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Delivering Public Health Insurance Through Private Plan Choice in the United States

Jonathan Gruber

The United States has seen a sea change in the way that publicly financed health insurance coverage is provided to low-income, elderly, and disabled enrollees. When programs such as Medicare and Medicaid were introduced in the 1960s, the government directly reimbursed medical providers for the care that they provided, through a classic “single payer system.” Since the mid-1980s, however, there has been an evolution towards a model where the government subsidizes enrollees who choose among privately provided insurance options. Currently, almost one-third of Medicare enrollees are in privately provided insurance plans for all of their medical spending, and another 43 percent of Medicare enrollees have standalone private drug plans through the Medicare Part D program. More than three-quarters of Medicaid enrollees are in private health insurance plans. Those receiving the subsidies made available under the Patient Protection and Affordable Care Act of 2010 do so through privately provided insurance plans that are reimbursed by the government. In most of these cases, individuals have a choice across these private insurance options, and choices are typically from quite large choice sets.

Figure 1 illustrates these trends. The figure has three lines that contrast enrollment in pure public versus privately delivered insurance. The line that starts highest shows enrollment in “single payer only” government insurance since the mid-1980s, excluding enrollment in private plans for Medicare and Medicaid enrollees. The

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lower line shows enrollment in publicly financed private plans through Medicare and Medicaid, while the additional line starting in 2006 includes enrollment for prescription drug coverage only through private Medicare Part D plans. If such Part D coverage is included in the privatized bucket, then by 2006 there were more beneficiaries enrolled in some type of private coverage than in government-sponsored single-payer programs. Even absent Part D, starting in 2010 there was more enrollment in privatized plans. Public insurance in the United States is now primarily a privately run endeavor, at least in terms of enrollment. Expenditures on private plans remain below expenditures on directly insured government care, which reflects the fact that, as discussed below, the healthiest enrollees are more likely to join private programs, but even in expenditure terms, the gap is shrinking.

This trend is in contrast to the rest of the developed world. There is a large diversity of health care financing systems around the globe, including direct public health provision in the United Kingdom, publicly provided insurance in Canada, and mandatory nonprofit private insurance in Germany and Switzerland. These countries have had significant changes to their health care systems in recent years, but in each case, the basic context of insurance has remained the same—private has stayed private, while public has stayed public.

This remarkable evolution of the provision of US public health insurance has potentially wide-ranging impacts. Moreover, it is central to current health care policy debates. For example, one of the leading policy disagreements is over moving
the Medicare program to a full “premium support” program, in which elders will choose from a wide variety of private (and potentially public) insurance options. Another controversy is over whether to replace the Medicaid program with subsidies to private insurance plans among which enrollees would choose.

Privatized delivery of public health insurance appears to be here to stay, with debates now focused on how much to expand its reach. Yet such privatized delivery raises a variety of thorny issues. Will choice among private insurance options lead to adverse selection and market failures in privatized insurance markets? Can individuals choose appropriately over a wide range of expensive and confusing plan options? Will a privatized approach deliver the promised increases in delivery efficiency claimed by advocates? What policy mechanisms have been used, or might be used, to address these issues?

A growing literature in health economics has begun to make headway on these questions. In this essay, I discuss that literature and the lessons for both economics more generally and health care policymakers more specifically. I begin with a review of the original structure of the major US health insurance programs: Medicare and Medicaid, and discuss the introduction of privatized insurance delivery into Medicare and Medicaid through managed care plans, as well as the broader introduction of exchange-based models through the Medicare Part D program and the Affordable Care Act. I turn to a brief heuristic discussion of the issues raised in shifting from public to private provision. I review the economic literature on what is known about the transition to such a privatized model, and discuss the key lessons and policy issues that must be addressed in evaluating future expansions of privatized public insurance. I highlight in particular two of the key policy issues going forward, risk adjustment and choice consistency, which in turn are the focus of the subsequent two papers in this symposium.

The Changing Nature of Public Health Insurance

The Original Structure of Medicare and Medicaid

Over the long run, the largest single expansion in the US welfare state was the introduction of Medicare and Medicaid in the mid-1960s. These programs started small but grew rapidly. By 2015, these programs accounted for government expenditures of $1.2 trillion, which is 37 percent of total national health expenditures and is larger than total private health insurance expenditure (based on the National Health Expenditure Data from the Centers for Medicare & Medicaid Services). These programs were established as classic single-payer health insurance systems. Individuals chose only whether to enroll in the program, and had no other choices to make with respect to their insurance coverage. The government contracted directly with providers for the cost of providing care to enrollees.

Medicare was originally set up with two different components. Part A is primarily focused on hospital expenditures and is financed by a dedicated payroll tax with no additional premium contribution from individuals; individuals are automatically
enrolled at age 65 if they (or their spouses) have sufficient work history. Part B is primarily focused on physician expenditures. Upon turning 65, eligible individuals are able to enroll in Part B by paying a monthly premium set to cover 25 percent of the cost of the program, with the remaining 75 percent coming from general revenue financing.

Medicaid was established as a state program to cover individuals who had low income and assets, but it also covers single mothers, elderly, and disabled. The program is administered by the states but jointly financed by the state and federal governments; the federal government share is an inverse function of state income and averages 57 percent of program costs. Over time, the program has expanded to have higher income limits for certain groups, such as children and pregnant mothers, along with a broader expansion under the Affordable Care Act to all low-income families (in participating states). Although Medicaid is sometimes described as a program for those with low incomes, seniors and the disabled account for 61 percent of program spending (but are only 23 percent of enrollees) (Paradise 2017).

**Medicare: The Advent of Choice**

Medicare was incredibly successful in expanding insurance coverage among the elderly, and in reducing their exposure to risks of high medical spending (Finkelstein and McKnight 2008). But program costs also exploded in its early years, rising from $64 million in federal expenditures in 1966 to $32.1 billion in 1980 (Gruber 2015). This rapid rise led policymakers to focus on controlling costs through two different channels. The first was regulatory changes in the reimbursement of providers, including the introduction of physician fee schedules and “prospective reimbursement” of hospitals (in which hospitals are paid for services according to pre-established fees). The second cost-saving approach, and the focus of the discussion here, was the introduction of an option for enrollees to join “managed care” plans, starting in 1985.

Managed care plans, traditionally known as health maintenance organizations (HMOs), represented a very different model than the existing model. Under a fee-for-service model, providers billed for the cost of each service and were reimbursed by the government. Under this alternative model, private plans would be paid a fixed amount by the government to cover all of the medical spending of enrollees; the government shifted the entire risk to the managed care entity. This part of Medicare has been called by many names over time but is currently referred to as the Medicare Advantage program.

The government initially reimbursed these plans 95 percent of the county’s per enrollee spending on traditional Medicare. Over time, various floors were introduced which raised reimbursement to selected Medicare Advantage plans based on location (for example, urban versus rural plans). The government also “risk adjusts” payments to Medicare Advantage plans to try to reflect the underlying patient health in these plans. In 2006, the government moved to a bidding system whereby plans could submit a bid for the expected costs of providing Medicare-like services to recipients; if the bids were below the county-level benchmarks, three-quarters of
the difference was rebated to consumers in the form of lower premiums or richer benefits, while one-quarter is rebated to the government. The Patient Protection and Affordable Care Act of 2010 kept this system in place, but substantially reduced the county benchmarks, while adding aspects such as bonuses paid to plans based on plan quality.

Figure 2 shows the time series of enrollment in this Medicare managed care option. Enrollment grew rapidly throughout the 1990s, declined significantly due to reimbursement reductions in the early 2000s, and then grew rapidly again after reimbursement increases in the mid-2000s. Despite reimbursement reductions in the 2010 Affordable Care Act, enrollment growth in managed care has not slowed and currently stands at a peak of almost one-third of Medicare enrollees.

From an enrollee perspective, Medicare Advantage plans present a clear trade-off. Relative to traditional Medicare, these plans significantly limit provider choice and manage care through tools such as utilization review (processes for pre-approval of medical procedures).

On the other hand, traditional Medicare features significant patient cost-sharing, with a large deductible for hospital utilization and an (uncapped) 20 percent coinsurance for physician care, while Medicare Advantage plans typically feature much smaller copayments. Moreover, before drug coverage was added to traditional Medicare through the introduction of Part D in 2006, Medicare Advantage plans covered prescription drugs while traditional Medicare did not. Elders had a variety of options for covering these out-of-pocket costs under Medicare: the
poorest elders received coverage of the costs through Medicaid, while others could purchase private “Medigap” insurance that covered the costs. Medicare Advantage was another such option, which was typically much cheaper than Medigap plans. Overall, by signing up for Medicare Advantage, patients were trading off provider choice for a reduction in cost-sharing.

**Managed Care Takes Over Medicaid**

In its early years, the Medicaid program was delivered exclusively (like Medicare) through fee-for-service reimbursement of providers by states. States set fee schedules and other reimbursement rules for providers who saw Medicaid patients. These fees were typically well below private reimbursement rates, and even below Medicare rates, so that many providers were reluctant to see Medicaid enrollees (Gruber 2015).

In the early 1990s, in an effort to save costs, states began to contract with private Medicaid managed care organization (MMCOs) that were reimbursed a fixed amount by states for absorbing all of the financial risk of covering Medicaid enrollees. Figure 3 shows the share of Medicaid enrollees in MMCOs. This figure grew from under 10 percent of enrollment in 1990 to over 50 percent by 1998, and has grown steadily since, now standing at almost 80 percent of enrollment. The share of Medicaid spending in MMCOs is much lower, however, because the growth in managed care has been much stronger in the low-cost nonelderly/nondisabled population than for the elderly and disabled, who as noted earlier, account for a majority of total Medicaid spending.

The process by which Medicaid enrollees end up in Medicaid managed care organizations has varied over states and across time. In the early years of the program, a number of states started with voluntary systems whereby enrollees could choose whether to enroll. Over time, however, a number of those states have moved to mandatory systems where enrollees are assigned to a MMCO. Currently, there is a mix of the two types of systems.

**Medicare Part D: The Codification of Choice**

A watershed moment in the shift from publicly provided health insurance to publicly financed but privately provided insurance was the introduction of the Medicare Part D program. When Medicare was established in 1965, it covered most medical needs for the elderly and disabled, including hospital and doctor costs, but it excluded coverage for prescription drugs. By the 1990s, the advancement of prescription drug treatments for common illnesses among the elderly drew attention to this gap in Medicare coverage.

The expansion of Medicare to prescription drug coverage could have taken two different paths. In one approach, a drug benefit could have been added to the Medicare program directly, with the government negotiating directly with drug

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companies to hold down drug prices. However, after a contentious debate, the policy that was chosen was for government to provide subsidies to private insurers who would then offer prescription drug coverage to the elderly, either through health maintenance organizations or as a stand-alone prescription drug. The Medicare Part D benefit marked the first time that a major government health insurance plan was totally privately provided.

Those eligible for Medicare Parts A and B were after 2006 made eligible for this new Medicare Part D benefit. Individuals chose from a large variety of prescription drug plans that covered at least a basic set of benefits, but typically covered more. Enrollees faced a premium that on average covered 25 percent of the cost of the program. At the same time, Medicare Advantage plans could continue to include drug coverage as part of their coverage packages. This resulted in a large number of options for seniors to choose prescription drug coverage; in 2009, the typical senior could choose from 48 different plans that offered prescription drug coverage (Abaluck and Gruber 2011).

The Affordable Care Act: The Future of Choice?

The most recent major change in choice among private-sector providers for the delivery of government-financed health insurance is the state-based exchanges in the Patient Protection and Affordable Care Act of 2010. Prior to the passage of this law, individuals buying insurance outside of an employer setting faced a fragmented market which featured significant barriers to enrollment, such as highly imperfect information on potential options and active selection against the sickest enrollees (Gruber 2015). The Affordable Care Act put in place a new organizational
structure for the health insurance market that sought to address these shortcomings. A new regulatory structure for the market disallowed health-based insurance offerings or pricing, established a minimum set of benefits that must be included in all plans, and organized the market around a set of “metallic tiers” of coverage with similar benefits structures.

Perhaps most significantly, the federal government provided large tax credits to offset the cost of these insurance plans for low-income enrollees. These tax credits were structured so that low-income families pay a capped share of their income (from 2 percent of income at the poverty line to 9.5 percent of income at four times the poverty line), and the government absorbed the rest of the cost for the second-lowest-cost plan in the silver metallic tier (the second lowest tier). The Affordable Care Act also included an individual mandate that penalized individuals who did not sign up for insurance coverage, further incentivizing individuals to enroll through exchanges (unless they had other options available such as employer or government-provided insurance).

Enrollment in the state-based exchanges grew rapidly in their first year of operation, but has stabilized more recently. In a minority of states, the exchanges are state-run entities; in the majority, enrollees enroll through a federal website that shows each state’s choices. Initially, 2.6 million enrollees were in state-administered programs and 5.4 million in the federally run exchange. Over time, as some states have stopped providing their own exchanges, enrollment in state-administered exchanges has stagnated at 2.8 million while enrollment in the federally run exchange has risen to 8.7 million. The differences between state- and federally-administered exchanges are not obvious to the enrollee, but Frean, Gruber, and Sommers (2017) find that enrollment grew much faster, and consumers were more responsive to subsidies, in state-administered exchanges (perhaps due to other correlated state outreach programs).

What Are the Tradeoffs in Moving to Choice of Private Plans?

This radical shift from purely public insurance options to a choice of private plans raises a number of important economic issues. In this section, I review these issues. I then turn to the available evidence on these issues from the US experience with privatized insurance delivery.

The issues that arise in moving to a privatized system of insurance choice can be divided into the allocative and production side. On the allocative side, the benefit of choice is that it allows chosen health insurance to reflect preference heterogeneity, allowing allocative efficiency across plans. Individuals differ in their demand for insurance for a number of reasons, ranging from demographic characteristics to tastes for risk. Forcing individuals into a plan that doesn’t reflect their preferences imposes an allocative cost. For example, Lucarelli, Prince, and Simon (2008) use aggregate data on plan market shares to conduct a study of how plan features affect demand for prescription drug insurance plans, and they estimate sizeable welfare
losses from limiting the option set facing seniors. But the study assumes that seniors are choosing optimally, and therefore, by that definition, restricting their choice set can only be harmful.

On the other hand, having choice across plans invokes two costs. The first is adverse selection: if individuals match their individual tastes, then the plans preferred by the least healthy enrollees may end up with the highest prices. Adverse selection does not necessarily doom an insurance market; as highlighted by Finkelstein and McGarry (2006), it depends on the correlation between tastes for risk and health status. For example, in some insurance markets, those who have lower risk-tolerance and are generally safer tend to buy more insurance, not less. But adverse selection has generally been documented to be a significant issue in health insurance markets, as documented strikingly by Cutler and Reber (1998). A series of articles by Einav and Finkelstein, nicely reviewed in this journal in 2011, show how to measure the consequences of adverse selection. Einav and Finkelstein find that while adverse selection exists across insurance plan choices, it has relatively modest welfare costs.

One reason why the consequences of adverse selection might not be large relates to the second potential cost of choice: choice frictions. These include the standard problems of switching costs, as well as behavioral problems that arise in evaluating a complicated set of health insurance choices. For example, Handel (2013) documents strong evidence for inertia in private health plan choices and argues that it offsets the pressures towards adverse selection; however, Polyakova (2016) finds in the context of Medicare Part D that inertia leads to an increase in adverse selection. So the sign of this effect is not obvious. Likewise, a set of articles reviewed below find “choice inconsistencies” in the context of the Medicare Part D program, whereby individuals are not optimizing their plan choice. A recent paper by Handel, Kolstad, and Sinnewijn (2015) reviews the evidence on how choice frictions impact the demand side of the insurance market and discuss the fact that “more is not always better” when it comes to decisions facing choice frictions.

The other set of issues around privatized choice arises on the producer side. Once again, the standard economics argument is clear: allowing choice across plans will put competitive pressure on those plans to deliver care efficiently, whereas a monopoly public insurer faces no such pressure. Once again, although the basic intuition continues to apply, this issue is much more complicated in the context of insurance markets than in goods markets.

One reason is that it is more difficult to define “efficiency” in an insurance market. Normally economists would define productive efficiency in terms of producing at minimum costs per quality-adjusted unit of output. But quality-adjustment is very difficult in health insurance—particularly when concepts of “quality” may vary across individuals. This insight also further amplifies adverse

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2 Note that these are just the welfare costs of adverse selection across plans, not the welfare costs of adverse selection in terms of accessing insurance markets. The latter may be much larger, as discussed in Hackmann, Kolstad, and Kowalski (2015).
selection concerns, in that private insurers will have an incentive to target outcomes that are most valued by the healthiest potential enrollees.

The tradeoff here is nicely illustrated by two recent articles. On the one hand, Einav, Finkelstein, and Polyakova (2016) document that while public insurance programs typically incorporate uniform cost-sharing across prescription drugs, private prescription drug plans under Medicare Part D distinguish cost-sharing across categories of drugs that are differentially price-elastic, which is more efficient. On the other hand, Geruso, Layton, and Prinz (2016) document that within private plans on the state-level health insurance exchanges established by the Patient Protection and Affordable Care Act of 2010, prescription drug cost sharing is designed in a manner to discourage enrollment among less-healthy enrollees. Similar studies of plan benefits designed to promote virtuous selection are discussed below; in that discussion, where possible, efficiency will be defined relative to observable health outcomes such as mortality.

Two other issues involve the capabilities of public and private insurers. One issue is the ability of public versus private insurers to reduce unit prices for health care, which turns on the dynamics of competitive bidding versus regulatory price setting. The other issue is the ability of private insurers to impose care management restrictions that may be politically difficult to impose with public insurance. These issues are discussed further below in the context of Medicare Part D and Medicare Advantage.

Evidence on the Effects of Privatized Delivery of Health Insurance

Medicare Advantage: More Efficient Care, But Sorting by Risk

There is a rapidly growing literature on the Medicare Advantage program, comparing it to outcomes under traditional Medicare. This literature has drawn three important conclusions.

First, patients who choose Medicare Advantage are much healthier than patients who choose traditional Medicare (as reviewed by Brown, Duggan, Kuziemko, and Woolston 2014). Those who move into Medicare Advantage have costs that are 20–37 percent lower than those who remain in traditional Medicare. Of course, such a gap could theoretically be due either to differences in health or to more efficient provision of care. However, Batata (2004) notes that if those moving into Medicare Advantage were, on average, as healthy as those who remain in traditional Medicare, then when individuals move across programs there should be no change in average costs of traditional Medicare. In fact, as more individuals move from traditional Medicare to Medicare Advantage, the average costs of traditional Medicare do rise. Batata finds that the marginal cost of traditional Medicare disenrollees who move to Medicare Advantage is $1,030 lower, or 20–30 percent cheaper than the average cost of traditional Medicare enrollees.

More recently, Brown et al. (2014) show that substantial health differences exist between enrollees in Medicare Advantage and traditional Medicare. They find that the health care spending of those switching to Medicare Advantage plans from
fee-for-service have total annual health care costs that are $2,850 (or 45 percent) lower than those in traditional Medicare, and have risk scores (measures of underlying patient burden) that are 20–30 percent lower than in traditional Medicare. They also find that those who are in good health are more satisfied with Medicare Advantage than with traditional Medicare, and as for the 3 percent of Medicare Advantage enrollees who switch back to fee-for-service each year, it is the sickest enrollees who are most likely to switch back.

Second, health care utilization and costs are much lower under Medicare Advantage than under traditional Medicare (for an excellent review, see McGuire, Newhouse, and Sinaiko 2011). Of course, this literature faces the important problem mentioned above—enrollment in Medicare Advantage is not random. To account for this, previous studies have taken a variety of approaches. One subset of research has estimated cross-sectional models that include a rich set of controls for individual’s age, health status, and related factors, assuming that there are no remaining unobserved differences between those who choose to enroll in managed care and those who do not (Curto, Einav, Finkelstein, Levin, and Battacharya 2017; Landon et al. 2012). Another branch of studies has used instrumental variable approaches, with their methods assuming that certain factors (for example, the penetration of Medicare Advantage in a local market) influence plan choice but do not affect utilization (Mello, Sterns, and Norton 2002). Yet another strand of this literature has used longitudinal data to follow individuals over time and compare the evolution of Medicare spending or other outcomes of interest among those switching between Medicare Advantage and traditional Medicare and those not switching; Brown et al. (2014) examine cases of voluntary switching, while Parente, Evans, Schoenman, and Finch (2005) examine cases of switching following exit of the plan that people had been using.

Recently, Duggan, Vabson, and I have taken a different approach to the selection problem by exploiting plan exits from counties in New York in the early 2000s (Duggan, Gruber, and Vabson forthcoming). Individuals who were enrolled in Medicare Advantage in those counties were exogenously removed from the program, and we study the subsequent effect on this population’s use of health care relative to other counties and relative to the traditional Medicare population that was not affected by exits. Consistent with the previous literature, we find significant increases in inpatient health care utilization and costs when individuals are exogenously moved from Medicare Advantage to traditional Medicare, although in this study we were unable to examine outpatient care.

Third, the literature has generally found no significant impact on patient outcomes, although this evidence on this point is more limited than on the previous two findings. Duggan, Vabson, and I find that the exit from Medicare Advantage when private plans ceased to operate had no impact on patient mortality, hospital readmissions, or reported hospital quality (Duggan, Gruber, and Vabson forthcoming). Taken together with the evidence on utilization and costs, this literature suggests that Medicare Advantage is delivering care more efficiently than traditional Medicare.
Medicaid Managed Care Organizations: Mixed Evidence on Efficiency

The literature on managed care within Medicaid has delivered somewhat less-clear conclusions than studies of managed care within Medicare. Where there is enrollee choice between fee-for-service Medicaid and Medicaid managed care organizations, there is some evidence of selection. For example, Glied, Sisk, Gorman, and Ganz (1997) find that those who voluntarily selected MMCOs in New York City were healthier. As a result, the large literature that cross-sectionally compares MMCO enrollees to those in traditional Medicaid should be taken with some caution (for a review of that literature, see Kaestner, Dubay, and Kenney 2005).

To address this selection, several papers have relied on the introduction of state-level mandates that the enrollees join Medicaid managed care plans, and then applied a difference-in-difference approach. The results using this approach are quite mixed. Duggan (2004) studied such mandates in California and found that they led to increased government spending, while Harman, Hall, Lemak, and Duncan (2014) showed that such a mandate in Florida lead to lower Medicaid spending. Herring and Adams (2011) and Duggan and Hayford (2013) use national samples and find no effect of mandated movements into Medicaid managed care organizations. Duggan and Hayford, do, however find that managed care reduced Medicaid spending in states that had generous baseline fee-for-service provider reimbursement rates in Medicaid. Their results suggest that managed care achieved savings for Medicaid mainly through the government’s ability to negotiate lower prices with health plans and that managed care plans had little impact on the actual practice of Medicaid providers. Marton, Yelowitz, and Talbert (2014) confirm this finding using a case study of Kentucky, where they find that MMCOs lowered costs under some contracting arrangements but not under others.

There is more limited evidence on how a shift to managed care affects patient outcomes. Duggan (2004) found that MMCOs improved the quality of health care, while Aizer, Currie, and Moretti (2007), who examined prenatal care and birth outcomes in California, found that managed care decreased the quality of prenatal care and increased the incidence of low-birth-weight, pre-term births, and neonatal mortality.

Medicare Part D: Savings, But Choice Inconsistency

In the decade since the Medicare Part D program was introduced, a substantial literature has emerged to study this new mode of government insurance delivery.

One important conclusion is that the competition between private insurers has led to lower-than-expected expenditures for the program. Expenditures in the first 10 years of Part D were $147 billion below what was initially projected ($740 billion) by the Congressional Budget Office (2013). Duggan and Scott Morton (2010, 2011) show that this result arises from reduced drug prices for customers insured under Medicare Part D relative to what was expected from this new market. This finding is perhaps surprising, because economic intuition suggests that insuring consumers will make their demand less price-elastic, leading to higher prices in the imperfectly competitive prescription drug market. But in this case, insurers used their
"formulary design" to negotiate lower prices. That is, insurers could choose the set of drugs for which consumers would face lower or higher prices (or which would be unavailable), and they used this power to negotiate lower prices from manufacturers in return for better formulary placement.

This important finding suggests a sizeable fiscal benefit from the competitive structure of Medicare Part D. Of course, it does not prove that prices would not have been even lower if Medicare had negotiated directly for lower drug prices. In the Medicaid program, the government negotiates prices to be paid for drugs using a "most favored nation" clause that insists that drug prices paid by Medicaid be no higher than those paid by other payers. This provision has significantly lowered drug prices in the Medicaid program, albeit with important external impacts on pricing to other payers (Duggan and Scott Morton 2006). An important ongoing policy debate is the efficacy of government price regulation versus reliance on a competitive mechanism in the context of the imperfectly competitive market for pharmaceuticals.

Another area of significant study examines the ability of consumers to choose across the dozens of Medicare Part D options that they have available. Abaluck and Gruber (2011) and Heiss, Leive, McFadden, and Winter (2012) show that the vast majority of enrollees do not chose the cost-minimizing plan. More specifically, Abaluck and Gruber (2011) argue that there are two major "choice inconsistencies" under Part D: individuals are much more sensitive to premium differentials across plans than to out-of-pocket cost differentials; and consumers consistently overweight "salient" plan characteristics based on their overall impacts, not their impacts on those specific consumers. We estimate that there are welfare losses of 25–30 percent from these choice inconsistencies. Ketcham, Lacarelli, Miravete, and Roebuck (2012) argue that foregone savings from the program are minimized over time through learning; in contrast, Abaluck and Gruber (2016a) find that choice inconsistencies actually grow over time with little individual or cohort learning. For a debate over these findings, see Abaluck and Gruber (2016c) and Ketcham, Kumino, and Powers (2016).

There is also evidence of some adverse selection arising in the Medicare Part D market. Polyakova (2016) shows that there is a significantly higher enrollment in the most generous plans by the sickest enrollees. Conversely, Carey (2017) and Lavetti and Simon (2016) demonstrate that formularies are designed strategically by insurers to avoid the sickest enrollees.

On the one hand, these studies suggest that competition in Medicare Part D has restrained price increases over time. On the other hand, this market has experienced choice failures and adverse selection. The existing evidence does not show whether a single-payer option without choice would have done better.

State-Based Exchanges: Increasing Volatility

The latest move towards privatization of public insurance delivery is through the exchanges established with the Patient Protection and Affordable Care Act of 2010. While these exchanges have been in operation for only a few years, a sizeable
literature has emerged on their effects. In addition, this literature draws on the experience of the Massachusetts insurance “connector,” similar in design to the state-based exchanges, which has been in operation since 2006.

The state-based exchanges established by the Affordable Care Act have been marked by considerable volatility in pricing and plan offerings. For the first two years, the market was relatively stable. In the initial year of 2014, the average premium was 15 percent below what had been projected by the Congressional Budget Office when the law passed (Cohn 2016). Moreover, enrollees in most areas had a wide variety of choices: 74 percent of enrollees had products from at least three insurance companies to choose from, and only 520 of the 3,142 US counties only offered one plan, with most of those 520 counties being very low population (Avery et al. 2015).

But premiums rose and options were reduced for open enrollment in 2016 and even more so for open enrollment in 2017. Premiums rose by 22 percent on average in 2017. Choices fell, with only 57 percent of enrollees having three or more companies to choose from and 21 percent of enrollees having only one company. Despite this large increase in premiums, after taking into account the initial low pricing by insurers, premiums were on average just about where the Congressional Budget Office had projected them to be when the law passed.

This pricing volatility reflects several factors. Predicting insurance costs in a brand new market is challenging. The exchanges were not designed to be the only route to purchase individual coverage (except in Washington, DC, where the exchange had a monopoly), so insurers had to predict which of the existing non-group-insured would migrate to the new exchange products as well as which uninsured would enroll.

This effort was further hampered by important policy developments. First, the Obama administration allowed many more individuals than expected to remain in “grandfathered” insurance plans, which kept some of the best risks out of the new pools. Second, administrators allowed generous use of “special enrollment periods” which allowed flexibility for individuals to enter the market, but also promoted further selection. Third, the Republican Congress refused to appropriate funds for the “risk corridors,” the payments to/from unprofitable/profitable insurance plans that were supposed to help buffer the financial risk facing entrants in this new market. These risk corridor payments were supposed to amount to as much as $8.2 billion over 2014 and 2015, but only $362 million in payments were made; these payments could have significantly offset the losses to insurers from early under-pricing (Cohn and Young 2017).

A final reason for the volatility is a much higher rate of plan-switching in the state-based exchanges than has been previously experienced in health insurance choice environments. Switching rates in employer-sponsored insurance are quite low and in Medicare Part D are around 10 percent (Abaluck and Gruber 2016a), but in the exchanges the switching rates have been roughly 35 percent (Centers for Medicare and Medicaid Services 2017, p. 7). This likely reflects the fact that subsidies are tied to the second-lowest-cost “silver” plan, so as plans move in the
ranking due to relative changes in premiums, enrollees must switch to preserve their subsidy levels.

**Structuring Privatized Offerings of Publicly Funded Health Insurance**

This ongoing shift to privatized public insurance raises a key set of policy issues involving adverse selection by the private providers of health insurance and problems of the inconsistency of choices of consumers who are confronted with multiple private insurance plans. In this section, I provide an overview of these key policy issues, which are then the focus of the two more detailed papers following in the symposium.

**Adverse Selection**

Adverse selection is endemic in these types of insurance-market choice environments. There are two approaches to addressing this problem. The first is risk adjustment, which involves using redistributive mechanisms to offset the losses from adverse selection, and in this way to improve market functioning. In theory, such redistributive mechanisms could happen either before care is provided when the government makes payments to insurance companies, or after the care has been provided and the costs are known, or some mixture of the two. For example, the federal government has introduced risk adjustment mechanisms into the reimbursement structure for Medicare Advantage plans that target reimbursement not just to the age and gender of the enrollee, but also to their underlying health care costs (measured before care is provided, based on previous utilization). Evidence on the effectiveness of these government efforts is mixed, with Brown et al. (2014) arguing that selection actually worsened in the early years of this program, and Newhouse, Price, McWilliams, Hsu, and McGuire (2014) arguing that the program was ultimately successful in removing selection from Medicare Advantage. The Geruso and Layton paper in this symposium includes a detailed discussion of risk adjustment approaches.

The second approach to addressing adverse selection is through supply-side restrictions on the structure of the market. As an example, consider how policy should react to low-cost “limited network” plans that restrict the insured to lower-cost providers in return for a lower premium. These plans have proved enormously popular in general, and in particular on the state-based exchanges. Moreover, such plans can represent a useful cost-saving innovation, because the restrictions in provider choice can deliver substantial savings that can be passed on to the consumer. While there have been few studies, there are no documented significant costs to health care outcomes from these network restrictions; Gruber and McKnight (2016) find that the introduction of such limited network plans for public employees in Massachusetts led to significantly lower health expenditures with no adverse impact on care delivery.
However, Sheppard (2016) does find that limited network plans exacerbate adverse selection by excluding the providers who deliver care to the least profitable patients—who also tend to be the patients who place greater value on broader networks of providers with fewer restrictions. This finding raises a critical design tradeoff in setting “minimum standards for network adequacy among insurers”: higher standards for network adequacy will reduce the cost savings from narrow networks but will also reduce the risk that sicker enrollees are denied access to necessary providers.

A similar tradeoff arises in the contentious policy arena of setting minimum benefits standards for health insurance plans. Any publicly financed insurance plan must define what constitutes the “insurance” that it is being paid for, and there is broad agreement that such insurance should include physician and hospital care. But what about prescription drugs? Mental health? Maternity coverage? These services are vital to some populations, but not others.

In a world without selection, the question of which benefits to include in the minimum package is just a question of distribution. Including a richer set of minimum benefits will redistribute from nonusers of those benefits to users. For example, including maternity coverage in a minimum benefit set will reduce a gap in insurance prices that would otherwise exist between male and female enrollees. But with adverse selection, plans that include more generous benefits must be aware of the risk that they will attract heavier users of health care, which means that such plans may be overpriced or perhaps not be offered at all. A standard approach to this issue is to define a minimum set of benefits so that no one is left without “essential” services, but the definition of “essential” is highly sensitive and open to debate.

Addressing Choice Inconsistencies

As discussed earlier, there is a lively debate over the nature of consumer choice between insurance plans, which has often focused on results from Medicare Part D. To the extent that consumer choices are inconsistent, meaning that a number of consumers have a tendency to choose plans that are not most cost-effective for their personal needs, competition between private health insurance firms will not work effectively. There is as yet little work evaluating the consistency of choices in other health insurance environments such as Medicare Advantage, Medicaid managed care, and the state-based Affordable Care Act exchanges.

If future researchers tend to find that choice inconsistencies are rather widespread and lasting, what policies might be used to address them? Abaluck and Gruber (2016b) discuss this question in detail, using data on health insurance plan choice across roughly 250 school districts in the state of Oregon. They document significant choice inconsistencies in the health insurance decisions made by employees of these school districts and then model three alternative interventions designed to address these inconsistencies. First, government might require enrollees to re-enroll at regular intervals, thus pushing back against inertia and promoting more active choice. However, we find that this approach does nothing to improve the quality of choices. This conclusion is consistent with the finding noted
earlier, from Abaluck and Gruber (2016a), that those who switch to a new plan don’t choose any more consistently than they originally did. Second, government might provide better decision support to improve choices. However, randomized access to a decision support tool did not significantly improve choices because the recommendation from the decision support tool was often ignored. Third, government might restrict the number of choices, or the number of dimensions across which choices may vary. We find that with improvements in “choice architecture”—and in particular smaller choice sets—individuals make much better choices. This finding of an important role for choice architecture is demonstrated by the work of Ericson and Starc (2016) as well as others. This evidence and the policy implications are reviewed in the paper by Ericson and Sydnor in this symposium.

There is a relatively small but emerging literature raising the issue of whether seniors can choose appropriately across their various Medicare Advantage options. For example, McWilliams, Afendulis, McGuire, and Landon (2011) show that seniors were less likely to choose Medicare Advantage at all when they had more than 15 plans to choose from, and that elders with cognitive limitations were less responsive to benefit generosity across plans. Sinaiko and Zeckhauser (2016) show strong inertia in plan choice between Medicare Advantage and traditional Medicare.

Conclusion

The United States has been experiencing a radical transformation in the delivery of public health insurance that has largely flown under the radar. Policy discussions often treat public health insurance programs as a sort of government monopsony, whereas in fact the majority of enrollees in public insurance programs financed by the federal government are in private insurance plans funded by the government. The pace of this shift from public to private provision has been notable in recent years. In particular, the delivery of expanded health insurance through the use of state private insurance exchanges through the Patient Protection and Affordable Care Act of 2010 has added to the roles of publicly financed, privately provided insurance.

The existing experience with privatized delivery of public insurance has had successes and failures. There is clear evidence that care is delivered more efficiently under Medicare Advantage plans than under traditional Medicare, and the costs of the privatized Part D prescription drug benefit program were much lower than projected due to innovative insurer plan design. On the other hand, there is less clear evidence for efficiency in privatized Medicaid plans, and there is clear evidence of the problems that enrollees face making choices in this complicated environment.

How should policymakers evaluate this tradeoff? One certainty is that unfettered private choice is not optimal, and that, as demonstrated empirically by Ericson and Starc (2016), structuring choice can improve choice quality. Better risk-adjustment should also be incorporated in order to reduce incentives for private
insurers to compete over the health risk of their enrollees rather than the delivery of efficient care. In principle, with a sufficiently structured choice environment and proper risk adjustment, the productive benefits of choice can outweigh the allocative difficulties, particularly given the strong evidence for more efficient health care delivery by private Medicare Advantage plans.

Further expansion of the private choice-based model of public insurance is an ongoing subject of policy discussions. For example, one occasionally discussed possibility is that the entire Medicare system could be moved to a “premium support,” or defined contribution, model. Under this model, all Medicare enrollees would be entitled to a voucher amount that they could apply to choice from a set of private plans—and perhaps to a public plan as well (the so-called “public option”). Designing a choice-based model for delivery of public health insurance, and evaluating how it compares with a publicly provided alternative, requires addressing issues of adverse selection by private providers, choice inconsistencies by consumers, and the characteristics of competitive forces and government mandates in this setting.

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