

MEDICARE ADVANTAGE NEWS

New Study on Financial Impact of Member Inertia Could Aid CMS, MA Plan Messaging

A new study comparing the costs of Medicare Advantage plans that beneficiaries chose to stay in vs. those that were available to them at a lower overall expense suggests that seniors may not be actively and routinely comparing plans and are subject to a certain amount of inertia that may keep plans from offering more competitive products. While the findings support previous studies illustrating the general stickiness of MA consumers, they attempt to quantify the amount of money “left on the table” associated with remaining in a plan over time, which may be helpful to CMS as it makes pending revisions to the Medicare Plan Finder (MPF) or to MA sponsors as they enhance their messaging to enrollees.

In an effort to ensure that Medicare beneficiaries have access to “meaningful benefit information” when selecting plans this fall, CMS in May said it intends to make changes to the Medicare Plan Finder tool that include showing data on more benefit categories and an expanded display for drug costs and coverage (*MAN 6/8/17, p. 1*). And a CMS official that same month emphasized the agency’s interest in improving the beneficiary plan selection process.

Using linked administrative enrollment and plan data for a sample consisting of 93,519 beneficiaries enrolled in MA prescription drug (MA-PD) plans in 2013, the study published in the June *American Journal of Managed Care* considered differences in plan costs and how they varied as beneficiaries stayed in the same plan for longer periods of time. The study’s authors, Paul Jacobs, Ph.D., of the Agency for Healthcare Research and Quality and Eamon Molloy, Ph.D., of the Congressional Budget Office (CBO), asserted that while other research has examined the inertia of enrollees in stand-alone Medicare Prescription Drug Plan products, little attention has been paid to how that plays out in the MA market and how it impacts beneficiaries financially.

In comparing beneficiary plan selections, researchers considered total premiums and expected out-of-pocket medical costs (OOPC), which are listed on the MPF and derived by CMS using a standardized sample of representative beneficiaries. They limited their regression analyses to beneficiaries enrolled in Medicare for six years or more. The findings included:

◆ *The minimum expected spending plan (MESP) — the plan with the lowest combined premium and OOPC — cost 19%, or \$697, less than what beneficiaries paid on average in 2013, which was \$1,667 in premiums and \$2,078 in OOPC.*

◆ *The difference between expected spending in a beneficiary’s chosen plan vs. that of the MESP rose with the number of years a person was continuously enrolled in the same plan.* For example, beneficiaries in their first year in a plan paid \$552 more than they would have spent in the lowest cost plan, and those in a plan for six years or more paid \$786 more than the minimum plan.

◆ *For each year a beneficiary stayed in their same plan, their additional spending in excess of the lowest cost choice went up by approximately \$50.*

◆ *In 2013, 97% of MA beneficiaries had at least one plan available to them that would have reduced their overall expected spending and about 87% had three or more such plans.* Moreover, 64% could have found a cheaper plan without switching their plan type or their insurer.

The authors suggested that MA enrollees could “reduce their exposure to healthcare spending by switching to plans with lower premiums, although there may well be rational reasons for paying these costs, which we cannot observe.” Moreover, the results are reflective of a “plan choice environment” where seniors are passively re-enrolled in their plans each year, a trend that is likely leading MA insurers to raise premiums or cost sharing “in the hopes that they could profit from inertial consumers,” added the authors. One potential consequence of that inertia, they warned, is that it lessens the incentive for insurers to compete for enrollees by lowering premiums or designing benefits to meet consumer preferences.

Seniors Face Limitations When Mulling Switches

The authors acknowledged that the study had several limitations, such as an absence of MA claims data that could have enabled comparisons of what beneficiaries would have actually spent on cost sharing had they chosen differently. The authors also pointed out that prior research has shown that seniors with cognitive limitations may have trouble assessing the various tradeoffs as-

sociated with switching plans, and that when faced with multiple no-premium plans, attributes such as provider networks, cost sharing and covered benefits are harder for consumers to understand and compare. Additionally, because many members pay premiums through withholdings from their Social Security benefits, they may be discouraged from actively considering their choices even when premiums increase, they suggested.

Jacobs and another CBO analyst made similar observations on member inertia in a 2015 study, which evaluated the sensitivity of consumers to premiums and benefits when choosing Medicare plans after the introduction of Part D. They found that when selecting MA plans, enrollees were roughly two to three times more responsive to dollars spent to lower cost sharing rather than reductions in their premium. In that study, researchers suggested that efforts to enhance premium differences between plans and raise the level of awareness of such differences could drive seniors to opt for more competitively priced plans.

"This is what I would call a perennial story. Every year CMS has been encouraging people to shop to get the best price," observes Jim Yocum, senior vice president of federal programs with Connecture, which conducted a study last year showing that Part D beneficiaries' out-of-pocket costs would have been 16% higher on average if they'd chosen the plan with the lowest possible premium (*MAN 12/15/16, p. 3*). But the new study advances existing research by illustrating "that the scale of the cost savings increases over time, and it quantifies that the longer you go without shopping, the more you spend over and above the cheapest plan," he remarks. Connecture works with brokers, private carriers and government agencies such as CMS to help them build a web-based consumer shopping, enrollment and retention platform.

“ [When you] annualize the savings... the number becomes bigger and the impetus to act increases when you start talking bigger numbers.

Being able to put a number to consumers' potential lost savings could help plans highlight the differences in benefit packages during open enrollment or in communicating potential cost savings to existing enrollees. "I think that's one of the reasons we've structured all of our comparison tools, including what is used on Medicare.gov, to annualize the savings. Because the number becomes bigger and the impetus to act increases when you start talking bigger numbers," says Yocum. "And there is a persistent subset within the Medicare population that will attempt to optimize both premiums and an estimated OOPC, and are still trying to keep that monthly cost below some figure in their head, and we've seen that since the beginning of the program. So I think targeting that population with better messaging or just messaging that they will read would benefit the carriers and the beneficiaries themselves."

Nevertheless, there is an important limitation to the research, weighs in Mike Adelberg, principal with FaegreBD Consulting. "The researchers note that beneficiaries are well served financially by comparison shopping each fall," he says. But for some, particularly those beneficiaries with chronic diseases, "switching plans could involve disruptions in provider and drug continuity. These disruptions might outweigh cost savings," he points out.

View an abstract of the *AJMC* study at <http://tinyurl.com/y9rq7f74>. Contact Adelberg at michael.adelberg@faegrebd.com or Yocum via Jeff Hyman at jhyman@connecture.com. ✧