase while federal payments would decrease. This reveals the central trade-off between subsidy generosity and benefits to the private purse versus the public purse. This trade-off is unlikely to be solved with economics alone, although it should be noted that economic theory would argue that the political process has a bias toward today's enrollees because of their ability to vote, suggesting that the subsidy levels will be more generous than what a social planner, balancing the needs of today's beneficiaries against tomorrow's taxpayers, would choose.

The second issue for premium support is what to require plans to cover and how. Allowing plans to cover whatever they want could induce innovation in skinny plans that offer low benefits and low premiums, competing for beneficiaries with this model. The same is true for discretion over patient cost sharing—plans could, in principle, compete for enrollees with low premiums and high patient cost sharing. At a minimum, it seems reasonable to require plans to be actuarially equivalent but to allow them latitude in how they determine cost sharing, formularies, and network generosity. This approach would provide high-powered incentives to MA plans to find ways to cut waste and compete on services that enrollees want.

The third concern is how to grow the subsidy over time. If the growth is tied to GDP growth, then a growing number of beneficiaries will not be able to afford health care, because the growth rate of health care exceeds that of GDP growth. Ultimately, the right subsidy depends on the value of the insurance that is being provided, which in turn depends on the quality of underlying health care and its improvement. But these are hard to measure and know in advance. As such, tying the growth rate to something similar to GDP growth+1 may provide an attractive compromise between fiscal prudence and economic sense.

The fourth concern with premium support is the role of Medicare FFS. In theory, Medicare FFS is not needed for premium support to flourish, but it may be necessary in some rural areas where MA plans do not want to compete. Alternatively, one could increase the payment to MA plans in those areas (it does not seem essential to create an entire FFS service). Medicare FFS could also create competition, as its presence increases the incentives for MA plans to compete. This is possible, but it has fairly dubious logic, as it is hard for private firms to compete with an entity that cannot go out of business. The Medicare FFS program does not have a residual claimant, making it harder for MA plans to compete. Therefore, if one of the policy goals is to grow MA, then the appropriate

response is not to have a "public option" where Medicare FFS competes (unfairly) with MA. But this approach raises the question about how to devise a payment for MA plans. Here, our intuition is to rely on the architecture of the exchanges in the ACA, where there is no public option. With enough competition, MA plans will bid at cost, and no FFS benchmark will be necessary.

There is empirical support for our conjecture. Duggan, Starc, and Vabson (2016) find that more generous MA reimbursement increases the number of firms offering MA and also an increase in the number of Medicare recipients in these plans.

Eight: Payment reforms to increase incentives for managing costs

The capitated payment structure of MA does an effective job of providing firms with the appropriate incentives to consider the externalities of spending across various categories. This can be seen in the coverage of prescription drugs, where MA programs offer more generous coverage for medications that offset future medical spending.

The existing FFS program, however, has few such natural incentives built into the program. For example, Medicare Part D plans have no exposure to future health expenditures, resulting in little coordination of benefit design across the programs.

In addition, under the existing FFS system, medical providers have little incentive under the traditional program to control costs. Medicare operates under a prospective payment system based on diagnosis related groups (DRGs) where, broadly speaking, hospitals are compensated based on the condition they treat. Therefore, firms want to minimize the costs of treating a specific DRG, but they have little incentive to reduce the number of DRGs in the population. At the extreme, this lack of incentive is exemplified by the fact that many hospitals find it profitable when patients are readmitted, that is, the hospital is paid both for the initial visit and for the readmission.

Recognizing this concern about cost containment in FFS Medicare, CMS has created several ACOs, which attempt to provide incentives for providers to reduce the spending of enrollees, provided they meet certain quality criteria. Our reading of ACOs' performance is that they have resulted in small cost savings, and perhaps not nearly enough to justify payment reform as a general approach that should be directly pursued by the government. Rather, our view is that MA plans are free to create whatever payment reform they need to manage costs—including creating ACOs.

One commonly stated (incorrect) reason that the performance of ACOs has been relatively jaundiced is that the program is new; however, the program has been in existence since 2012, resulting in seven years of data for analysis. A second reason is that through the end of 2015, 99.2 percent of ACOs were in so-called one-sided contracts that rewarded ACOs with bonuses if spending was sufficiently below benchmarks but did not impose a risk of financial losses for spending above benchmarks. This is not a sufficient explanation for the general lack of savings. A third reason may be that ACO savings depend on Medicare

FFS rates, and as these rates are cut (as they have been), it becomes harder for an ACO to save money. This challenge represents the general "hold-up" problem that we mentioned in our design principles. It highlights that the key to allowing private firms to lower costs (assuming ACOs are like private firms) is not to remove the incentives for cost reduction.

One new result from the recent performance of ACOs is intriguing: a recent report finds that ACOs' savings may be partly explained by the strength of incentives facing different ACOs. ACOs that are large health systems containing a hospital, offering many specialties and services, will find it harder to lower spending than smaller organizations that offer a narrower suite of services. There are two reasons for this: the first is that the larger the team (organization), the lower the incentives for any given physician in that organization to reduce costs. The second is that the larger the organization, the more likely it is to serve FFS patients who are not in the ACO program. Reducing waste and unnecessary procedures for these patients would lower total revenues for the ACO, muting the incentives to reduce waste in ACO patients. In contrast, physician groups that formed smaller ACOs face stronger incentives to save. Moreover, they do not lose revenue when they reduce unnecessary procedures for a patient, regardless of whether that patient is covered by an ACO contract.

The evidence for this theory is striking. Hospital-integrated ACOs have not saved any money once one accounts for their bonus payments. In contrast, physician-group ACOs have saved somewhere between 1.5 and 3.6 percent relative to FFS (McWilliams et al. 2018). The first-order point is that the savings are meager relative to the size of the fiscal challenge. But the heterogeneity in performance suggests that smaller ACOs, unaffiliated with hospitals, may hold the most promise.

These results on ACO performance are consistent with our emphasis on using MA as the vehicle for lowering Medicare costs. MA plans have reduced use far more than ACOs do, despite being much larger than ACO plans. They have also saved money by doing exactly the sorts of things that ACOs were supposed to do, like shifting patients into less expensive settings, such as primary over specialist care, and outpatient care over inpatient care; and by employing various types of use management to discourage the use of grey-area services. Therefore, the key to savings may not be an organization's size as much as the incentives to save. Economists have found that after adjusting for enrollee mix, spending per enrollee in MA is 9 to 30 percent lower than in FFS Medicare (Curto et al. 2019), and there is evidence that MA plans achieve these savings by substituting less expensive care and engaging in use management (Curto et al. 2019). Even at the lower-bound 9 percent number, the savings are about three times larger than the most successful ACOs.

Conclusion: An Economic Analysis of Medicare for All Proposals

To illustrate the use of economic principles to evaluate Medicare reform proposals, we analyze the underlying principle of Medicare for All proposals that were

being proposed at the time of this writing (Kliff 2018).[8] We avoid discussing specific proposals, mostly because they are incomplete, but emphasize the broader principles and trade-offs that all reform proposals should grapple with but often ignore. Regardless of their exact slogans and specifics, these policies have two goals: to achieve universal health insurance coverage and to decrease the growth rate of this spending (some proposals claim to reduce the level of health care spending, but we view them as unserious because they privilege political expediency over the hard work of grappling with the underlying trade-offs).

With respect to the first goal, either allowing individuals to buy into Medicare or establishing Medicare as the single-payer insurance system for the United States would likely close the coverage gap and establish universal coverage for the country's population. The reduction in uninsurance would be accompanied by an increase in spending for at least four reasons—and would immediately conflict with the second goal of reducing spending growth. Spending would increase because people would receive access to valuable medical care (which costs money) and would be insured (making them substantially less price sensitive); providers would also be incentivized to do more (because their patients are insured); and over the long term, the increase in insurance will induce new medical innovations (because there is greater willingness to pay for innovation) (Chandra and Skinner 2012).

In terms of reducing spending growth, there are a variety of channels by which the proposed policies could potentially accomplish this goal. For example, collapsing the existing market of multiple insurers (Medicaid, Medicare, many employers, the VA, and military systems) into a single entity would likely decrease administrative costs from redundant and conflicting billing practices. In addition, a single firm would not need to market products that would decrease these expenditures. The exact magnitude of the reduced economic cost of lower administrative spending is less clear, but it has been estimated to be substantial (almost 40 percent) in the context of U.S.-Canada comparisons (Cutler and Ly 2011). While administrative costs like prior authorization are viewed as waste in most media reports, private insurers rely on these methods to reduce use of dubious technologies that reduce premiums growth. To the extent that their marketing costs better match consumers to efficient plan designs, there could be negative effects from the reduced spending. Put differently, reducing the reliance on private insurance does not automatically reduce health care spending or its growth; and even when it does, it does not automatically imply that the enrollees' well-being has improved, for some would have preferred more generous plans.

The greatest source of savings from a single-payer system would be the adoption of Medicare's regulated price schedule, which currently reimburses providers (doctors and hospitals) at rates far lower than the commercial market. Commercial insurers are generally viewed as being unable to achieve Medicare's prices because they lack Medicare's market power with providers. However, the economic benefits of a greater use of monopsony (single purchaser) power are unclear because of the countervailing effects of lower payments on the incentives to pursue certain types of medical innovation. As we note, price setting by a monopsonist introduces scope for the related ability to engage in the classic

"hold-up" problem, in which a new innovation introduced by a private firm is paid a subcompetitive price by the monopsonist, which discourages the innovation in the first place. Both forces mean that lower prices achieved through regulation should not be judged solely by the reduced budgetary costs in the short term, but also by their effect on subsequent innovation.

Proposing Medicare as the correct vehicle for accomplishing the twin goals of growing coverage and lowering spending rests on the implicit belief that the existing social insurance program for the elderly is the most cost-effective means of providing health insurance coverage in the United States. However, there are many concerns about the existing system that challenge this belief. These concerns are perhaps more important when considering Medicare for All because some of the negative consequences of existing features of Medicare will be magnified as the program increases in size and scope.

At a minimum, there are many ways in which the existing Medicare program provides incomplete insurance coverage compared to many private products. FFS Medicare for those who lack supplemental coverage provides exceptionally incomplete financial coverage. For example, enrollees lack meaningful insurance for outpatient coverage and have no limits on the financial costs they can incur. About 20 percent of Medicare beneficiaries in FFS Medicare lack supplemental coverage, and, despite reducing use, this is not a feature that ought to be extended to others (Cubanski et al. 2018).

In addition, FFS Medicare places few limits on the coverage of medical services or the use of step-therapy and prior authorization to reduce access. All services are covered, and there is far less use management than is typically seen in commercial insurance products (as noted above, Medicare relies on a blunt set of cost-sharing measures to reduce use). Furthermore, lacking pressure from a competitive market, there is little incentive for the FFS Medicare program to develop innovative methods of controlling the use of medical services. Medicare has experimented with a variety of pay-for-performance programs, with lackluster results (Frakt and Jha 2018).

Medicare's primary tool for reducing spending growth is lower regulated prices (as opposed to cost-effectiveness analysis)—these prices could have insidious effects when there is no private market and the program exerts monopsony pricing. The reliance on lower prices rather than the more efficient consumption of medical services is not an accident and represents the benefits of a greater use of monopsony power in the procurement of health care services. Fundamentally, the relative costs and benefits of the use of this market power are partly a function of the size of the Medicare program. This is effectively a statement of the elasticity of supply of medical services and devices, which is a function of the size of the insurer in the overall market.

While Medicare is a large public insurer, it is not the only large payer in the market. In 2017, there were approximately 55 million enrollees (17 percent of the population). To put that in perspective, United Healthcare currently provides health care coverage for 38 million individuals and represents only one of many private insurers in the United States.[9] The fact that Medicare is not the only large payer in the market limits some of the negative consequences of its exercising its

market power as a large purchaser. However, if Medicare expands to be a dominant (or, depending upon the plan, the only) health insurance plan, then the impact of the use of buyer power could be quite large. To illustrate this point briefly, Medicare introduced a prescription drug benefit (Medicare Part D) several decades after private insurers had. Had there been no private insurers, the missing innovation from Medicare's reliance on monopsony power (as opposed to competition) would be harder to spot. The trade-off between the benefits of lower prices that provide greater access but at the cost of less innovation in plan design is central to all Medicare reform proposals.

In summary, current Medicare for All proposals do not grapple with the central economic trade-offs that require more attention for these proposals to be successful (which is not an impossibility). The inattention to central economic issues has been a theme that runs through other proposals to reform Medicare—perhaps because of a combination of political expediency and uncertainty about the magnitude of these effects. Many effects are hard to know—such as the magnitude of incentives necessary to create and capture value, the link between payment and future innovation, and the point at which Medicare starts to resemble a monopsony payer. But the current approach of believing that regulation is immune to these forces, or can circumvent them through more regulation, is not different from believing them to be small or zero. This is an unfortunate state of affairs for Medicare, as it is a large program with great economic, medical, and insurance significance for the disabled and elderly and, through spillover effects, for all Americans.

In contrast to this approach, we believe that Medicare's long-term significance can be increased with a greater appreciation for the economic forces that underlie the program. Our approach relies on reforming and expanding the MA program, as we believe that it represents the best vehicle for creating a social insurance program that balances access and coverage with long-term innovation in new therapeutics, prevention, and care-delivery models. But we also note that simply expanding the current MA is insufficient, for current reimbursement and risk adjustment in the MA program should be improved before the program is expanded. An expansion of the MA program also serves as a substitute for Medicare running its own pay-for-performance schemes, which are prone to tinkering and moving the goalposts. These proposals can also be paired with premium support, mirroring the approach that was set up by the ACA. These reforms can also be augmented by a number of proposals to make sense of high prescription drug prices—an area that will likely require more attention in coming years. Reforming how Part B drugs are paid for by delegating the task of price negotiation to vendors, reforming plan design in Medicare Part D to make payers more price-conscious about expensive drugs, and removing the requirement that drugs in "protected classes" must be covered are fruitful areas for Medicare reform efforts.

Notes

1. Throughout this article, we use the term *social benefits* in lieu of the conventional *social welfare* term from economics and public finance. We do this to avoid confusing the reader who is interested in welfare reform.

2. For a broad summary of these various plans, please see https://www.vox.com/2018/12/13/18103087/medicare-for-all-explained-single-payer-health-care-sanders-jayapal.

3. Medicare payments equal the amount that Medicare has paid out to different sources, excluding any income from premiums and other offsetting repayments. Net Medicare outlays equal Medicare payments minus income from premiums and other offsetting payments. Medicare payments will therefore always be higher than net Medicare outlays.

4. We acknowledge that health insurance provides more than the traditional economic definition of insurance (i.e., smoothing consumption across negative and positive states of the world).

5. "How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans? A 2012 Update," The Henry J. Kaiser Family Foundation (blog) (April 5, 2012), https://www.kff.org/health-reform/issue-brief/how-does-the-benefit-value-of-medicare/.

6. For more information on how risk-adjustment is conducted by CMS, see https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c07.pdf.

7. These features include both explicit and implicit regulations. Explicitly, providers that choose not to enroll in an MA network can only charge a provider the out-of-network rate. This reduces the bargaining power of providers. Implicitly, providers realize that if prices raise the premiums of MA plans too high, enrollees will default to the FFS system, and the provider will only earn the FFS rate.

8. "Compare Medicare-for-All and Public Plan Proposals," The Henry J. Kaiser Family Foundation (blog) (April 11, 2019), https://www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals/.

9. This includes 27 million commercial lives, 5 million Medicare advantage enrollees, and 6.4 million Medicaid managed care enrollees. In addition, United Healthcare provides supplemental Medicare coverage for 4.5 million customers.

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