Medicare Advantage: A Model Whose Time Has Come

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The American health care system has two distinguishing characteristics.

First, similarly situated individuals pay the same premium, regardless of their medical conditions. Put differently, no one who acquires health insurance ever pays an actuarially fair price.

Second, insurers invariably lose money on people who are known to be relatively sick and make money on people who are known to be relatively healthy before they ever enter the insurance pool.

As a result, no health plan wants a sick enrollee – especially one who requires expensive drugs. No employer. No commercial insurer. No (Obamacare) marketplace insurer. And if the truth were known, no government-run system wants a high-cost enrollee either – including Medicare and Medicaid.

Health plans respond to these conditions in three ways.

First, they try to attract the healthy and avoid the sick. They can do this by making their plan designs attractive to the former and unattractive to the latter and /or by overproviding to the healthy and underproviding to the sick.

Second, they avoid creating specialized products for people with special needs. In a free market for health insurance, you would expect one type of insurance plan to meet the needs of diabetics, another for people with congestive heart failure, another for respiratory disease. Instead, we tend to get one-size-fits-all: same deductible, same coinsurance, etc., regardless of medical condition.

Third, they help create a health care system that is incredibly bureaucratic. Prices don't serve the function they serve in other markets. In fact, most of us never see a real price for anything. Competition also doesn't serve the function it serves in other markets.

In general, health care providers do not compete on price, and when they don't compete on price, they don't compete on quality either.

There is one exception to all of the above: the Medicare Advantage (MA) program. This is the only place in our health care system where a doctor who discovers a change in a patient's health condition can send that information to the insurer (in this case Medicare) and receive a higher premium, reflecting the higher expected cost of care.

Because of a highly sophisticated risk adjustment system, MA plans not only do not try to avoid the sick, they actually try to attract them. There are “special needs plans” for diabetics, for heart disease, for respiratory ailments, etc. By specializing in a particular type of care these plans have the potential to evolve into what Harvard Business School professor Regina Herzlinger calls “focused factories,” or centers of excellence.

The video player is currently playing an ad.

(Note: there is risk adjustment in the (Obamcare) marketplace. But it is highly imperfect.)

The MA program is also one of the few places in the health care system where health plans find it profitable to keep people healthy.

As good as I think the MA system is, it could be made better, as I suggest below. But first, let’s consider three frequently asked questions.

Is Medicare Advantage saving taxpayers money?

It may surprise you know that no one really knows for sure. The reason: there has never been a true apples-to-apples comparison between the cost of traditional Medicare (TM) and the cost of the MA program.

For example, many people in TM are also in an employer plan. (Those people are probably relatively healthy.) Others are also in Medicaid. (Those are probably less healthy.)

One well known estimator of the taxpayer cost of TM and MA plans (the **Medicare Payment Advisory Commission** or MedPAC) claims that MA costs 20 percent more than if the same patients were in TM. However, MedPAC makes no attempt to separate out the different kinds of enrollees.

A conclusive study would separate out 16 categories of enrollees and compare the taxpayer cost in TM and in MA separately for each. Yet for that to happen, the CMS has to do something it has never done before: release the data. Interestingly, Rep. Aaron Bean (R-FL) has introduced a bill in Congress that is designed to force that very kind of disclosure.

In the meantime, a more rigorous study by Milliman estimates that taxpayers save $576 per enrollee per year when an enrollee joins an MA plan. This is consistent with an industry financed study by Elevance.

The Elevance study also found that as MA penetration in a market increases, all doctors in the area begin to practice more efficient medicine. Owing to these “spillover effects,” a 10 percent increase in market share by MA plans leads to an average decrease in spending on all Medicare beneficiaries of between $105 and $127 per person, per year.

Does Medicare Advantage save money for seniors?

To get comparable coverage, enrollees in TM must enroll in parts A, B, and D plus purchase medigap insurance (averaging $2,604 in 2023). By contrast, many MA plans have zero premiums and offer extra benefits (hearing, dental and eye care) that TM does not offer.

An analysis (commissioned by a MA-advocacy group) found that MA enrollees with 3+ chronic conditions spent on average about $3,165 less per year out-of-pocket than those in TM.

Bottom line: most analysts agree that not only does MA save seniors money, but MA plans are delivering more efficient health care.

Does Medicare Advantage deliver higher quality care?

Numerous studies have found that MA plans are providing higher quality care at a lower cost. When enrollees with comparable characteristics are compared:

- MA enrollees experience 20-25 percent fewer hospitalizations and make 25-35 percent fewer emergency room visits.
- They produce better outcomes for such conditions as knee and hip replacements, strokes, and heart failure.

On diabetes care, Kaiser Permanente's former CEO, George Halvorson notes:

Diabetes is the number one cause of amputations in America. In fee-for-service Medicare, 20 percent of diabetic patients will develop foot ulcers, and 20 percent of those ulcers turn into amputations. In contrast, even the less successful [MA] programs end up with half as many ulcers and less than a third of the amputations compared to fee for service. Some best-care settings get the amputation rate down to two percent.

Halvorson also addresses the issue of blindness:

We can reduce blindness in older diabetics by more than 60 percent by managing the blood sugar levels of patients. [In] fee-for-service Medicare for low-income people. . . we currently have less than 30 percent of those patients with controlled blood sugar and they have high levels of blindness. . . . Fee-for-service Medicare caregivers . . . often make more money when they treat patients with blindness multiple times rather than prevent blindness.

[By contrast,] Medicare Advantage plans are capitated in their payment model, so they routinely identify every diabetic and then those plans all tend to do the right things to help

blood sugar management for those patients. Far too many low-income people who are not on Medicare Advantage plans go blind and then they stay blind for life.

How could Medicare Advantage be improved?

Good as Medicare Advantage is, the program would be better if there were less regulation.

For example, if an MA plan gets its amputation rate down to 2 percent, it cannot advertise that fact during open enrollment. If its blindness rate is really low, it can't advertise that fact either. If these facts are established by an independent research origination with no financial interest in the study conclusions, that has to be kept secret as well.

Similarly, if a plan has fewer pre-authorizations or if pre-authorizations are cleared up faster than in other plans, consumers don't get to learn about those facts either.

Every communication from an MA plan to potential enrollees has to have the government's approval! And CMS appears to really not like quality comparisons among plans.

This is not the way a normal market works.