

Can Insurance Market Competition Coexist With Provider Price Regulation? Evidence From Medicare Advantage

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Abstract

Proposals to contain health care costs often draw from 1 of 2 primary policy approaches—price regulation or market competition. These approaches are often viewed as in conflict, even though some health economists have long argued that they may be compatible, and desirable, given the unique characteristics of health care markets. Medicare Advantage (MA) markets provide a real-world example supporting the view that provider price regulation and insurance market competition can be complementary.

Keywords

Medicare Advantage, health insurance competition, health insurance markets, Medicare, price regulation

What do we already know about this topic?

MA plans pay traditional Medicare rates for physician and hospital services, but despite little need for price concessions, MA plans still form narrow networks.

How does your research contribute to the field?

The research described in this commentary shows that regulated pricing in health care can be compatible with insurance market competition along other dimensions like quality ratings and service intensity.

What are your research's implications toward theory, practice, or policy?

Overall, the MA program shows that provider price regulation can facilitate rather than impede insurance market competition, enabling effective cost containment.

Proposals to contain health care costs often draw from 1 of 2 primary policy approaches—price regulation¹ or market competition.² These approaches are often viewed as in conflict, even though some health economists have long argued that they may be compatible,³ and desirable, given the unique characteristics of health care markets.⁴ Medicare Advantage (MA) markets provide a real-world example supporting the view that provider price regulation and insurance market competition can be complementary.

The MA program, which allows Medicare beneficiaries to receive their Part A and B benefits through private plans, is similar to the managed competition approach of the Affordable Care Act's (ACA) Marketplaces. However, in MA, provider prices are indirectly set by the Medicare program, rather than negotiated between insurers and providers as in other markets. The Social Security Act bars all providers from balance billing Medicare patients, including MA enrollees, at rates above the Medicare-allowed amounts for services received in- or out-of-network. This

limitation on balance billing directly affects MA plans' negotiating leverage, as providers can either be in-network at Medicare-equivalent rates or out-of-network at Medicare-equivalent rates.^{5–7} In fact, MA plans are often able to negotiate “best of both worlds” pricing, using the Medicare payment amounts for hospital and physician services,^{5–7} where the rates typically fall well below commercial rates, while negotiating lower-than-traditional Medicare rates for durable medical equipment,⁶ lab tests,⁶ and post-acute care.⁸

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This price regulation, however, does not inhibit cost competition among MA plans through other mechanisms,⁹ such as reducing service volume and moving care to less intensive sites of service. Another strategy relies on narrow networks. In commercial insurance markets, it is well-established that insurers develop narrow networks to reduce unit prices in exchange for volume directed toward in-network providers.¹⁰ But MA plans do not need to obtain price concessions from providers, given indirect price regulation by Medicare. The Medicare-equivalent rates used by MA plans are already significantly lower than commercial rates, which are approximately 75% to 89% above Medicare and rising.^{11,12} Yet, despite this protection, MA plans also form narrow networks, although somewhat less often than commercial insurance markets.^{13,14}

A recent qualitative study sought to identify the reasons MA plan pursue narrow networks through 15 interviews with MA program experts and senior staff of MA plans and health systems.¹⁵ The findings highlight the role of nonprice competition made possible, in part, by unit price protections. In MA, these unit price protections mean that winners and losers in MA markets are not determined by which plan negotiates the lower price from providers, but by other factors like performance on quality- and service-related “star ratings” and total cost of care, which are more aligned with the goals of other alternative payment models in the Medicare program (Figure 1).¹⁶

Interviewees said that star ratings are a critical area for competition in MA markets and that increasing or maintaining MA star ratings was a major driver for forming narrow networks. MA star ratings are based on measures like enrollees’ health outcomes, receipt of preventive services, and complaints and appeals.¹⁷ Plans with star ratings of 4 or higher out of 5 receive payment bonuses, giving plans a revenue incentive to improve star ratings. In addition, beginning in 2019, the Centers for Medicare & Medicaid Services will have the authority to terminate MA contracts for consistently receiving low star ratings.¹⁸ Star ratings are an incomplete and far-from-perfect measure of health plan quality,¹⁹ however, and they vary significantly by geography,²⁰ perhaps reflecting local variations in provider quality more than plans’ contributions to quality. Regardless, higher ratings mean higher revenues.

Interviewees indicated that increased revenue from high star ratings motivates plans to selectively contract with providers who have better scores on outcome and process metrics—a strategy they are able to pursue where providers are plentiful and performance on quality measures varies significantly. Recent MA enrollment data reveal a competitive advantage for plans with high ratings. Since star rating payment bonuses were implemented, enrollment in 4- and 5-star MA plans eligible for those bonuses has grown rapidly, from 37% of MA enrollees in 2013 to 66% in 2017.²¹

Plans also seek to lower total costs through narrow networks. Plans reported that narrowing networks allows insurers to direct enrollees to providers with lower utilization rates and lower-intensity places of service (e.g. home health rather than

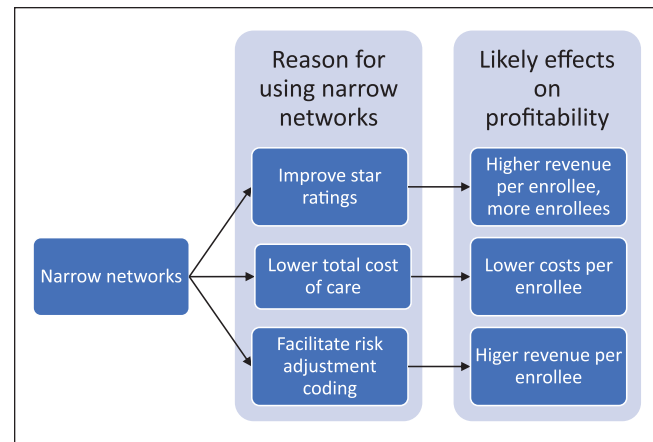


Figure 1. Reasons for narrow networks in Medicare Advantage plans and potential effects on plan profitability.

a skilled nursing facility). In addition, health systems noted that they seek alternative payment models with MA plans to more directly manage the total cost of their patients and maximize net revenues, and some health systems have even created their own MA plans. Many of these health systems have also participated in Accountable Care Organizations (ACOs), but preferred MA alternative payment arrangements for their stability and higher revenue.

Finally, risk adjustment diagnosis coding is a significant consideration for all MA plans. One recent study estimated that this practice could increase Medicare spending by \$200 billion over the next 10 years.²² However, interviewees noted that risk adjustment diagnosis coding is not a key consideration for deciding to form narrow networks. While narrower networks make provider education about risk adjustment diagnosis coding procedures easier, plans focus on diagnosis coding regardless of network size because it is important for increasing revenue.

Prior research has shown that increasing MA penetration is associated with shorter hospitalizations and lower costs in traditional Medicare and commercially insured populations,²³⁻²⁵ suggesting positive spillover effects from MA that are unrelated to prices. However, studies of service denials and appeals have shown that MA plans may inappropriately limit care or avoid high-risk enrollees,^{26,27} a common response to capitation.²⁸

While the MA system has flaws,²⁶ including increasing market concentration,⁹ it is a robust health insurance market that is increasingly popular with both beneficiaries and health plans.^{18,29} In fact, the success of the MA program is likely because of, not in spite of, regulated provider pricing and other regulatory infrastructure that encourages plans to compete on star ratings and total cost of care instead of the ability to negotiate lower unit prices.³⁰ The traditional Medicare program has put similar, though weaker, incentives in place in the ACO program, rewarding health systems that reduce total cost of care while maintaining or improving performance on

quality measures.³¹ With the growth of both ACOs and MA, an increasing share of Medicare enrollees are covered by alternative payment models that promote competition along nonprice dimensions under regulated pricing. Overall, the MA program shows that provider price regulation can coexist with insurance market competition and may, in fact, free insurers to compete on quality measures and site of care if the right incentives and oversight are in place.

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