Avalere

To: Third Way

From: Avalere Health

Date: December 16, 2014

Re: Estimated Federal and Beneficiary Impact of Medicare Default Choice to High-Value Plans

Summary

Third Way asked Avalere Health to estimate the federal and beneficiary cost and savings associated with proposed Medicare's default choice to highest-value plan policy. Under this proposal, new Medicare enrollees who do not actively choose to enroll either in a Medicare Advantage (MA) plan or fee-for-service (FFS) would be automatically enrolled in the highest-value plan in their region. These new enrollees who are assigned to default choice plan would then have the option to change to their enrollment to another plan, either in a MA plan or to traditional FFS.

Avalere estimates this proposal would reduce the federal deficit by $69.5 billion over the FY 2015 – FY 2024 budget window. We estimate $80.5 billion in lower federal spending as new enrollees are automatically enrolled in high value MA plans rather than traditional FFS plans. We estimate $11.0 billion in higher federal spending due to market shifts as MA plans respond to the new risk profile of enrollees.

Estimated Effect on the Federal Deficit due to Medicare Default Enrollment Option

$ in billions, by fiscal year

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	**2015-2024**
Default enrollment of new enrollees	-1.3	-2.7	-4.1	-5.5	-7.0	-8.5	-10.1	-11.9	-13.7	-15.7	-80.5
Effect of market changes on existing MA enrollment	-0.1	0.3	0.8	1.3	1.4	1.6	0.7	0.9	1.6	2.6	11.0
Net change in spending	**-1.4**	**-2.4**	**-3.3**	**-4.2**	**-5.6**	**-6.9**	**-9.4**	**-11.0**	**-12.1**	**-13.2**	**-69.5**

Data Sources

We used the following data sources to develop our estimate:

- Kaiser Family Foundation Medicare Policy Issue Brief. "Seniors' Knowledge and Experience With Medicare's Open Enrollment Period and Choosing a Plan: Key Findings from the Kaiser Family Foundation 2012 National Survey of Seniors." October 2012.
- Dorn, Stan. "Automatic Enrollment Strategies: Helping State Coverage Expansions Achieve Their Goals." Prepared for State Coverage Initiatives, Academy Health, Aug 2007. Available at: http://www.statecoverage.org/files/Automatic%20Enrollment%20Strategies%20-%20Helping%20State%20Coverage%20Expansions%20Achieve%20Their%20Goals.pdf
- Cunningham, Peter. "Few Americans Switch Employer Health Plans for Better Quality, Lower Costs." National Institute for Health Care Reform, January 2013. Available at: http://www.nihcr.org/Health-Plan-Switching
- Afendulis, C. et. al. "Dominated Choices and Medicare Advantage Enrollment." National Bureau of Economic Research Working Paper, May 2014. Available at: http://www.nber.org/papers/w20181
- Brown, J. et. al. "How does risk selection respond to risk adjustment? New evidence from the Medicare Advantage Program." National Bureau of Economic Research Working Paper, Oct. 18, 2012. Available at: http://www.nber.org/papers/w16977
- Congressional Budget Office. "April 2014 Medicare Baseline." April 2014. Available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2014-04-Medicare.pdf
- Centers for Medicare & Medicaid Services. "2014 Medicare Trustees Report." July 2014. Available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html?redirect=/reportstrustfunds/
- Centers for Medicare & Medicaid Services. "Medicare Plan Payment Data for 2012." December 31, 2013. Available at http://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Plan-Payment-Data-Items/2012data.html?DLPage=1&DLSort=0&DLSortDir=ascending

Assumptions and Methodology

Enrollment and Participation in Medicare Default Choice to High-Value Plan

Under the default choice policy, new Medicare enrollees who do not make voluntary health plan choice during the open enrollment period would be automatically enrolled in a benchmark plan that provides the highest value for their region.

We first estimated that approximately 4.2 million new Medicare beneficiaries who are age 65 will enroll in Medicare in 2015. We also assumed, based on our analysis of 2005-2012 Medicare 100 percent denominator file, 29 percent of 65-year old Medicare beneficiaries will enroll to Medicare Advantage (MA) program rather than traditional fee-for-service (FFS) Medicare program in 2015, and this percentage will continue to grow to 38 percent by the end of 2024.

In order to estimate the effect of the default policy on new Medicare entrants, we used a recent

study on seniors' experience and knowledge with Medicare's open enrollment period and choosing a plan. The Kaiser Family Foundation's 2012 National Survey of Seniors found that 41 percent of seniors were not aware of Medicare's open enrollment period.[1] We assumed that this non-aware group will not make voluntary health plan choice and will therefore be automatically assigned to an MA plan due to the proposed policy.

We further assumed that 5 percent of this group will opt out during the initial enrollment period.[2] In later years, we assumed 2.5 percent of default choice program participants will switch out to the traditional FFS program.[3]

Table 1: Expected MA Enrollment Changes in Aged Medicare Beneficiaries

(in millions)	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	FY 21	FY 22	FY 23	FY 24
Expected MA enrollment for newly-eligible (age 65) Medicare beneficiaries										
Baseline expected MA enrollment	1.2	1.3	1.4	1.5	1.6	1.7	1.8	1.9	2.0	2.1
Additional MA enrollment due to default choice policy	1.2	1.2	1.2	1.2	1.2	1.3	1.3	1.3	1.3	1.3
Total	**2.4**	**2.5**	**2.6**	**2.7**	**2.8**	**2.9**	**3.0**	**3.1**	**3.3**	**3.4**
Expected MA enrollment for all aged Medicare beneficiaries										
Baseline expected MA enrollment	13.7	14.3	15.0	15.8	16.5	17.1	16.9	17.5	18.1	18.7
Additional MA enrollment due to default choice policy	1.2	2.3	3.4	4.4	5.4	6.4	7.4	8.3	9.2	10.0
Total	**14.9**	**16.6**	**18.3**	**20.3**	**21.9**	**23.5**	**24.3**	**25.8**	**27.3**	**28.7**

MA Enrollment Behavior for Existing Enrollees

Evidence suggests that MA enrollees do not routinely change plans once the enrollees have made a selection. Studies have suggested a combination of status quo bias and information overload prevent individuals from changing plans to select a plan with a better benefit.[4]

We assume that a portion of MA enrollment over the next 10 years will shift into a higher value plan due to the increased visibility required in the policy proposal. We expect approximately 5 percent of enrollment will shift in the first year, reaching 23 percent of enrollment by 2024.

Annual Spending per Enrollee

We assume that Medicare beneficiaries will be assigned to a high quality MA plan under the default enrollment policy. We examined 2012 MA plan payment data from CMS and found that the overall weighted average payment, which includes both the amount bid by the plan as well as the rebate received for being under the local benchmark, was approximately $818 per month. We then determined that, if all enrollees who had access to a plan with a quality rating of 4.5 or

[1] Kaiser Family Foundation Medicare Policy Issue Brief. "Seniors' Knowledge and Experience With Medicare's Open Enrollment Period and Choosing a Plan: Key Findings from the Kaiser Family Foundation 2012 National Survey of Seniors." October 2012.
[2] Dorn, Stan. "Automatic Enrollment Strategies: Helping State Coverage Expansions Achieve Their Goals." Prepared for State Coverage Initiatives, Prepared for Academy Health, Aug 2007. Available at: http://www.statecoverage.org/files/Automatic%20Enrollment%20Strategies%20-%20Helping%20State%20Coverage%20Expansions%20Achieve%20Their%20Goals.pdf
[3] Cunningham, Peter. "Few Americans Switch Employer Health Plans for Better Quality, Lower Costs." National Institute for Health Care Reform, January 2013. Available at: http://www.nihcr.org/Health-Plan-Switching
[4] Afendulis, C. et. al. "Dominated Choices and Medicare Advantage Enrollment." National Bureau of Economic Research Working Paper, May 2014. Available at: http://www.nber.org/papers/w20181

5 stars enrolled in that plan, the average payment rate in 2012 would have been $791 per month, or 3.5 percent lower than the actual average MA payment rate in that year. Likewise, if all enrollees who had access to a plan with a quality rating of 4 stars or higher had enrolled in that plan, the average payment rate would have been $802 per month, or 2 percent lower than the actual average MA payment rate.

We assumed that the auto-assigned enrollees would be put in plans with the highest quality rating available. Since over 66 percent of all Medicare enrollees had access to a plan with a rating of 4.5 or 5 stars in 2014, we have assumed the majority of new enrollees will be placed in plans with this level of quality. In addition, while we do assume that high quality plans will likely increase their payment rates for the change in the risk associated with auto-assigned new enrollees (see below), we also believe that high quality plans with lower payment rates will expand their service areas to capture these new auto-assigned enrollees, and that the competitive pressure of this expansion will result in payment rates that are 3.5 percent lower than the average MA payment rate absent this proposal.

CBO currently estimates that the overall weighted average payment to all MA plans in 2014 will be $8,800 while the Medicare FFS program spends an average of $10,160 per person. These payment amounts reflect the relative risk scores of enrollees which measures beneficiaries' estimated relative costs based on demographics and health characteristics. CMS adjusts payments to MA plans using the Hierarchical Conditions Category (HCC) risk model. The HCC model estimates the total annual cost of an enrollee based on a wide range of factors, both demographic and condition-specific. In 2012, the average MA enrollee's risk score was approximately 1.035, while the average FFS enrollee's risk score was 1.00. New enrollees will likely have lower risk scores, which would result in lower average payments in either MA or FFS.

We assume that all MA plans will increase their required payments due to the default enrollment policy. We assume that by 2024, high quality plans will have increased their required payments by approximately 3 percent to account for the different risk profile of the individuals who were automatically assigned to the plan. In the same year, we assume that all other MA plans will have increased their required payments by approximately 1 percent to account for the shifts in enrollment. We further assume that the FFS program spending will have increased by approximately 1 percent due to the loss of nearly 50 percent of new-to-Medicare beneficiaries by 2024.

Beneficiary Spending Effects

Third Way also requested an examination of the expected effects on beneficiary spending. For Medicare fee-for-service beneficiaries with prescription drug and Medigap coverage, the average annual premium in 2014 is approximately $4,002 (including $2,664 for Medigap[5], $1,259 for Part B[6], and $479 for Part D[7]). For MA plans, the average annual premium is approximately $2,298 (including $1,259 for Part B and $1,040 for the MA plans with 4.5 stars and higher[8]).

The premium cost data shows that high-quality Medicare advantage plans cost approximately

[5] The average Medigap premium is based on 2010 Medigap premium data from the Kaiser Family Foundation, "Medigap: Spotlight on Enrollment, Premiums, and Recent Trends". The data is trended to 2014 using Medicare per capital growth.
[6] The 2014 standard premium for Medicare Part B health coverage is $104.90.
[7] Kaiser Family Foundation, "Medicare Part D: A First Look at Plan Offerings in 2014".
[8] CMS Medicare Advantage Plan Landscape data for 2014

$1,700 less than the traditional Medicare fee-for-service program. The cost advantage of MA is more significant for Medicare new enrollees who have relatively low out-of-pocket cost.

Overall, we estimate the default enrollment option could lower beneficiary costs associated with premiums by nearly $58 billion over 10 years. We note that we are unable to accurately estimate the out-of-pocket costs for individuals who will be automatically enrolled in high quality MA plans due to a lack of data.

Appendix: Expected MA Enrollment Changes in Aged Medicare Beneficiaries By State *(in thousands)*

	FY2015				FY2024				
State	Baseline expected enrollment	Additional enrollment due to default choice	Baseline Expected MA penetration	MA penetration with policy	Baseline expected enrollment	Additional enrollment due to default choice	Baseline Expected MA penetration	MA penetration with policy	% MA growth with policy (FY15 – FY24)
Alabama	190.2	20.6	24.3%	26.9%	259.5	177.3	27.3%	45.9%	168.3%
Alaska	0.2	1.7	0.4%	2.4%	0.3	14.6	0.4%	15.0%	3736.4%
Arizona	344.1	23.6	38.4%	41.0%	469.4	202.7	43.2%	61.8%	143.2%
Arkansas	94.8	12.7	19.6%	22.2%	129.3	109.6	22.0%	40.6%	184.8%
California	1,807.7	119.1	39.9%	42.5%	2,466.0	1,025.1	44.8%	63.5%	141.6%
Colorado	228.9	16.4	36.7%	39.3%	312.3	141.2	41.2%	59.8%	145.1%
Connecticut	125.7	13.5	24.5%	27.1%	171.4	116.2	27.5%	46.1%	167.8%
Delaware	11.0	3.8	7.7%	10.3%	15.1	32.5	8.6%	27.3%	315.9%
Florida	1,244.5	83.8	39.0%	41.7%	1,697.6	721.6	43.8%	62.5%	142.5%
Georgia	358.8	32.0	29.5%	32.1%	489.4	275.1	33.1%	51.8%	156.2%
Hawaii	92.5	5.2	47.1%	49.7%	126.1	44.4	52.9%	71.5%	135.2%
Idaho	71.7	5.9	32.1%	34.7%	97.9	50.6	36.0%	54.6%	151.6%
Illinois	321.3	44.2	19.1%	21.7%	438.2	380.8	21.4%	40.1%	186.9%
Indiana	211.6	24.5	22.7%	25.4%	288.7	210.7	25.5%	44.2%	173.0%
Iowa	67.5	12.2	14.5%	17.1%	92.1	105.2	16.3%	34.7%	212.7%
Kansas	53.3	10.4	13.5%	16.1%	72.7	89.5	15.1%	33.5%	221.2%
Kentucky	175.0	18.4	25.0%	27.6%	238.8	158.6	28.1%	46.7%	166.4%
Louisiana	183.8	16.8	28.8%	31.4%	250.7	144.6	32.3%	50.9%	157.7%
Maine	51.5	6.5	20.7%	23.3%	70.2	56.2	23.3%	41.9%	180.1%
Maryland	65.5	19.7	8.7%	11.4%	89.4	169.7	9.8%	28.4%	289.9%
Massachusetts	203.1	25.9	20.6%	23.3%	277.1	222.8	23.2%	41.8%	180.4%
Michigan	475.7	40.5	30.9%	33.5%	649.0	348.5	34.7%	53.3%	153.7%
Minnesota	388.3	19.4	52.8%	55.4%	529.8	166.5	59.3%	77.9%	131.4%
Mississippi	61.4	12.0	13.5%	16.1%	83.8	102.9	15.2%	33.8%	222.8%
Missouri	247.7	24.2	26.9%	29.5%	337.9	208.3	30.2%	48.9%	161.7%
Montana	28.0	4.2	17.4%	20.0%	38.3	36.5	19.5%	37.8%	193.9%
Nebraska	30.6	6.7	12.1%	14.5%	41.8	57.3	13.6%	30.5%	224.4%
Nevada	116.8	9.4	32.8%	35.4%	159.3	80.6	36.8%	55.5%	150.5%
New Hampshire	14.3	5.6	6.7%	9.4%	19.6	48.1	7.6%	26.2%	345.8%
New Jersey	188.9	31.9	15.6%	18.2%	257.6	274.7	17.5%	36.1%	206.6%
New Mexico	93.6	7.9	31.3%	34.0%	127.6	67.6	35.2%	53.8%	152.9%
New York	994.2	71.5	36.5%	39.2%	1,356.2	615.6	41.0%	59.7%	145.4%
North Carolina	410.3	37.3	28.9%	31.5%	559.6	321.4	32.4%	51.1%	157.4%
North Dakota	14.3	2.5	14.8%	17.3%	19.5	21.8	16.7%	34.5%	206.9%
Ohio	685.7	45.9	39.3%	41.9%	935.3	395.2	44.1%	62.7%	142.3%
Oklahoma	91.4	14.5	16.6%	19.2%	124.6	124.4	18.7%	37.3%	199.8%
Oregon	263.6	15.8	44.0%	46.6%	359.6	135.6	49.4%	68.1%	137.7%
Pennsylvania	827.1	54.2	40.1%	42.8%	1,128.3	466.3	45.1%	63.7%	141.3%
Rhode Island	59.9	4.3	36.2%	38.8%	81.7	37.4	40.7%	59.3%	145.8%
South Carolina	167.9	19.7	22.4%	25.0%	229.1	169.8	25.1%	43.8%	174.1%
South Dakota	20.9	3.3	16.6%	19.2%	28.5	28.5	18.6%	37.0%	198.4%
Tennessee	326.8	26.2	32.8%	35.4%	445.8	225.3	36.9%	55.5%	150.5%
Texas	861.9	76.4	29.7%	32.3%	1,175.8	657.7	33.3%	51.9%	155.9%
Utah	93.3	7.2	33.9%	36.6%	127.3	62.2	38.1%	56.7%	148.7%
Vermont	7.7	2.8	7.2%	9.9%	10.5	24.0	8.1%	26.8%	329.5%
Virginia	190.2	28.6	17.5%	20.1%	259.4	245.9	19.7%	38.3%	194.8%

Washington	285.0	24.9	30.1%	32.8%	388.8	214.0	33.8%	52.5%	155.0%
D.C.	8.6	1.9	12.0%	14.7%	11.7	16.2	13.5%	32.1%	238.0%
West Virginia	90.0	8.9	26.4%	29.1%	122.7	77.0	29.7%	48.3%	162.7%
Wisconsin	304.1	22.3	35.9%	38.5%	414.9	191.9	40.3%	58.9%	146.3%
Wyoming	2.7	2.0	3.5%	6.0%	3.6	17.3	3.9%	21.8%	557.4%
Other US	457.1	17.3	69.4%	72.0%	623.6	149.1	77.9%	96.6%	123.9%
Total US	***13,710.8***	***1,166.3***	***30.9%***	***33.5%***	***18,703.3***	***10,036.9***	***34.9%***	***53.5%***	***153.4%***