Trial Presentation

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Assignment

For the Medicare Advantage program and the Health Insurance Exchanges, I have been asked to opine upon:

- The role that competition among private insurers plays in each program
- How the exercise of market power in each program affects enrollees and taxpayers
- The role that regulation plays in each program

Key Conclusions: Medicare Advantage

- Medicare Advantage relies on competition among private health insurers to:
  - Deliver lower premiums and more generous benefits for seniors
  - Reduce the financial burden on taxpayers
- Medicare Advantage is susceptible to the exercise of market power by health insurers
  - Competition occurs primarily between Medicare Advantage plans
  - Health insurers in the Medicare Advantage program already possess market power
  - Any increase in that market power will harm seniors enrolled in Medicare Advantage and the taxpayers who fund the program
- Regulation cannot replace competition

Key Conclusions: Health Insurance Exchanges

- Health Insurance Exchanges rely on competition among private health insurers to:
  - Deliver affordable, quality health insurance to individuals
  - Reduce the financial burden on taxpayers
- A substantial reduction in competition would result in:
  - Higher premiums
  - Reduced options
- Presence of subsidies makes the Exchanges especially vulnerable to the exercise of market power
- Regulation cannot replace competition

The Elements of the Medicare Program

Part A:
Hospital inpatient care

Part B:
Outpatient care and doctors visits

Part C:
Known today as Medicare Advantage

Part D:
Outpatient prescription drug coverage

Original Medicare Overview

- Primary source of health insurance for Americans aged 65 and older (as well as others with certain disabilities)
- **Part A**
  - Hospital inpatient care
  - $1,288 deductible
- **Part B**
  - Hospital outpatient care and doctor's visits
  - $166 deductible
  - 20% co-insurance
  - 2016 premium: $104.90/month

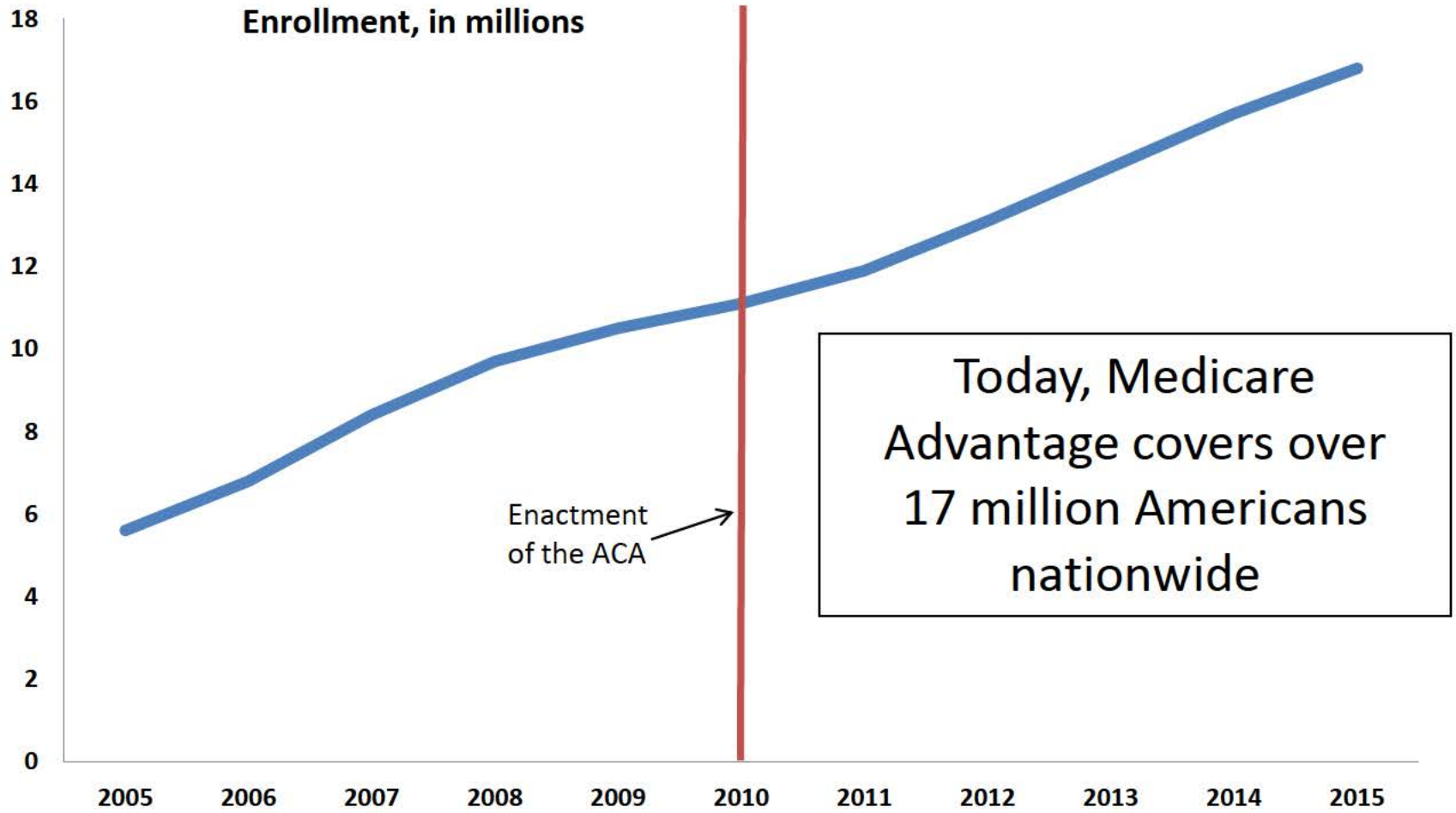
Original Medicare Overview

- No limit on out-of-pocket costs
  - Unlimited exposure to potentially catastrophic medical costs
- Does not cover:
  - Dental, vision, hearing aids
  - Prescription drugs
    - Available separately through Medicare Part D
    - Average premium: $39 per month
- No network
  - Enrollees may see any provider that accepts Medicare

Medigap

- Health insurance policies sold by private insurers to Original Medicare enrollees
  - Also called "MedSupp"
- Covers most or all out-of-pocket costs from deductibles, copays, or co-insurance under Medicare Parts A and B
- Does not cover:
  - Dental, vision, or hearing
  - Prescription drugs
- Premiums average $183/month nationally
- Guaranteed coverage if a senior enrolls within six months of becoming eligible for Medicare

Medicare Advantage Enrollment Continues to Grow



See Ex. 6, Supplemental and Rebuttal Report of Richard Frank

Medicare Advantage Plans

- Must cover at least Part A and B services
- Must limit out-of-pocket costs to $6,700 or less
- Cost sharing
  - Copayments and co-insurance are set by health plan
- Usually also cover:
  - Dental, vision, hearing aids
  - Prescription drugs

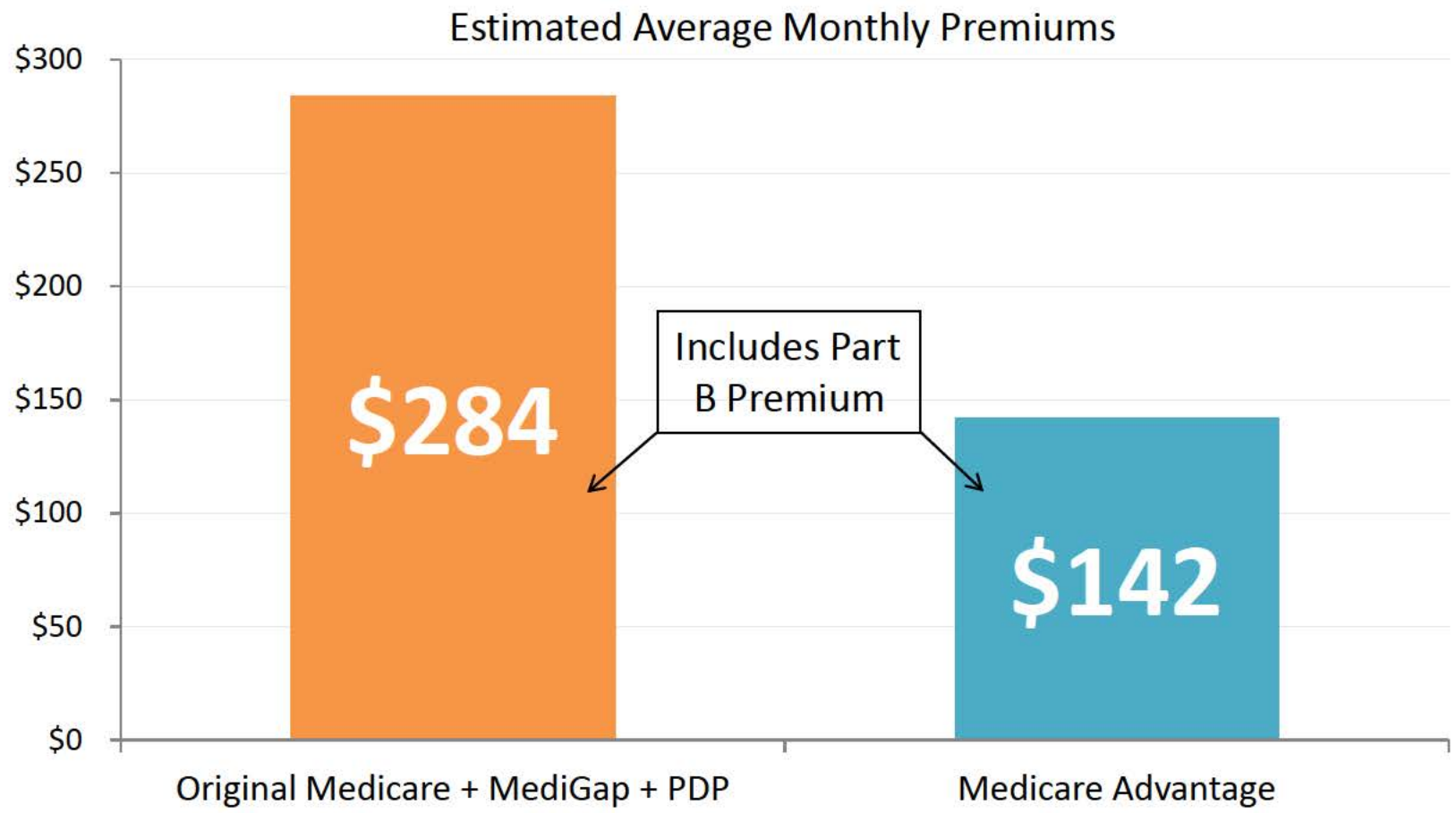
Medicare Advantage Plans

- **Network**
  - Enrollees typically limited to in-network providers or will face higher cost-sharing
- **Premium**
  - Most enrollees pay no Part C monthly premium
  - Some enrollees' Part B premiums are subsidized by their plan

Key Medicare Advantage and Original Medicare Differences

Benefit	Original Medicare	Medicare Advantage
Out-of-pocket limit	No	$6,700 or less
Supplemental benefits	No	Yes
Prescription drug coverage	No	Yes
Unrestricted provider network	Yes	No

Medicare Advantage Plans Have Lower Premiums



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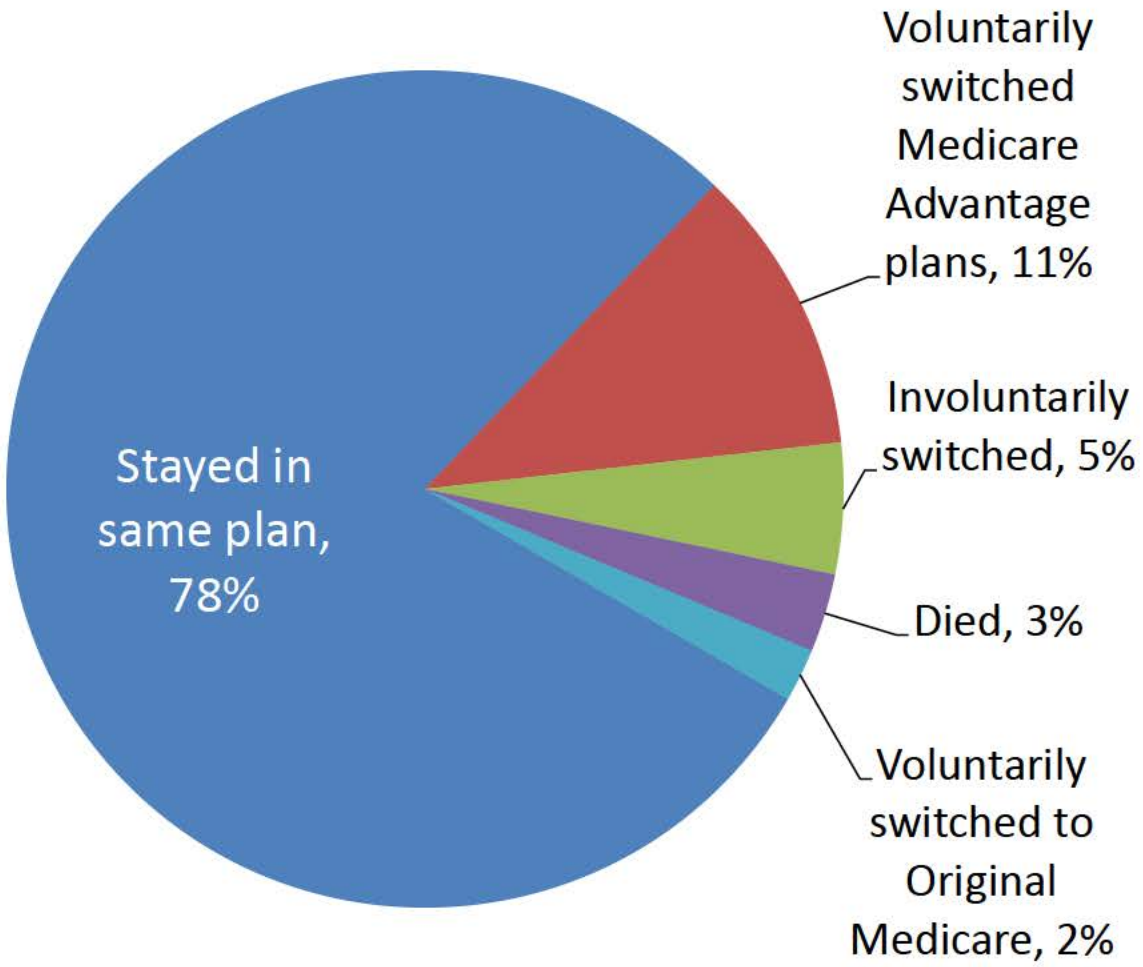
Medicare Advantage Enrollees

- Medicare Advantage attracts different enrollees than Original Medicare
  - Lower levels of income and education
  - Minorities
  - Urban
  - Healthier
    - Risk scores tend to be 20-30% lower

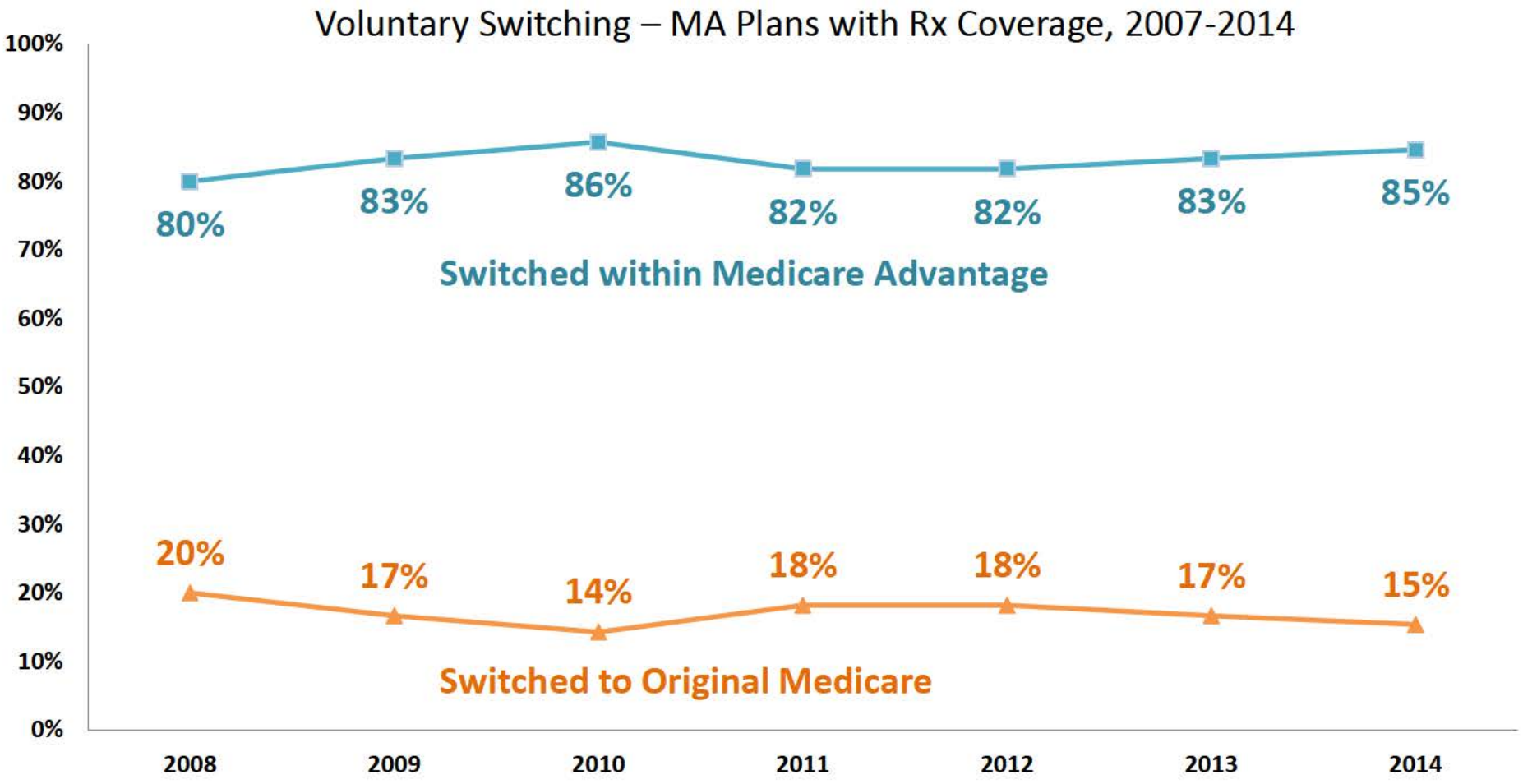
Few Medicare Advantage Enrollees Change Plans

Only **2%** of Medicare Advantage enrollees voluntarily switched to Original Medicare in 2013-2014.



See Medicare Advantage Plan Switching: Exception or Norm?, KFF Issue Brief, 20 September 2016.

Switching from Medicare Advantage to Original Medicare is Rare



See Ex. 5, Supplemental and Rebuttal Report of Richard Frank.

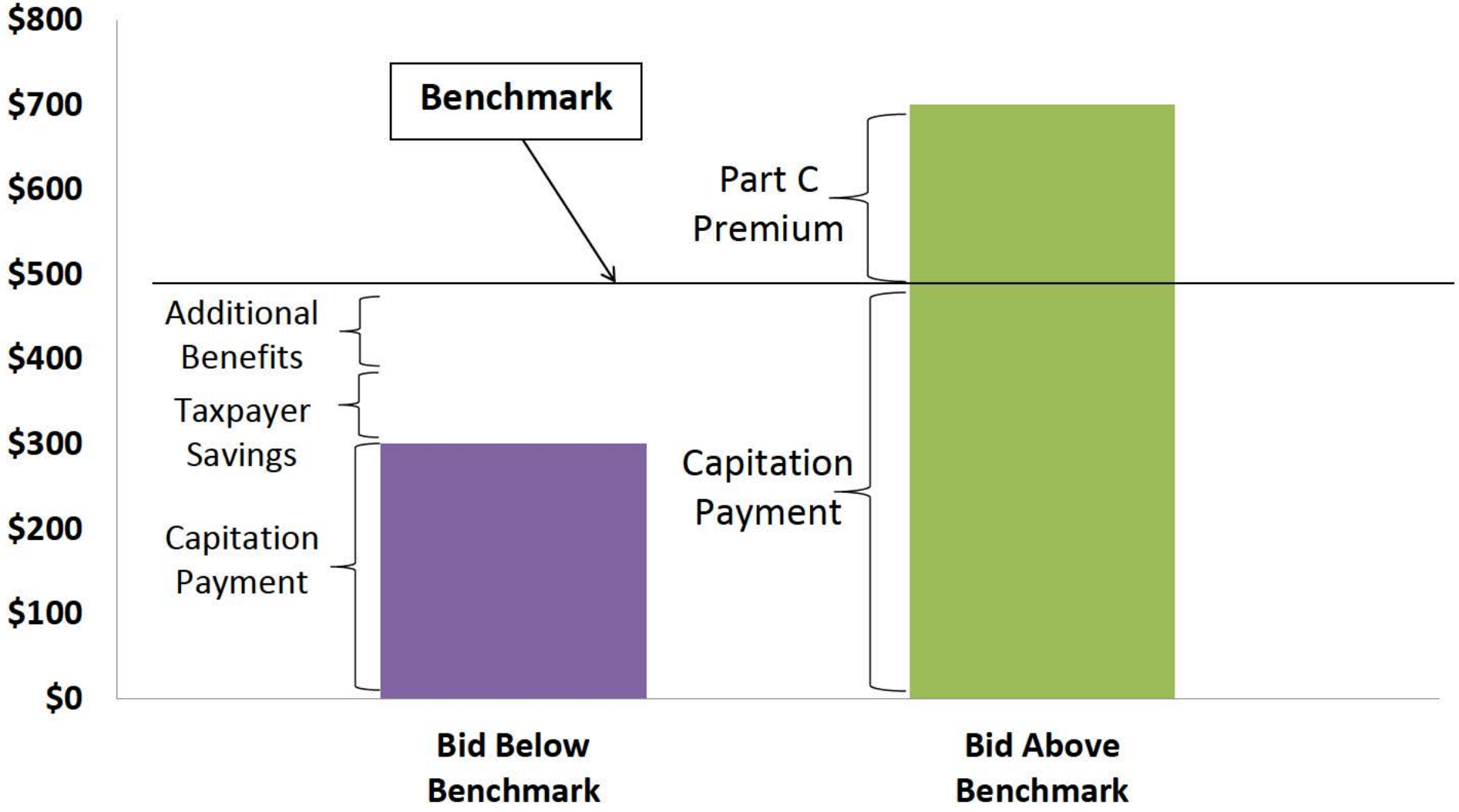
Why is Switching Rare?

1. Preferences
   - Medicare Advantage plans are significantly different than Original Medicare options
2. Familiarity with managed care
   - Seniors entering Medicare increasingly have experience with commercial managed care products
3. Employer wrap-arounds
   - Many employers offer coverage that "wraps around" Original Medicare
4. Behavioral
   - Status quo bias

Payment to Medicare Advantage Plans

- Medicare Advantage plans receive a fixed per-beneficiary per-month payment (capitation)
- These capitation payments are determined by a bidding process
  - Each Medicare Advantage plan bids relative to its own benchmark
    - Benchmark reflects average spending in local Original Medicare
  - If plan bids above benchmark, beneficiaries pay a Part C premium
  - If plans bid below the benchmark, savings are shared by beneficiaries and taxpayers
- Implications for elasticity of demand:
  - Beneficiaries face 100% of the consequences of higher bids, but receive only a portion of the savings for lower bids

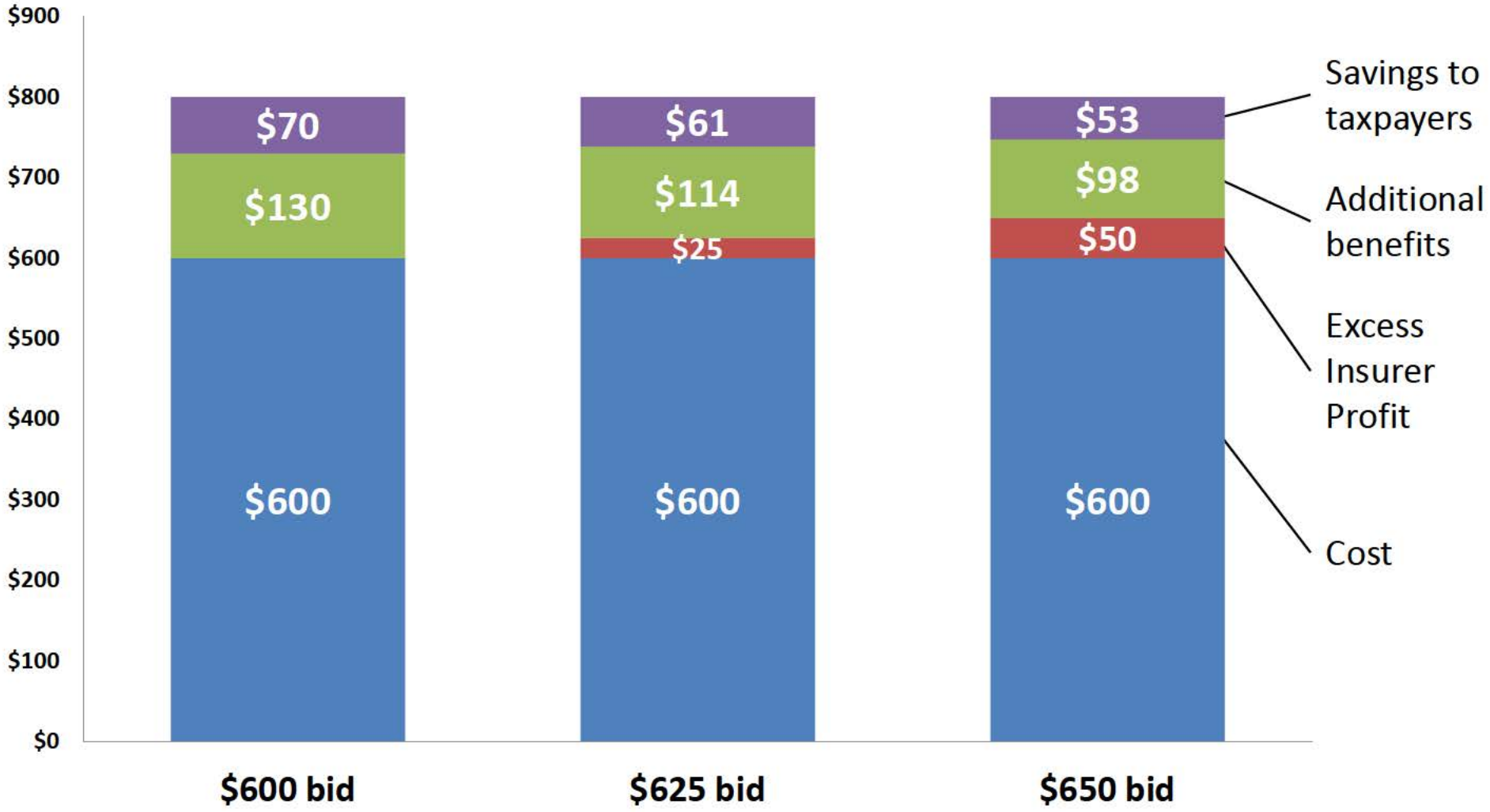
Medicare Advantage Bidding



Factors That Increase Medicare Advantage Plan Revenue

- "Star" quality ratings
  - Plans with a star quality ratings of 4 or above get a 5% increase in their benchmark
  - The higher is a plan's star quality ratings, the higher is its rebate
- Risk adjustment
- Upcoding

Competitive Bidding in Medicare Advantage



See Ex. 1, Supplemental and Rebuttal Report of Richard Frank.

Evidence of Market Power in Medicare Advantage

- Pass through of benchmark changes
  - Insurers do not pass through 100% of benchmark changes
  - Percentage that is passed through decreases with concentration
- Bidding patterns
  - $0 premium plans
  - Higher concentration and fewer plans correlated with higher bids

Accountable Care Organizations

- ACOs designed to alter care delivery within Original Medicare
- **But:**
  - Dominant payment model is one-sided risk
  - Enrollment and evidence of savings to date is modest
  - Many ACO enrollees get care outside of their ACO's network because:
    - ACOs have no restrictions on provider choice
    - Many ACO networks are incomplete
  - No flexibility in benefit design
  - No prescription drugs or supplemental benefits
- Medicare Advantage enrollment continues to grow despite introduction of ACOs

Regulation Cannot Replace Competition

- County benchmarks
  - Lean directly on competition: desire to attract enrollees improves efficiency
- Bid review
  - Incentive to minimize costs comes, by design, from competition with other insurers
- Medical Loss Ratio (MLR):
  - Not designed to give insurers incentive to minimize claims or submit the lowest bid possible: that comes from competition
- Presence of market power today highlights regulation's limits

The Health Insurance Exchanges

- Created by Congress in the Affordable Care Act in 2014
- Designed to promote access to affordable health insurance
  - Tax subsidies for premiums
  - Subsidized cost-sharing
  - 85% of exchange enrollees are eligible for subsidies
- Created centralized marketplace for individuals to compare and select among health insurance options offered by private insurers
- 2016 enrollment was 11.1 million

The Health Insurance Exchanges

- Rely on competition among private insurers
  - The exchanges create a marketplace on which insurers can compete for enrollees
- Benefits of competition
  - Affordable premiums
  - Wide range of health care coverage options

The Health Insurance Exchanges

- Insurers submit proposed plan offerings and associated premiums
- Plans are classified into 4 "metal tiers"

Metal	Plan Pays	Consumer Pays
Bronze	60%	40%
Silver	70%	30%
Gold	80%	20%
Platinum	90%	10%

- 70% of enrollees are in silver plans
- 22% are in bronze plans
- 8% combined are in gold and platinum plans

The Health Insurance Exchanges

- Premium Subsidies ("Advanced Premium Tax Credit")
  - Subsidy available to any person purchasing on the exchanges whose income is 100-400% of the federal poverty level ($24,300 for a family of four in 2016)
  - Fixed dollar amount (based on premium of second-lowest-cost silver plan)
  - Applicable to all metal tier premiums
  - 85% of all on-exchange enrollees were subsidy-eligible
  - Subsidies reduce premium by 74%

The Health Insurance Exchanges

- Premium subsidies and competition
  - Subsidy insulates enrollee from full effect of premium increases, reducing enrollee incentive to exit the market
  - Reduces pressure on plans to keep premiums low absent competition
  - Subsidy design means taxpayers bear largest share of financial burden of premium increases
- Presence of multiple insurers keeps premiums low

Regulation Cannot Replace Competition

- Regulations are designed to facilitate competition
- Regulations cannot substitute for competition among private insurers
  - **Rate review**
    - Mechanism for insurer to disclose and explain proposed unusual or extraordinary year-over-year premium increases
    - CMS lacks authority to reject proposed premium increase
  - **Medical Loss Ratio**
    - Calculated at the state level over the previous three years
    - Not structured to respond to localized exercise of market power

Conclusions

- Medicare Advantage and the Exchanges rely on competition among private insurers to deliver low premiums and high quality
  - Competition among private plans in Medicare occurs primarily within Medicare Advantage
  - As more insurers participate on the Exchanges, premiums go down
- A substantial reduction in competition in either program will harm enrollees and taxpayers
- Regulation cannot replace competition
  - Rate review and MLR requirements are not substitutes for competition among private insurers

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