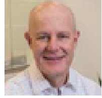
THIRD WAY

REPORT *Published August 19, 2015 • 21 minute read*

Give Medicare Beneficiaries Complete Information About Their Plans



David Kendall
Senior Fellow for Health and Fiscal Policy
@DavidBKendall

Jacqueline Garry Lampert

Like millions of Americans, Mary is worried about managing her Type 2 diabetes—particularly about controlling her cholesterol and lowering her risk of developing coronary heart disease. But she cannot find reliable information on how well her current doctors, who are in original, fee-for-service Medicare, are helping patients just like her. That's because original Medicare doesn't track these quality measures or provide consumers with effective information.

While original Medicare leaves patients in the dark, Medicare Advantage plans are required to disclose objective ratings based on their quality of care. Mary can simply go to Plan Finder—an online portal that compares plans that offer prescription drug coverage including Medicare Advantage plans—to find plans in her area rated highly for cholesterol screenings for people with diabetes. She may find that some of these plans offer her someone who will help schedule her medical appointments, coordinate her care, and find additional support services within her community. This will help Mary choose a plan whose members are getting the recommended care for diabetes, including care that lowers her risk of heart disease. If original, fee-for-service Medicare were required to provide the same consumer-friendly, comparative-quality information as Medicare Advantage, Mary could make informed decisions about *all* the plans available to her, so she could choose the right coverage for her and her health condition. This would make her happier and healthier. Along with a new enrollment process for Medicare beneficiaries described in a separate Third Way Idea Brief, this effort would produce federal savings of $57.3 billion over 10 years. [1]

This idea brief is one of a series of Third Way proposals that cuts waste in health care by removing obstacles to quality patient care.

This approach directly improves the patient experience—when patients stay healthy, or get better quicker, they need less care. Our proposals come from innovative ideas pioneered by health care professionals and organizations, and show how to scale successful pilots from red and blue states. Together, they make cutting waste a policy agenda instead of a mere slogan.

What Is Stopping Patients From Choosing The Right Medicare Plan?

There are three main obstacles preventing beneficiaries from choosing the right Medicare plan for their needs: 1) Inadequate quality assessments from fee-for-service Medicare plans, 2) overly complicated (and sometimes conflicting) quality assessments for Medicare Advantage plans, and 3) no way to estimate the complete financial impacts of different health plan choices.

1. Inadequate quality assessments from fee-for-service plans.

Medicare beneficiaries do not have a clear way of knowing about the quality of care provided in the original, fee-for-service Medicare program. In contrast, Medicare Advantage plans receive a star rating based on their quality of care and their customer satisfaction. After adopting the quality rankings for Medicare Advantage plans, Congress has never gone back to requiring the same for original, fee-for-service Medicare. The lack of this information is especially striking on Medicare's Plan Finder. This online comparison tool provides an overall star rating for each Medicare Advantage plan and prescription drug coverage plan (Part D). Beneficiaries can view plan star ratings on specific quality measures that may be of personal interest (such as cancer screening), help with managing chronic conditions, and customer service. But Plan Finder does not provide similar information about original Medicare. [2]

This omission is likely due to the origins of Medicare. Medicare was not conceived as an organized system of care when it was enacted in 1965. At that time, it was a single, public health plan that paid for health care with a fee for every service plus supplemental coverage from private health plans, also known as Medigap. But, today, 30% of Medicare beneficiaries are enrolled in a Medicare Advantage plan that combines the coverage of original Medicare and supplemental coverage, which provides lower cost sharing and other benefits not covered by original Medicare. Virtually all Medicare beneficiaries, no matter where they live, can choose between Medicare Advantage and original Medicare. [3] On average, they have 19 choices including original Medicare. [4] Those choosing original Medicare have an additional 30 choices, on average, for Part D prescription drug plans and a multitude of choices for supplement medical coverage. [5] That is awfully complicated.

The plan one chooses has consequences for the quality of care one receives. Nationally, the quality of care (based on current, but limited, research) can be higher in Medicare Advantage plans compared to original Medicare according to Harvard professors Joseph Newhouse and Thomas McGuire. [6] Still, original Medicare has been doing much to improve its quality, winning bipartisan support for improving care while lowering costs. Starting with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and continuing with the Affordable Care Act, Congress has given Medicare Administrators broad authority to roll-out successful innovations. [7] However, by not requiring the original Medicare plan to report on its overall performance as a plan, beneficiaries are kept in the dark about one of the most important choices they will make concerning their health and well-being.

Medicare beneficiaries should know what they are getting when they enroll in original Medicare. While Medicare does provide quality reports on individual providers (like Hospital Compare), research indicates that a single indicator of quality —one that is easy to understand and process—is critical in

helping consumers make smarter health care choices. [8] When this information is aggregated in a consumer-friendly way, like the star ratings for Medicare Advantage and Part D plans, consumers can avoid information overload when trying to process the material. [9]

2. Overly complicated (and sometimes conflicting) quality assessments for Medicare Advantage plans.

As both public and private payers tie reimbursement to health care quality, the number of programs requiring quality data submission and quality measures has dramatically increased. [10] Rising use of quality measures is a welcome development, but the lack of coordination across public and private payers, and among public quality measurement programs, has created a significant burden on providers—and confusion for patients. For example:

- Quality reporting requirements vary even within programs managed by the Centers for Medicare & Medicaid Services (CMS), such as the Physician Quality Reporting System (PQRS), Physician Value-based Payment Modifier, the Shared Savings Program for Accountable Care Organizations, and the Electronic Health Record Incentive Programs. [11]

- Hospitals report that measures, definitions, and requirements vary across different quality reporting programs with limited coordination between federal, state, and local reporting programs. [12]

Public and private initiatives, such as the Office of the National Coordinator for Health Information Technology's (ONC) Health eDecisions Standards and Interoperability Initiative, the Health Resources and Services Administration's (HRSA) Measure Management Review Board, the Department of Health and Human Services' (HHS) Measurement Policy Council, and the Buying Value initiative in the private sector, aim to develop common performance

measures, standardize and align reporting requirements, and generally reduce the reporting burden on providers. [13] While the enactment of the permanent "doc fix" legislation has the potential to simplify reporting requirements, CMS will need to ensure that the multiple simplification efforts do not create new complexities.

Also, quality measurement is too often reliant on clinical process measures, which are, in some cases, only weakly correlated with outcomes—perpetuating the problem of volume over value in original Medicare. [14] For example, Medicare currently requires cardiologists to report on how often they evaluate the pumping action of the lower left chamber of a patient's heart even though that evaluation does not make any difference in whether the patient survives heart disease. [15]

3. No way to estimate the financial impacts of different health plan choices

Beyond quality information, beneficiaries cannot adequately compare their total costs of original Medicare (and accompanying Part D and Medigap plans) with their costs under a Medicare Advantage plan. The CMS Medicare Plan Finder permits the comparison of original Medicare, Part D prescription drug plans, and Medicare Advantage plans. [16] However, it does not combine the costs of original Medicare with a Part D plan when comparing to a Medicare Advantage plan that provides prescription drug coverage. In addition, Plan Finder does not include Medigap plans, which are purchased by 26% of original Medicare beneficiaries nationwide. [17]

Medicare Plan Finder also only allows the comparison of three plans at a time. This is inadequate. This means that a beneficiary could only compare, for example, original Medicare, one prescription drug plan, and one Medicare Advantage plan. While limiting comparisons does help to reduce choice overload, it is difficult to make a decision while looking at options in sets of three choices. Furthermore,

when beneficiaries can't see the total cost of health care, they may be less motivated to make a choice, which reinforces status quo bias—which explains the tendency for people to accept things as they are and avoid making new decisions. [18] Very few Medicare beneficiaries switch plans annually despite the fact they could get better coverage at lower costs. [19]

Where Are Innovations Happening?

The lesson from places that have tested consumer behavior with Medicare quality ratings is that quality matters. When options are made clear, beneficiaries are more likely to choose plans that offer high quality at an affordable price. In other words, they choose value.

For example, CMS announced that 60% of Medicare Advantage enrollees are in plans with four or more stars for 2015, an increase of about 31% from 2012 enrollment levels. [20] A recent study found that star ratings drive enrollment decisions for both first-time enrollees and for beneficiaries who switch plans. [21] For first-time enrollees, a 1-star increase in a plan's rating was associated with a 9.5 percentage point increase in the likelihood of enrollment. For a beneficiary facing a choice of 14 plans (the median for this sample), likelihood of enrollment in a particular plan increased from 7.1% to 16.6% with a 1-star higher quality rating. For beneficiaries switching plans, a 1-star increase in quality rating was associated with a 4.4 percentage point increase in the likelihood of enrollment. Notably, a plan with a star rating at least as high as the beneficiary's current plan was associated with a 6.3 percentage point increase in the likelihood to enroll.

Another study focused on the influence of cost and quality data presentation on consumer provider choices found that most respondents were open to making high-value choices, and the presentation of easily understood quality information increased the likelihood that respondents would make the high-value choice. [22] When respondents were presented with

specific cost information (an actual dollar amount) but no quality data, 80% chose the high-value option. [23] That rate rose to 90% when a strong quality signal was provided. Notably, respondent confidence in provider choice increased when the quality signal was strengthened. [24]

An online service, eHealth, has assembled much of the critical information to assist Medicare beneficiaries in comparing coverage choices on its website, eHealthMedicare.com. Here, beneficiaries may compare up to four Medicare Advantage, Medigap, or Medicare Part D prescription drug plans. Notably, when comparing Medicare Advantage or Medigap plans, eHealthMedicare.com automatically includes comparable premium and cost-sharing information for Medicare on the same screen, providing beneficiaries with a more complete picture of their potential financial obligations. However, the site does not provide the beneficiary's total cost—for example, by adding original Medicare and Medigap premiums together—and does not allow comparison of Medicare Advantage and Medigap plus original Medicare on one screen. Another drawback is the disclaimer indicating that eHealthMedicare.com does not provide a complete list of plans available in a beneficiary's service area. Enrollment for many plans is available online and for all plans via phone.

How Can We Bring Solutions To Scale?

Congress should make the two main parts of Medicare—original Medicare as well as Medicare Advantage—comparable for consumers based on quality ratings. Here are five keys steps for policymakers to do that, while reducing the reporting burden on providers from new quality measures:

1. Congress should improve the star rating system for Medicare Advantage plans.

Changing the quality measures that go into the star-rating is an important first step to ensure the best possible foundation before expanding them into original Medicare. This change

will focus quality ratings on outcomes, rather than care processes.

This proposal draws on an idea under consideration by the Medicare Payment Advisory Commission (MedPAC).[25] MedPAC offers a number of examples of these types of measures, including potentially preventable hospital admissions, potentially preventable emergency department visits, hospital readmission rates, mortality rates after hospital admission, healthy days at home, and patient experience measures.[26] While several of these measures focus on provider quality, the results would be aggregated at the Medicare Advantage plan level, within a geographic area, to provide a picture of the quality of care received by plan members. MedPAC analysis indicates that at least two of these measures (potentially preventable admissions and potentially preventable emergency department visits) can be calculated using Medicare claims data, which would reduce the reporting burden on providers.[27] At the same time, it is important to develop and rely on quality measures that plans can directly improve upon like the Healthcare Effectiveness Data and Information Set (HEDIS) outcome measures. Similarly, some quality measures such as long-term mental health status should be excluded from the star ratings when they do not differentiate the quality of care between plans.

Another improvement is to fix a problem with the Medicare Advantage star rating system that discourages health plans from providing the best care for the sickest patients. Some health plans are concerned that the star rating system does not account for plans that serve a higher number of dual-eligible members (also called "duals"), who are eligible for both Medicare and Medicaid.[28] These members have higher rates of chronic disease, disability, and mental illness. They need more resources in order achieve the good results. At the same time, some consumer groups are concerned that adjusting star ratings for plans that have more duals would effectively lower the bar for taking care of lower income beneficiaries.[29]

In order to make the star ratings fair and encourage health plans to provide the best care for everyone, their star rating should be higher when they do well serving a greater number of dual eligible members to the extent the health plan deserves credit for doing so. [30] One way to fix this problem in short-term is for CMS to look at plans' performance on quality indicators that apply particularly to duals (like diabetes care) and increase their star rating if their performance is higher than other plans serving similar levels of dual eligible members. This approach would be similar to the way that the patient satisfaction surveys are adjusted for demographic characteristics like low-income subsidy or dual status eligibility. [31] In the long-run, CMS should convene all of the key stakeholders for help in developing better adjustments to star-ratings that account for differing levels of difficulty in patient care for each plan, known as a case-mix adjuster.

A final improvement to the quality measurements would be to have a more strategic and stable approach to changing star ratings. The Centers for Medicaid and Medicare Services could plan out the introduction of new quality measures or changes to existing measures so that they leverage quality improvements with the largest potential impact on a patient's health. Such a strategic approach should also allow plans more time to prepare for new measures than under the current approach. The star ratings would be more stable if CMS would finalize the quality measures before the measurement period begins each year and set clear terms for achieving a high star rating on each measure, such as retaining the four-star thresholds. As part of improving the overall star rating process, CMS should consider engaging a wide range of stakeholders through an annual formal public comment period, with a 60-day comment period (or longer), for both long-term and short-term changes in the quality measures.

2. Congress should apply quality measures from Medicare Advantage to original Medicare.

Original, fee-for-service Medicare should report on its quality of care as a plan (within a geographic area) and receive a star rating like Medicare Advantage plans. Original Medicare's star rating should be displayed for beneficiaries in Medicare's Plan Finder, alongside Medicare Advantage plan choices and star ratings. By making original Medicare accountable for its quality of care, Medicare will continue to evolve from simply being a bill payer to becoming an entity that manages risk and assumes accountability for beneficiary health outcomes. CMS will need to do a thorough review of exactly which components of the star ratings can be adopted quickly and which will need additional time for development and review.

This proposal is related to an idea advanced by MedPAC to calculate Medicare fee-for-service quality results in order to compare them to Medicare Advantage in a defined geographic area. [32] MedPAC proposes to use the new population-based outcomes measures both for public reporting and for making payment adjustments to Medicare Advantage plans and accountable care organizations (ACOs). [33] The focus of our proposal, however, is simply to make the quality comparison between original Medicare and Medicare Advantage clear to beneficiaries.

As MedPAC notes, this proposal will require an accompanying policy change in that Medicare and Medicare Advantage quality reporting would need to occur at the same geographic level and at a level that is meaningful to beneficiaries. [34] Currently, Medicare Advantage plans report quality measures at the contract level, which may span large geographic areas containing multiple, distinct health care markets. Moreover, each contract can include multiple kinds of options offered by a plan that may have different quality results.

Congress should direct Medicare to establish smaller quality collection and reporting for geographic areas that relate to the areas in which beneficiaries make plan choices as long as the results were statistically reliable for the smaller areas and account for differences in service areas between plans. The state level would be too broad and would not account for local

differences. Plus, not all Medicare Advantage plans are statewide. County-level data would not necessarily correspond to provider service areas. Metropolitan Statistical Areas (MSAs) might be a suitable set of boundaries. For assessing Medicare Advantage plans, MSAs also make sense except where they cross state lines, because health plans are state-regulated and their operations are often state-based. Only within the District of Columbia MSA would a cross-MSA region be fully justifiable due to the tradition of health plans' operations crossing state boundaries. Medicare Part D plan regions would also require adjustments to make true apples-to-apples comparisons.

3. Congress should ensure that consolidating provider quality measures reduces the reporting burden on providers.

The 2014 bipartisan, bicameral "doc fix" included a provision to consolidate three existing quality incentive programs into one incentive payment. [35] Under the merit-based incentive payment system (MIPS), certain providers paid under the Medicare physician fee schedule would receive an annual payment adjustment based on their performance. MIPS would consolidate quality reporting and incentives now contained within the Physician Quality Reporting System, the Value-Based Payment Modifier, and electronic health record meaningful use standards. As CMS implements this new law, Congress should use its oversight powers to help make sure the reporting burden on providers gets easier.

In another initiative, CMS has recently offered eligible professionals participating in the Physician Quality Reporting System (PQRS) a new reporting mechanism via a qualified clinical data registry (QCDR). [36] A QCDR could be an existing registry, certification board, or other similar entity that collects medical and/or clinical data for the purpose of quality improvement. [37] Ideally, eligible professionals are already submitting quality data on patients across multiple payers, not just Medicare beneficiaries, to the QCDR. Under this new

initiative, the QCDR then provides this multi-payer data to CMS to satisfy the eligible professional's PQRS reporting requirements. By meeting certain requirements, eligible professionals can use this reporting avenue to earn a 2014 incentive payment and avoid the 2016 payment adjustment.

4. CMS should overhaul the Medicare Plan Finder in order to provide accessible cost and quality information to inform beneficiary enrollment decisions.

Specifically, Medicare Plan Finder should include original Medicare's new star rating to facilitate direct quality comparison between original Medicare and Medicare Advantage. Plan Finder should also permit beneficiaries to view their total cost of care on one screen whenever possible. For a beneficiary who elects original Medicare, this would include the Part B premium and deductible as well as the premium, deductible, and copay/coinsurance structure for the prescription drug plan they elect and the premium for the Medigap plan in which they may choose to enroll. For a beneficiary who elects a Medicare Advantage plan without drug coverage, the premium, deductible, and copay/coinsurance structure for their separate prescription drug plan should be included. Only when all costs are viewed together, on one screen, can beneficiaries make an informed choice.

Plan Finder should display quality and cost information together and Medicare should consult with experts to determine best practices for the display of information to consumers in a way that encourages high-value choices. Finally, plan finder should make its data available to other consumer comparison tools like HealthCare.com, that are in the business of helping consumers shop for coverage as Kayak.com does for travel. A proliferation of comparison tools could go hand-in-hand with easing highly restrictive plan marketing prohibitions like stopping a Medigap plan from

including information about Medicare Advantage plan in the information packets requested by consumers.

5. Congress should make it easier for beneficiaries to act upon their choices once they find their preferred plan on the Medicare Plan Finder.

Enrollment in a plan of a beneficiary's choice should be as simple as a click of button. Plan Finder already lets beneficiaries enroll in Medicare Advantage and Medicare Part D plans. It should also include the option to enroll in a Medigap plan as well. Greater use of this centralized enrollment process could potentially reduce some of the health plan marketing costs. Plans could choose between relying on health plan finder or their own marketing just as they do in the marketplaces under the Affordable Care Act.

Savings

Providing comparative quality information for beneficiaries will drive Medicare Advantage plans and original Medicare to improve quality. In turn, higher quality care generally leads to lower costs. For example, despite significant cuts to the Medicare Advantage program, the average plan quality has increased as average premiums have decreased. [38]

In 2014, 38% of Medicare Advantage plans received a four star or more quality rating and enrolled 53% of Medicare Advantage enrollees in these plans, compared with 14% and 24%, respectively, in 2011. [39] At the same time, Medicare Advantage premiums for beneficiaries are 10% lower since the enactment of the ACA. [40] When combined with Third Way's proposal to change the default enrollment for new beneficiaries, this proposal will save the federal government $57.3 billion over 10 years. [41] It will save beneficiaries $1,704 on average in lower premiums. [42]

Questions and Responses

Will comparing original Medicare quality to Medicare Advantage quality be meaningful when original Medicare has not explicitly accepted responsibility for the health of a population the way a Medicare Advantage plan does?

Medicare has an implicit responsibility for beneficiary health and should engage in care coordination and quality improvement activities the way Medicare Advantage plans do. Measuring quality across the members of original Medicare will reveal gaps in care that are important to patients as well as Medicare's administrators. It will push original Medicare to improve its performance, acknowledge where it falls short, and recognize where it is superior.

How could original Medicare ensure it would have the same incentive to report good performance data as in private Medicare Advantage plans?

Medicare Advantage plans and the providers in their network can work as a team to document and improve their star ratings. Original Medicare has not assumed that kind of leadership with its providers. Instead, it has largely acted as a steady source of payment for them. As part of reporting on quality measures, original Medicare should develop a management plan to guide where it can do the most to improve its performance. It could work with Quality Improvement Organizations (QIOs), which are already involved in checking the quality of care of providers. It could be very productive to encourage the QIOs to develop better data collection and quality improvement strategies as part of their work with providers.

What about improving the information about Medicare Advantage plans to help consumers make an informed choice?

For many consumers, the choice of provider may be the most important factor in choosing a plan.. To support selection of a

plan, one idea is that beneficiaries could simply enter provider names in Medicare Plan Finder and see a list of plans that include specific providers. Plan Finder should also include comparisons about plan's varying requirements to get access to prescription drugs like prior authorizations and step therapy, where patients must first see if lower cost drugs work for them before getting access to more expensive ones.

How can Medicare prevent plans and providers from gaming the star ratings?

As developments surrounding Medicare's Nursing Home Compare star rating program have shown, beneficiaries are eager for easily understandable quality information, like star ratings, but they must be assured the data on which the ratings are reported are legitimate. [43] Medicare recently announced changes to verify and audit data that was previously merely self-reported with no government review. Medicare should establish verification and audit measures for all self-reported quality measures.

TOPICS

MEDICARE/MEDICAID 53 | HEALTH CARE COSTS 51

END NOTES

1. David Kendall and Elizabeth Quill, "Rethinking Medicare Enrollment: Make High-Value Health Coverage the Easy Choice," Report, Third Way, August 19, 2015. Available at http://www.thirdway.org/report/rethinking-medicare-enrollment-make-high-value-health-coverage-the-easy-choice.

2. United States, Department of Health and Human Services, Centers for Medicare & Medicaid Services, "Medicare Plan Finder." Accessed August 12, 2015. Available at: https://www.medicare.gov/find-a-plan/questions/home.aspx.

3. Marsha Gold, Gretchen Jacobson, Anthony Damico, and Tricia Neuman, "Medicare Advantage 2014 Spotlight: Plan Availability and Premiums," Issue Brief, Kaiser Family Foundation, November 25, 2013. Accessed August 12, 2015. Available at: http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-plan-availability-and-premiums/.

4. Marsha Gold, Gretchen Jacobson, Anthony Damico, and Tricia Neuman, "Medicare Advantage 2014 Spotlight: Plan Availability and Premiums," Issue Brief, Kaiser Family Foundation, November 25, 2013. Accessed August 12, 2015. Available at: http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-plan-availability-and-premiums/.

5. Jack Hoadley, Juliette Cubanski, Elizabeth Hargrave, and Laura Summer, "Medicare Part D: A First Look at Plan Offerings in 2015," Issue Brief, Kaiser Family Foundation, October 10, 2014. Accessed August 12, 2015. Available at: http://kff.org/medicare/issue-brief/medicare-part-d-a-first-look-at-plan-offerings-in-2015/. See also Gretchen Jacobson, Christina Swoope, Michael Perry, and Mary C. Slosar, "How are Seniors Choosing and Changing Health Insurance Plans? Findings from Focus Groups with Medicare Beneficiaries," Report, Kaiser Family Foundation, May 13, 2014, p. 5. Accessed August 12, 2015. Available at: http://kff.org/medicare/report/how-are-seniors-choosing-and-changing-health-insurance-plans/.

6. Joseph P. Newhouse and Thomas G. McGuire, "How Successful is Medicare Advantage?" *The Milbank Quarterly* (subscription),June 2014, pp. 376-379. Accessed August 12, 2015. Available at: http://www.milbank.org/publications/the-milbank-quarterly/search-archives/article/3974/how-successful-is-medicare-advantage-?back=/issue/2014/2.

7. United States, Congress, House of Representatives, "H.R. 1 — Medicare Prescription Drug, Improvement, and Modernization Act of 2003", 108th Congress, 1st Session, June 25, 20113, December 8, 2003. Accessed August 12, 2015. Available at: https://www.congress.gov/bill/108th-congress/house-bill/1/text?q=%7B%22search%22%3A%5B%22medicare prescription drug%2C improvement%2C and modernization act%22%5D%7D. See also United States, Congress, Senate, "S. 1932 — Deficit Reduction Act of 2005," 109th Congress, 1st Session, October 27, 2005, February 8, 2006. Accessed August 12, 2015. Available at: https://www.congress.gov/bill/109th-congress/senate-bill/1932/text?q=%7B%22search%22%3A%5B%22%5C%22deficit reduction act%5C%22%22%5D%7D. See also United States, Congress, House of Representatives, "H.R. 6331 — Medicare Improvements for Patients and Providers Act of 2008," 110th Congress, 2nd Session, June 20, 2008, July 15, 2008. Accessed August 12, 2015. Available at: https://www.congress.gov/bill/110th-congress/house-bill/6331/text?q=%7B%22search%22%3A%5B%22%5C%22medicare improvements for patients and providers%5C%22%22%5D%7D. See also United States, Congress, House of Representatives, "H.R. 3509 — Patient Protection and Affordable Care Act," 111th Congress, 2nd Session, September 17, 2009, March 23, 2010. Accessed August 12, 2015. Available at: https://www.congress.gov/bill/111th-congress/house-bill/3590/text?q=%7B%22search%22%3A%5B%22%5C%22patient protection and affordable care act%5C%22%22%5D%7D.

8. Judith H. Hibbard, Jessica Greene, Shoshanna Sofaer, Kristin Firminger, and Judith Hirsh, "An Experiment Shows That A Well-Designed Report On Costs And Quality Can Help Consumers Choose High-Value Health Care," Health Affairs (subscription), March 2012, p. 562,564. Accessed August 12, 2015. Available at: http://content.healthaffairs.org/content/31/3/560.abstract.

9. A related concept, choice overload, sometimes called decision paralysis, explains that people can be easily overwhelmed by increased choices. Research has shown that as the number of options presented to people increase and the information about those options increases, people process a smaller fraction of the choices and information. Benjamin Scheibehenne, Rainer Greifeneder, Peter M. Todd, "Meta-Analytic Review of Choice Overload," *Journal of Consumer Research*, October 2010. Accessed August 12, 2015. Available at: http://www.jstor.org/discover/10.1086/651235?uid=3739936&uid=2&uid=4&uid=3739256&sid=21103663418467.

10. United States, Department of Health and Human Services, Agency for Healthcare Research and Quality, "2013 Annual Progress Report to Congress: National Strategy for Quality Improvement in Health Care," Report, July 2013. Accessed August 12, 2015. Available at: http://www.ahrq.gov/workingforquality/nqs/nqs2013annlrpt.htm.

11. United States, Department of Health and Human Services, Agency for Healthcare Research and Quality, "2013 Annual Progress Report to Congress: National Strategy for Quality Improvement in Health Care," Report, July 2013. Accessed August 12, 2015. Available at: http://www.ahrq.gov/workingforquality/nqs/nqs2013annlrpt.htm.

12. Megan Ix, "Reducing the Administrative Burden of Health Care Quality Reporting," Findings Brief, Changes in Health Care Financing and Organization, the Robert Wood Johnson Foundation, Academy Health, December 2008, p. 2. Accessed August 12, 2015. Available at: http://www.academyhealth.org/files/pdf/findings1208.pdf.

13. United States, Department of Health and Human Services, Agency for Healthcare Research & Quality, "2013 Annual Progress Report to Congress: National Strategy for Quality Improvement in Health Care," Report to Congress, July 2013, Accessed August 12, 2015. Available at: http://www.ahrq.gov/workingforquality/nqs/nqs2013annlrpt.htm.

14. United States, Medicare Payment Advisory Commission, "Medicare and the Health Care Delivery System," Report to the Congress, June 2014, p. 43. Accessed August 12, 2015. Available at: http://www.medpac.gov/documents/reports/jun14_entirereport.pdf?sfvrsn=0.

15. Gregg C. Fonarow, et al., "Association Between Performance Measures and Clinical Outcomes for Patients Hospitalized with Heart Failure," *The Journal of the American Medical Association*, January 3, 2007, p. 61. Accessed August 12, 2015. Available at: http://jama.jamanetwork.com/Issue.aspx?journalid=67&issueID=5084&direction=P.

16. "Medicare Plan Finder," Website. Accessed August 12, 2015. Available at: https://www.medicare.gov/find-a-plan/questions/home.aspx.

17. Gretchen Jacobson, Jennifer Huang, and Tricia Neuman, "Medigap Reform: Setting the Context for Understanding Recent Proposals," Kaiser Family Foundation, January 2014, p. 1. Accessed August 12, 2015. Available at: http://kff.org/medicare/issue-brief/medigap-reform-setting-the-context/.

18. William Samuelson, Richard Zeckhauser, "Status Quo Bias in Decision Making," *Journal of Risk and Uncertainty*, 1: 7-59, 1988, Accessed August 12, 2015. Available at: http://dtserv2.compsy.uni-jena.de/___C125757B00364C53.nsf/0/F0CC3CAE039C8B42C125757B00473C77/$FILE/samuelson_zeckhauser_1988.pdf.

19. Joseph P. Newhouse and Thomas G. McGuire, "How Successful is Medicare Advantage?" *The Milbank Quarterly* (subscription), June 2014, pp. 357. Accessed August 12, 2015. Available at: http://www.milbank.org/publications/the-milbank-quarterly/search-archives/article/3974/how-successful-is-medicare-advantage-?back=/issue/2014/2.

20. United States, Department of Health and Human Services, Centers for Medicare & Medicaid Services, "Medicare Advantage Enrollment at All-Time High; Premiums Remain Affordable," Press Release, September 28, 2014. Accessed August 12, 2015. Available at: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-09-18.html.

21. Rachel O. Reid, Partha Deb, Benjamin Howell, William H. Shrank, "Association Between Medicare Advantage Plan Star Ratings and Enrollment," *Journal of the American Medicare Association*, January 16, 2013, pp. 267-274. Accessed August 12, 2015. Available at: http://jama.jamanetwork.com/article.aspx?articleid=1557733#ref-joc120139-10.

22. Judith H. Hibbard, Jessica Greene, Shoshanna Sofaer, Kristin Firminger, and Judith Hirsh, "An Experiment Shows That A Well-Designed Report On Costs And Quality Can Help Consumers Choose High-Value Health Care," *Health Affairs* (subscription), March 2012, p. 565. Accessed August 12, 2015. Available at: http://content.healthaffairs.org/content/31/3/560.abstract.

23. Judith H. Hibbard, Jessica Greene, Shoshanna Sofaer, Kristin Firminger, and Judith Hirsh, "An Experiment Shows That A Well-Designed Report On Costs And Quality Can Help Consumers Choose High-Value Health Care," *Health Affairs* (subscription), March 2012, p. 564. Accessed August 12, 2015. Available at: http://content.healthaffairs.org/content/31/3/560.abstract.

24. Judith H. Hibbard, Jessica Greene, Shoshanna Sofaer, Kristin Firminger, and Judith Hirsh, "An Experiment Shows That A Well-Designed Report On Costs And Quality Can Help Consumers Choose High-Value Health Care," *Health Affairs* (subscription), March 2012, p. 565. Accessed August 12, 2015. Available at: http://content.healthaffairs.org/content/31/3/560.abstract.

25. United States, Medicare Payment Advisory Commission, "Medicare and the Health Care Delivery System," Report to the Congress, June 2014, pp. 45-50. Accessed August 12, 2015. Available at: http://www.medpac.gov/documents/reports/jun14_entirereport.pdf?sfvrsn=0.

26. United States, Medicare Payment Advisory Commission, "Medicare and the Health Care Delivery System," Report to the Congress, June 2014, pp. 45-50. Accessed August 12, 2015. Available at: http://www.medpac.gov/documents/reports/jun14_entirereport.pdf?sfvrsn=0.

27. United States, Medicare Payment Advisory Commission, "Medicare and the Health Care Delivery System," Report to the Congress, June 2014, pp. 45-50. Accessed August 12, 2015. Available at: http://www.medpac.gov/documents/reports/jun14_entirereport.pdf?sfvrsn=0.

28. Inovalon, "White Paper: An Investigation of Medicare Advantage Dual Eligible Member-Level Performance on CMS Five-Star Quality Measures," Report, March 30 2015. Accessed August 11, 2015. Available at: http://www.inovalon.com/Duals; National Quality Forum, "Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors," Report, August 2014. Accessed August 11, 2015. Available at: http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx.

29. Medicare Rights Center, "Re: Request for Information – Data on Differences in Medicare Advantage (MA) and Part D Star Rating Quality Measurements for Dual-Eligible versus Non-Dual Eligible Enrollees," letter to Department of Health and Human Services, Centers for Medicare & Medicaid Services, November 3, 2014.

30. "Star Ratings: Adjusting for Socio-Economic Variation and Health Disparities Among Dual Eligibles," WellCare, Accessed August 12, 2015. Available at: http://mediad.publicbroadcasting.net/p/healthnewsfl/files/201411/WhitePaper-Medicare-Stars_Ratings_and_Duals-01-2013.pdf.

31. United States, Department of Health and Human Services, Centers for Medicare & Medicaid Services, "Case-Mix Coefficients for MA & PDP CAHPS," 2015, p. 3. Accessed August 12, 2015. Available at: http://www.ma-pdpcahps.org/Content/CaseMixAdjustment.aspx.

32. United States, Medicare Payment Advisory Commission, "Medicare and the Health Care Delivery System," Report to the Congress, June 2014, p. 46. Accessed August 12, 2015. Available at: http://www.medpac.gov/documents/reports/jun14_entirereport.pdf?sfvrsn=0. See also United States, Medicare Payment Advisory Commission, "Medicare Payment Policy," Report to the Congress, March 2010, pp. 320-321. Accessed August 12, 2015. Available at: http://www.medpac.gov/documents/reports/Mar10_EntireReport.pdf?sfvrsn=0.

33. United States, Medicare Payment Advisory Commission, "Medicare and the Health Care Delivery System," Report to the Congress, June 2014, pp. 47-48. Accessed August 12, 2015. Available at: http://www.medpac.gov/documents/reports/jun14_entirereport.pdf?sfvrsn=0.

34. United States, Medicare Payment Advisory Commission, "Medicare Payment Policy," Report to the Congress, March 2010, p. 320. Accessed August 12, 2015. Available at: http://www.medpac.gov/documents/reports/Mar10_EntireReport.pdf?sfvrsn=0.

35. United States, Congress, Senate, "SGR Repeal and Medicare Provider Payment Modernization Act of 2014," 113th Congress, 2nd Session, Sec. 2, February 6, 2014. Accessed August 12, 2015. Available at: https://www.congress.gov/bill/113th-congress/senate-bill/2000/text?q=%7B%22search%22%3A%5B%22%5C%22sgr repeal and medicare provider payment%5C%22%22%5D%7D.

36. United States, Department of Health and Human Services, Centers for Medicare & Medicaid Services, “Qualified Clinical Data Registry Reporting,” September 9, 2014. Accessed August 12, 2015. Available at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Qualified-Clinical-Data-Registry-Reporting.html.

37. United States, Department of Health and Human Services, Centers for Medicare & Medicaid Services, “2014 Physician Quality Reporting System (PQRS): Qualified Clinical Data Registry Participating Made Simple,” January 2014, p. 1. Accessed August 12, 2015. Available at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2014_QualifiedClinicalDataRegistry_MadeSimple.pdf.

38. United States, Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, “The Medicare Advantage Program in 2014,” Issue Brief, April 7, 2014, p. 11-13. Accessed August 12, 2015. Available at: http://aspe.hhs.gov/health/reports/2014/MedicareAdvantage/ib_MedicareAdvantage.pdf.

39. United States, Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, “The Medicare Advantage Program in 2014,” Issue Brief, April 7, 2014, p. 12. Accessed August 12, 2015. Available at: http://aspe.hhs.gov/health/reports/2014/MedicareAdvantage/ib_MedicareAdvantage.pdf.

40. United States, Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, “The Medicare Advantage Program in 2014,” Issue Brief, April 7, 2014, p. 2. Accessed August 11, 2015. Available at: http://aspe.hhs.gov/health/reports/2014/MedicareAdvantage/ib_MedicareAdvantage.pdf.

41. Avalere Health, “Estimated Federal and Beneficiary Impact of Medicare Default Choice to High-Value Plans,” Memo to Third Way, December 16, 2014. Available at: http://www.thirdway.org/report/medicare-savings-medicare-enrollment; See also “Final Scoring Memo: Default Choice,” Actuarial Research Corporation, Memo to Third Way, March 17, 2015. Available at: http://www.thirdway.org/report/national-health-expenditure-savings-medicare-enrollment.

42. Avalere Health, “Estimated Federal and Beneficiary Impact of Medicare Default Choice to High-Value Plans,” Memo to Third Way, December 16, 2014. Available at: http://www.thirdway.org/report/medicare-savings-medicare-enrollment.

43. KatieThomas, “Government Will Change How it Rates Nursing Homes,” *The New York Times*, February 12, 2015. Accessed August 11, 2015. Available at: http://www.nytimes.com/2015/02/13/business/government-will-change-how-it-rates-nursing-homes.html.