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# Medicare Advantage: Better information tools, better beneficiary choices, better competition

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## EDITOR'S NOTE

This white paper is part of the USC-Brookings Schaeffer Initiative for Health Policy, which is a partnership between the Center for Health Policy at Brookings and the USC Schaeffer Center for Health Policy & Economics. The Initiative aims to inform the national health care debate with rigorous, evidence-based analysis leading to practical recommendations using the collaborative strengths of USC and Brookings.

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# Introduction

Since the 1970s, and codified in the Tax Equity and Fiscal Responsibility Act of 1982, Medicare beneficiaries have had the choice of receiving their Medicare benefits through private health plans instead of the traditional fee-for-service (FFS) Medicare program administered by the federal government. The policy thrust of private plan participation in Medicare is that competition can foster both better quality and lower costs. Today, 1 in 3 of the 57 million Medicare beneficiaries are enrolled in private health plans, known as Medicare Advantage (MA) plans.<sup>1,2</sup> Although growth in Medicare per capita spending has slowed in recent years, there is still a compelling need to improve quality and control costs as roughly 10,000 baby boomers a day age into Medicare coverage.

As beneficiaries continue to choose MA plans, the potential payoff of increased plan competition on both quality and price grows as well. There are two critical improvements that can help realize the potential of MA to offer higher-value care: 1) requiring competitive bidding in a transparent and understandable market based on quality and price (which will be addressed in detail in a forthcoming paper);<sup>3</sup> and 2) engaging and equipping beneficiaries to make more informed plan choices in a competitive market.

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<sup>1</sup> Jacobson, Gretchen, et al., Medicare Advantage 2017 Spotlight: Enrollment Market Update, Kaiser Family Foundation Issue Brief (June 2017).

<sup>2</sup> Of the 19.0 million people enrolled in Medicare Advantage plans in 2017, about 2.3 million are enrolled in Special Needs Plans (SNPs) that are restricted to people who are dually eligible for Medicare and Medicaid; have certain chronic conditions; or live in nursing homes or are at risk of being institutionalized. See Kaiser Family Foundation, Medicare Advantage Fact Sheet (October 2017) at <http://files.kff.org/attachment/Fact-Sheet-Medicare-Advantage>. Given special requirements to enroll in SNPs, they are outside the scope of this paper.

<sup>3</sup> A forthcoming paper—Enhancing Competition to Improve Medicare Advantage—provides a detailed proposal for introducing MA competitive bidding.

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## Better Decisions Require Better Information

Across the country today, the level of MA plan competition varies. Many aged and disabled beneficiaries have a wide choice of plans, with the average beneficiary in 2017 having access to 19 plans.<sup>4</sup> But the number of private insurers, along with the kinds of insurance products they offer, can vary significantly among urban, suburban, and rural markets. Despite frequently having a wide array of plan choices, only about 1 in 10 beneficiaries voluntarily switches plans each year.<sup>5</sup> Staying in the same plan year after year may mean that seniors are missing out on better deals—higher-quality plans, lower-price plans, or some combination of both.

However, because many seniors have multiple chronic conditions requiring frequent visits to physicians with whom they develop important relationships, determining if a senior's doctor or hospital is in a new plan's network may outweigh lower cost. Nonetheless, evidence suggests that many beneficiaries either stay in traditional Medicare or remain in the same MA plan because they are overwhelmed by the complexity of their choices, lack relevant and understandable information to make informed choices, and they fear making a costly error if they choose incorrectly.<sup>6</sup>

Helping seniors make more informed choices when selecting an MA health plan can potentially give them better value for their premium dollars and increase plan competition, saving money for taxpayers as well. While seniors could benefit now from better information, tools, and more assistance in choosing higher-value MA health plans, the importance of empowering beneficiaries to make more informed choices grows even more critical if competitive bidding reforms are enacted to harness market forces to increase value in the MA program.<sup>7</sup> Whether in the current or a competitive bidding context, better value means maintaining or improving quality, reducing premiums and decreasing seniors' out-of-pocket costs while allowing them to receive care from the doctor or hospital they want, and helping constrain overall cost growth in the health care system.

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<sup>4</sup> Jacobson, Gretchen, et al. Medicare Advantage Plans in 2017: Short-term Outlook is Stable. (December 2016). Retrieved from <https://www.kff.org/report-section/medicare-advantage-plans-in-2017-issue-brief/>

<sup>5</sup> Jacobson, Gretchen, et al. Medicare Advantage Plan Switching: Exception or Norm? (September 2016). Retrieved from <http://files.kff.org/attachment/Issue-Brief-Medicare-Advantage-Plan-Switching-Exception-or-Norm>

<sup>6</sup> Jacobson, Gretchen, et al. How are Seniors Choosing and Changing Health Insurance Plans? (May 2014). Retrieved from <https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8589-how-are-seniors-choosing-and-changing-health-insurance-plans.pdf>

<sup>7</sup> For example, the proposal put forward in The President's Budget for Fiscal Year 2017 (<https://www.whitehouse.gov/sites/default/files/omb/budget/fy2017/assets/budget.pdf>) or by the Bipartisan Policy Center (<http://bipartisanpolicy.org/library/health-care-cost-containment/>)

Along with a brief overview of Medicare Advantage, this paper examines:

1. Health insurance literacy;
2. The so-called paradox of choice, when too many choices overwhelm consumers;
3. Existing beneficiary information resources, including the online Medicare Plan Finder;
4. Provider network issues in plan choice; and
5. Quality as a choice factor.

The paper makes the following recommendations:

1. Expand health insurance literacy efforts to help seniors better understand basic concepts of insurance, risk and financial tradeoffs between premiums, and patient cost sharing at the point of service.
2. Make print and online information resources and tools more accessible, understandable, and user-friendly.
3. Assess whether seniors' access to one-on-one counseling, such as under the current State Health Insurance Assistance Program (SHIP), is sufficient.
4. Limit the number of MA plan offerings by any carrier to one offering at each of three benefit levels—standard, standard-plus, and enhanced—and standardize benefits to facilitate beneficiary comparison shopping on price and quality.

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## Medicare Advantage Overview

Current MA products are similar to each other in several respects. They must offer benefits that are at least as comprehensive as traditional Medicare and cover all Part A and Part B services. In addition, MA products must include a program-specified limit on out-of-pocket financial liability, something not required in traditional Medicare.

Unlike traditional Medicare, where all beneficiaries have the same benefits and cost sharing, MA plans' benefit designs can vary widely – on the generosity of extra benefits, the type and levels of cost-sharing, premium amounts, and provider networks. Sponsors of MA plans, which we refer to as Medicare Advantage Organizations, for example, Aetna, often offer multiple plan options within a local market.

Depending on each county's FFS Medicare spending and the efficiency of the plan's providers, MA plans can offer supplemental benefits, such as dental and vision coverage or reduced premiums for Part D prescription drug coverage. Alternatively, they may charge an additional premium to join a basic MA plan, to pay for prescription drug coverage, or in many markets, to cover enhanced benefits. In 2017, half of beneficiaries enrolled in an MA plan with prescription drug benefits are in a plan with no additional premium for coverage other than the standard Part B premium (including

no premium for the Part D coverage).<sup>8</sup> About 8 in 10 Medicare beneficiaries have access to such a \$0 premium MA plan with prescription drug benefits.<sup>9</sup>

MA plan cost-sharing arrangements may differ in a variety of ways:

- The FFS Part A Medicare hospital deductible (\$1,316 in 2017) may be replaced by a much lower per-admission or per-day copayment.
- The Part B deductible (\$183 in 2017) and 20 percent coinsurance may be replaced by a combination of smaller primary care physician and specialty physician copayments.
- Emergency department visits that are subject to the Part B deductible and coinsurance might be subject to only a single per-visit copayment.
- Copayments may be used for lab tests, advanced imaging, or other services.

MA plans must include a maximum out-of-pocket limit on beneficiary costs for covered services. In 2017, the limit could be no higher than \$6,700, which is the 95<sup>th</sup> percentile of out-of-pocket spending by seniors. Some MA plans offer lower out-of-pocket limits; in 2017, 48 percent of MA enrollees had an out-of-pocket maximum of \$5,000 or less.<sup>10</sup>

Although many of these combinations of different cost-sharing elements are regarded as improvements over the standard design for traditional Medicare, the variations can be confusing and make comparisons difficult. Like most consumers, many seniors are not well informed about the components of health care plan design, including deductibles, copayments, and coinsurance. And unlike traditional Medicare, where beneficiaries have almost unfettered choice of physicians, hospitals, and other providers, MA plans use provider networks to steer or limit beneficiaries, depending on the insurance product, to certain providers. Moreover, it can be difficult to determine whether some services are covered or whether a certain physician or other provider is included in an MA plan's provider network.

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## Health Insurance Literacy

Health insurance is among the most complex products that consumers buy, and making a bad choice can be costly from both financial and health standpoints. While there has been significant research about low U.S. health literacy, less research has focused on the American public's level

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<sup>8</sup> Jacobson, Gretchen, et al., Medicare Advantage 2017 Spotlight: Enrollment Market Update (June 2017). Retrieved from <http://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/>

<sup>9</sup> Jacobson, Gretchen, et al., Medicare Advantage Plans in 2017: Short-term Outlook is Stable, Kaiser Family Foundation Issue Brief (December 2016).

<sup>10</sup> Jacobson, Gretchen, et al., Medicare Advantage 2017 Spotlight: Enrollment Market Update (June 2017). Retrieved from <http://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/>

of health insurance literacy and their ability to select the best plan for their families' financial and health circumstances.<sup>11</sup>

Many Americans lack a grasp of common health insurance terms. A 2013 survey found that more than half of U.S. adults could not accurately identify at least one of three common health insurance terms: premium, deductible, and copay.<sup>12</sup> Another 2013 survey of Americans aged 22-64 found that while about 3 out of 4 Americans were confident they knew how to use health insurance, only about 1 in 5 could correctly calculate how much they owed for a routine doctor visit.<sup>13</sup> And a 2009 study of older Americans' understanding of health insurance terms and Medicare found that overall levels of health insurance literacy were low to moderate, with the oldest adults, those with lower education and income, and those in poorer health demonstrating lower levels of health insurance literacy.<sup>14</sup>

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## The Paradox of Choice

Compounding the challenges of understanding complex health insurance terms and concepts, many seniors face an overwhelming array of plans to choose from, which research shows can prompt consumers to default to no action, especially when the choices are complex.<sup>15</sup> Research specific to MA indicates that too many choices can be overwhelming and lead to suboptimal enrollment decisions.<sup>16</sup> Other evidence also suggests that too many insurance offerings can hinder competition in different markets.<sup>17</sup>

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<sup>11</sup> Quincy, Lynn, Measuring Health Insurance Literacy: A Call to Action, Consumers Union, University of Maryland College Park and the American Institutes for Research, Washington, D.C. (February 2012); and American Institutes for Research, Developing a Measure of Health Insurance Literacy: Understanding Consumers' Ability to Choose and Use Insurance, Washington, D.C. (Feb. 19, 2013).

<sup>12</sup> Cox, Jonathan B., Slepian, Mitchell. Half of U.S. Adults Fail "Health Insurance 101," Misidentify Common Financial Terms in Plans. *AICPA.org*. (August 28, 2013). Retrieved from <http://www.aicpa.org/press/pressreleases/2013/pages/us-adults-fail-health-insurance-101-aicpa-survey.aspx>

<sup>13</sup> Paez, Kathryn A., Mallery, Coretta J. A Little Knowledge is a Risky Thing: Wide Gap in What People Think They Know About Health Insurance and What they Actually Know. American Institutes for Research *Issue Brief*. (October 2014). Retrieved from ([http://aircpce.org/sites/default/files/11801-451-05\\_Issue\\_Brief\\_102014.pdf](http://aircpce.org/sites/default/files/11801-451-05_Issue_Brief_102014.pdf))

<sup>14</sup> McCormack, et al. Health Insurance Literacy of Older Adults. *The Journal of Consumer Affairs*, Volume 43, Issue 2. (June 2009) Retrieved from <http://onlinelibrary.wiley.com/doi/10.1111/j.1745-6606.2009.01138.x/full>

<sup>15</sup> Cherneva, Alexander, Ulf Böckenholt, and Joseph Goodman, "Choice Overload: A Conceptual Review and Meta-analysis," *Journal of Consumer Psychology*, Vo. 25, No 2 (April 2015).

<sup>16</sup> McWilliams, Afendulis, McGuire, and Landon  
<http://content.healthaffairs.org/content/early/2011/08/16/hlthaff.2011.0132.abstract>

<sup>17</sup> Abulack and Gruber, 2009. <http://www.nber.org/papers/w14759>

Limiting each Medicare Advantage Organization (MAO) to offering up to three products, which differ by richness of benefits, in each rating region would simplify beneficiaries' choices. By standardizing benefits to some degree, seniors could focus on premium, provider network, and quality ratings. Evidence has shown that more standardized insurance products can make consumer choice easier and increase consumer welfare.<sup>18</sup> To still allow for broad consumer choice, however, one of each MAO's plan offerings in a region could be allowed wide latitude in their benefit structure.

Thus, the 20 or more products available in some regions might decrease to 12. For example, if four MAOs offered plans in a county and the number of product offerings was constrained to three major levels (standard, standard-plus, and enhanced).<sup>19</sup>

## **STREAMLINING MA PLAN DESIGN TO FOSTER COMPETITION**

As detailed in a forthcoming paper, we propose limiting each MAO to a maximum of three plans in an area, offering standard, standard-plus, and enhanced benefits. As a national average (which might vary regionally, based on differences in costs), the standard benefit could potentially have an actuarial value of 105 percent of the traditional Medicare value. It would conform closely to the traditional Medicare benefits and cost-sharing available to FFS beneficiaries, but it would add an out-of-pocket maximum that is now required under MA. In addition to being the lowest cost MA plan, it would provide a consistent basis for competitive bidding if pursued (since every MAO would be required to offer this benefit package) as well as offering beneficiaries the option of cash rebates to lower applicable Part B and Part D premiums.

The standard-plus benefit could then have an average actuarial value of 108 percent of the traditional Medicare benefit, with CMS specifying approximately 5 percentage points of the increased actuarial value as in the standard plan, leaving MAOs the flexibility to apply the remaining increment of increased actuarial value (e.g., 3 percentage points) to other improvements such as converting coinsurance to copayments for selected physician services (e.g., a \$10 copayment for all primary care visits) or reducing deductibles. Beneficiaries could readily compare differences in benefits among standard and standard-plus plans.

Enhanced plans would give MAOs greater flexibility to innovate, offering non-standard additional benefits over and above the features common to standard plans and those offered by an MAO in its standard-plus plan. MAOs would have to provide actuarial justification for the increases in expected per member per month costs associated with the standard-plus and enhanced plans, compared to their bids for the standard plan. CMS would have the authority to reject any proposed enhanced benefit product that they judge would induce biased selection by enrollees. Regardless of the plan level they select, MA enrollees would also remain prohibited from purchasing supplement Medigap insurance policies, just as they are under current law.

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<sup>18</sup> Ericson and Starc, NBER, <http://www.nber.org/papers/w19527>

<sup>19</sup> Jacobson, et al. Medicare Advantage Plans in 2017: Short-term outlook is stable. (December 21, 2016). Retrieved from <http://kff.org/report-section/medicare-advantage-plans-in-2017-issue-brief/>



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## Existing Information Resources for Medicare Beneficiaries

To harness market forces to increase value, seniors must be able to make an informed choice among the options available to them. To do that, there needs to be more information provided in a format that is accessible to seniors and better tools to assist them in making these choices on a more informed basis.

The Balanced Budget Act of 1997 created the National Medicare Education Program (NMEP) to educate beneficiaries through a variety of materials and resources, including the Medicare & You handbook and other printed materials, comparative MA plan and Part D information through the Medicare Plan Finder at the Medicare.gov website, the Medicare Compare database, toll-free telephone assistance, and a national open enrollment campaign each fall.

### COUNSELING SERVICES

The NMEP also enlists advocacy groups, governmental organizations, employers, providers, and others to assist beneficiaries in learning about their benefits and choices. The State Health Insurance Assistance Program (SHIP) is a free health benefits counseling service for Medicare beneficiaries. There are about 15,000 SHIP counselors across the country and almost 60 percent are trained volunteers. In 2013, \$51.9 million was spent on the SHIP program, which provided one-on-one counseling to more than 2.6 million of the 52.5 million Medicare beneficiaries at a cost of less than \$20 per beneficiary served.<sup>20</sup>

Certain state-run insurance markets, such as Covered California, devote considerably more resources on a per person basis for marketing and outreach, due to their perception of the value these activities have to help beneficiaries make better choices and foster competition. Given that net Medicare spending is nearly \$600 billion annually and spending on MA is about \$200 billion, \$50 million may be an inadequate investment in empowering beneficiaries to be engaged consumers and smart shoppers in a competitive MA market.

### A CLOSER LOOK AT THE MEDICARE PLAN FINDER

To harness market forces to increase value, seniors must be able to make an informed choice among the options available to them. To do that, seniors need to have more information provided in an accessible format and better tools to assist them in making these choices on a more informed basis.

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<sup>20</sup> Paez, Kathryn, Jennifer Lucado, and Deepa Ganachari, Medicare Complexity Taxes Counseling Resources Available to Beneficiaries, Issue Brief, Center on Aging at the American Institutes for Research (October 2016). <http://aircpce.org/sites/default/files/COA-IssueBrief-Counsel-508.pdf>





The main tool for seniors choosing MA plans is the Plan Finder on the Medicare.gov website. It permits three separate sets of comparisons: MA products without Part D prescription drug coverage, MA products with Part D benefits, and standalone Part D plans. Plan Finder also permits comparing MA benefit offerings with traditional Medicare. Seniors and disabled Medicare beneficiaries can customize Plan Finder by entering their prescription drugs and dosages and by selecting from the following options:

- Limiting monthly plan premium
- Limiting annual drug deductible
- Having limits on drugs or whether drugs used are on the formulary
- Star ratings for plan quality comparisons
- Coverage options (nationwide or “any doctor” who accepts Medicare)
- Whether eligible for Special Needs Plans (e.g., seniors eligible for both Medicare and Medicaid)
- Health status (poor, good, excellent)
- Selecting plans by company

The Plan Finder provides the following information about each plan (see Exhibit 1):

- Estimated annual drug costs—for drugs entered by the respective senior— including monthly premiums, annual deductible, copayments/coinsurance, and drug costs not covered by prescription drug insurance
- Monthly premium (broken out for both drug and health plan)
- Annual deductible and copayments/coinsurance for drug and health plan—in a very limited manner
- Health benefits for:
  - Doctor choice (any doctor vs. plan network doctor)
  - Out-of-pocket spending limit
- Drug coverage/drug restrictions, like formularies, and whether the plan offers medication therapy management services
- Estimated annual health and drug costs, plan benefits (coverage), costs for premiums, copayments, deductibles, coinsurance, and costs not covered by insurance for seniors in the three health categories
- Overall star (quality) rating

## Exhibit 1: Medicare.gov Plan Finder

Compare Plans 						
Sort Results by <span>Lowest Estimated Annual Health and Drug Cost</span>  <span>Sort</span> 						
 <b>Erickson Advantage Freedom (HMO-POS) (H5652-006-0)</b>  Organization: UnitedHealthcare						
Estimated Annual Drug Costs: [?]	Monthly Premium: [?]	Deductibles [?] and Drug Copay [?] / Coinsurance: [?]	Health Benefits: [?]	Drug Coverage [?], Drug Restrictions [?] and Other Programs:	Estimated Annual Health and Drug Costs: [?]	Overall Star Rating: [?]
<b>Retail</b> Pharmacy Status: Standard Cost-Sharing Annual: \$584 <b>Mail Order</b> Annual: \$546	\$46.00 Drug: \$45.50 Health: \$0.50 <b>Part B Premium [?]: No</b>	Annual Drug Deductible: \$0 Health Plan Deductible: \$0 Drug Copay/Coinsurance: \$5 - \$85, 33%	Doctor Choice: Plan Doctors Only (some exceptions) Out of Pocket Spending Limit: \$3,400 In-network 	All Your Drugs on Formulary: <b>Yes</b> Drug Restrictions: <b>Yes</b> <b>Lower Your Drug Costs</b> MTM Program [?]: <b>Yes</b>	\$3,490	 This plan got Medicare's highest rating (5 stars)
 <b>University of Maryland Health Advantage Complete (HMO) (H8854-001-0)</b> Organization: University of Maryland Health Advantage						
Estimated Annual Drug Costs: [?]	Monthly Premium: [?]	Deductibles [?] and Drug Copay [?] / Coinsurance: [?]	Health Benefits: [?]	Drug Coverage [?], Drug Restrictions [?] and Other Programs:	Estimated Annual Health and Drug Costs: [?]	Overall Star Rating: [?]

Source: Medicare.gov/find-a-plan

The Plan Finder summary page provides technical information that may be difficult for many seniors to understand. Plan options can be sorted by several criteria, including premium and lowest estimated annual health and drug costs.

Seniors are consumers with a mixture of different preferences and life circumstances. In particular, health status is a major dimension for seniors to consider when choosing what type of coverage makes the most sense for them. Currently, the Plan Finder tool uses three levels of health status: poor, good, and excellent health. This dimension can be readily self-reported by seniors and used as an input in determining their likely average out-of-pocket costs during a year.

Other dimensions like attitudes concerning financial risk and willingness to change providers are more difficult to ascertain. But indicators of these dimensions would be difficult to make feasible. The Plan Finder also does not display out-of-pocket costs specific to where that beneficiary lives.

Another important factor is promoting seniors' understanding of the terms used by MA plans, given the relatively low health insurance literacy of consumers discussed previously. Experts have developed guidelines for health plan comparison tools and what comprehension level and language is best understood by seniors of various ethnic groups.<sup>21</sup>

<sup>21</sup> What's Behind the Door: Consumer's Difficulties Selecting Health Plans. Consumers Union. Health Policy Brief. (January 2012). Retrieved from

However, it is unclear, what, if any, consumer testing has been done to improve the usability of the Medicare Plan Finder tool. According to a recent study, SHIP counselors report that while they find the Plan Finder tool useful in helping seniors identify appropriate MA and Part D plans, beneficiaries have great difficulty using the tool unassisted.<sup>22</sup>

What also is missing is any “natural language” processing (NLP) where a senior could type—or speak using an oral language processing program—questions in a more normal manner of speaking. As an example, both Apple (Siri) and Amazon (Alexa) use artificial intelligence assistants that can understand spoken questions and find relevant answers. While many newly retired seniors have used computers for their work and may be familiar with these types of searches, many older seniors may not have this skill.

This raises another issue: To what degree should seniors be expected to rely on computer tools and software vs. one-on-one counseling, whether via telephone or in person? Computer tools may be less effective, particularly for older beneficiaries, but counseling is more expensive to provide. The current system relies predominantly on computer tools.

Another criticism of the Plan Finder tool is that the calculation of annual out-of-pocket costs—aside from premiums—is obscure to users. While it is useful to have a simple way to indicate health status—poor, good, excellent—this simplified criterion may not provide sufficient clarity to seniors who seek to project their costs for specific needs, especially if they have one or more chronic conditions.

An added feature that would ask seniors to enter their chronic conditions—perhaps from a drop-down box or spelling out common conditions that have relatively predictable care needs—could be more useful. Adding detail to the kinds of services normally used by seniors with these conditions also could help beneficiaries better understand what their likely costs would be by incorporating more tailored information.

However, coding for these kinds of complex conditions and interactions might be a challenge, although CMS is now offering better access to its whole database of traditional Medicare claims data. Thus, it seems feasible to create illustrative expected “episode costs” that can be tailored to seniors of a certain age in a region with some group of chronic conditions. While incorporating more chronic condition information might lead to further risk segmentation among seniors, CMS has successfully operated a risk adjustment program for over 12 years that moves funds to plans that can demonstrate that they have a disproportionate share of enrollees with more costly conditions.

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<http://consumersunion.org/pub/pdf/Consumer%20Difficulties%20Selecting%20Health%20Plans%20Jan%202012.pdf>

Health Plan Comparison Tools in Exchange. Consumers’ Checkbook Center for the Study of Services. Retrieved from <http://www.checkbook.org/exchange/Health%20plan%20comparison%20tool--best%20practices%20recommendations.pdf>

<sup>22</sup> Ibid.

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## Provider Network Issues in Plan Choice

Another important aspect of plan choice for seniors is whether their current physician or hospital is included in the MA plan provider network. Currently, available sources related to provider networks are limited, may be difficult to access, or have incomplete or out-of-date information. As discussed previously, Medicare's Plan Finder only has a fairly vague reference to whether "any doctor" is included for original FFS Medicare or a preferred provider organization (PPO), or whether a doctor must be chosen from the plan's list, typically, a health maintenance organization (HMO). That is not particularly helpful to beneficiaries who are looking for a specific health care provider.

In most cases, a senior (or other consumer) is referred to a MA plan's website to determine whether a hospital or doctor is included in the network. Plans attempt to keep their websites current, but physicians and medical groups frequently change their participation with health plans. Physician contracts with plans tend to run until one party wants to make a change. And with greater activity of health systems in purchasing physician practices, contract changes are common in many areas. Consideration should be given requiring providers to give MA plans three months' notice of their intentions to end participation and requiring plans to add such information to their directories within one month. A similar requirement for plans to give providers notice—except in cases of fraud and abuse—should also be considered.

Plans could make additional efforts to query physicians and update web-based provider directories more frequently, but likely have already picked the "low-hanging fruit." In short, there is a great need for much better and more current—real-time—tools to help seniors determine whether their providers are included in various MA plan provider networks.

Other options to consider incorporating into the Plan Finder include a question about a senior's preference between lower premiums—for example, lower premiums and cost sharing for narrow networks of physicians or hospitals—and size of provider network or availability of specialists. Another aspect to include might be distance from the beneficiary's home to specialists or the desired hospital facility. In some areas, this dimension might be better expressed in driving time rather than physical distance, since in many urban areas, traffic congestion may mean that getting to a contracted facility within, say 10 miles, may be on the other side of a bridge that creates an hour-plus travel trip to the facility. Commercial geo-mapping programs (such as "Google Maps") already provide this functionality in other settings.

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## Quality Measurement as a Choice Factor

Many organizations are attempting to provide consumer-friendly quality performance ratings of health plans and providers. Medicare uses a 5-star rating system—5 stars is the highest quality

award—to measure the performance of MA plans on such dimensions as quality of care and customer service. While the Medicare Plan Finder incorporates star ratings into the plan selection process, interestingly, the word “quality” is not included in the initial description, leaving users to infer that the ratings are related to quality or drill down a level to get a fuller explanation of the rating system.

The star rating system encourages plans to improve their performance by giving plans that score an overall 4 stars or higher a 5 percent payment bonus. Medicare also allows beneficiaries to switch to a 5-star plan any time during the year—not just during the regular fall Medicare open-enrollment period.<sup>23</sup> And 5-star plans receive a special star symbol on the Plan Finder tool noting their high performance.

In contrast, if a plan earns only 1 or 2 stars for three years in a row, the Plan Finder tool flags the plan as low performing and prohibits beneficiaries from enrolling online—they can still enroll but must call the plan directly. These plans also are designated with a special symbol that looks like a caution sign; an upside-down red triangle with an exclamation point inside of it. Additionally, if beneficiaries are enrolled in a plan that gets 1 or 2 stars for three years in a row, Medicare mails them a letter to make them aware of the plan’s poor performance.

While the Plan Finder tool offers beneficiaries useful information by calling out both high and low performers, the reality is that most plans are clustered in the area from 3.5 stars to 4.5 stars. To some, this may indicate that the star rating system may be of limited use to many beneficiaries. Others might interpret this as a sign of success of these ratings—that many poorly rated plans have either improved to get into this range or dropped out of the MA market.

Work on better quality measures continues by many organizations, including the National Quality Forum, the National Committee for Quality Assurance, and others. This work and its usefulness to seniors should be closely monitored over the next five years to determine how to best make use of it.

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## Implications and Recommendations

Growing evidence suggests that educating and helping consumers to become more knowledgeable about health insurance and more comfortable in making choices among various product offerings can foster health plan competition in both quality and cost dimensions. However, the complexity of health insurance terms and benefit designs, coupled with American’s low levels of health insurance literacy, make this a formidable challenge, particularly for Medicare beneficiaries.

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<sup>23</sup> 5-star special enrollment period. Medicare.gov. Retrieved from <https://www.medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/five-star-enrollment/5-star-enrollment-period.html>

As more beneficiaries opt to enroll in MA, there is a growing need to improve information tools and assistance to beneficiaries to help them make more-informed decisions about their coverage, which in turn will generate more competition on price and quality among plans. The following recommendations offer an outline of how to help empower beneficiaries to make choices that will not only benefit them but the larger health care system as well.

1. Develop tools that can help beneficiaries understand how the various components of health insurance, such as deductibles, coinsurance, and copayments, interact and how they can balance tradeoffs between higher and lower premiums vs. higher and lower cost sharing at the point of service vs. narrower and broader choice of providers.
2. Invest in and improve consumer-support tools, like the online Plan Finder, for both MA plans and Part D prescription drug plans. Although the Plan Finder can be helpful, many seniors find the tool difficult to use or lacking in detailed information. Enhancing the ability of natural language processing software tools to better understand questions—for example, Siri for Apple users or Alexa for Amazon—and providing more real-world examples of common situations and tradeoffs seniors face when choosing and enrolling in a plan would be valuable. Other enhancements include adding functionality to the Plan Finder tool so that seniors can list their chronic conditions or choose from a drop-down box that would improve the accuracy of estimated costs and differences among plan options, and also list where they live.
3. Assess whether counseling programs are effective in improving consumer decisions. Currently, a relatively small number of beneficiaries use SHIP, and it is unclear why. Assessing whether greater access to one-on-one counseling for beneficiaries is needed is an important first step in helping them make better use of existing information resources and tools.
4. Standardize the types and number of MA product offerings, constraining them to three levels—standard, standard-plus, and enhanced—to facilitate beneficiary comparison-shopping on price and quality. That is, in each region, each MAO could offer three products: a standard benefits option (which every MAO participating in a region would have to offer and would have the same plan design), a standard-plus benefits option, and an enhanced benefits option.



The USC-Brookings Schaeffer Initiative for Health Policy is a partnership between the Center for Health Policy at Brookings and the USC Schaeffer Center for Health Policy & Economics, and aims to inform the national health care debate with rigorous, evidence-based analysis leading to practical recommendations using the collaborative strengths of USC and Brookings.

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