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How Well Are Seniors Making Choices Among Medicare's Private Plans and Does It Matter?
Kaiser Family Foundation
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TRICIA NEUMAN: Hello, everybody. Good morning. I see the mic is working and I'm happy about that. Welcome to the Kaiser Family Foundation and our Barbara Jordan Conference Center. I'm Tricia Neuman. I'm a Senior Vice President of the foundation and I direct our Program on Medicare Policy and I am really excited to see so many of you here to talk about something that I know will be of great interest on how seniors are making health insurance choices and what difference does it make.

With the new health insurance exchanges in the first year of operation, a lot of attention is focused on a certain group of consumers. We're actually going to turn our attention to another group of consumers who actually have some experience in dealing with health insurance choices. Of course, I'm talking about people on Medicare and we'll focus a bit on what they're doing with respect to choosing among Medicare Advantage and Part D plans.

Now, as many of you in this room know, people on Medicare have had a choice among private plans for years. For the past several decades people could choose between traditional Medicare and some could choose HMOs, the Balanced Budget Act, remember back in 1997, ramped up this idea and called it Medicare Plus Choice and gave people a choice among

different types of plans. The Medicare Modernization Act several years later gave this a further boost rebranding Medicare Plus Choice as Medicare Advantage and also providing a new Medicare drug benefit that was administered exclusively to private plans, either Medicare Advantage plans or prescription drug plans, stand-alone drug plans.

What does the landscape look like today? Here's sort of the basic overview, people have a choice between traditional Medicare and Medicare Advantage and there are about 30-percent of people in Medicare Advantage plans, 70-percent are in traditional Medicare. On average, people have a choice of about 18 plans if they're in a Medicare Advantage plan. If instead they choose traditional Medicare they have a choice of about 31 prescription drug plans.

As you can see, and this is an overall national average, there's plenty of choice that is available to people today on Medicare. Now, of course if they're in Miami, they have lots more choices. In fact, in Miami this year the count is something like 88 plans if you include both Medicare Advantage and prescription drugs so as we like to say here at the Kaiser Family Foundation that produces opportunities and challenges. Look at this poor guy, I love that photo.

Today's briefing is our effort to understand how seniors are choosing in this environment, a topic that is

important because private plans have emerged as a big part of the Medicare landscape. Here what you can see is about 75-percent of people today are now enrolled in some kind of a private plan that is subsidized by Medicare, whether it's a Medicare Advantage plan, which has about 30-percent of the population or a stand-alone drug plan, which has about 45-percent of the Medicare population. Given the number of plans that are available and the number of people in this marketplace, it's increasingly important to understand how this cost structure is working for Medicare, for all the stakeholders in the Medicare system, and of course for Medicare beneficiaries.

From a policy point of view, the hope is that people each year will think about what their healthcare needs are, what their preferences are in terms of pharmacies or drugs or doctors or hospitals, they will look at the health insurance landscape and they will choose a plan that is most suited for their individual needs or if not most suited for their individual needs, good enough. The hope is that consumers will use their clout to motivate private insurers to compete based on cost, based on quality and that in turn will leverage down costs, result in better quality, and perhaps even result in Medicare savings.

A few years ago we surveyed seniors and we said to them, what do you think about all this choice, because you know Kaiser is known for a lot of our survey and polling work. When we asked them what they thought here's what they said. What's your view of the number of Medicare plan choices? What you can see here is this. Forty-percent said we find all these choices quite helpful. Forty-one-percent, we find all these choices confusing. Nearly 20-percent were not willing to choose. Thank you for the giggle. We didn't, by the way, let them say both helpful and confusing because we thought almost everybody would say we thought it was helpful and confusing.

Today we're going to look more closely at the theory of choice and examine whether economic theory and human behavior are well aligned. We are going to be examining whether people are thinking about these opportunities to choose plans, to switch plans, to find the plan that’s best for them. We are going to think about what it means for Medicare and for the Medicare population. If people are not choosing, as many health policy analysts predict or hope that they will, we want to know what difference does it make.

With that introduction, in a moment you are going to be hearing from the nation's leading expert on choice and then we will turn to our panel of Medicare and healthcare experts to drill down more deeply and talk about what all this means for

the Medicare program, the healthcare industry, and for people on Medicare. To kick off this discussion I could not be more thrilled to introduce someone who I think of as the guru of choice. Barry Schwartz is a Professor of Psychology at Swarthmore College. He has studied the topic of choice for many years, maybe as long as there have been choices in Medicare, I don't know. He has written a really incredibly interesting book called *The Paradox of Choice.* I don't know if you've read it but if not I would suggest that you do. I reread it this weekend and I found myself nodding, sort of almost mocking myself when he talks about how people behave when they have lots of choices but also laughing because he's very entertaining as you are about to hear.

Professor Schwartz, I can say is the first person with a background in psychology that we have invited to talk about Medicare policy specifically so maybe we need to bring in a psychological perspective to policy a bit more. I think it might help some of us. I know he's the only person who I have invited to the stage who has a background and expertise in talking about blue jeans, jams, and cereals. Without further ado please join me in welcoming Professor Schwartz to the stage. [applause]

BARRY SCHWARTZ: Thank you.

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BARRY SCHWARTZ: I'm not sure I can live up to that introduction. I'm not the world's expert on choice but I did write a book that a lot of people seem to have paid attention to and that's what I'm going to talk to you about. I know much less about the choice and how it plays out in connection with healthcare than everybody else on the panel so I'm going to try and give a general picture of choice and its vicissitudes and then the people who follow me will, I hope, affirm what I've told you in connection specifically with healthcare. Ah, yes.

There is in the United States and most other western developed countries what I have to come to call an official syllogism that we so take for granted that we don't even realize that we believe it and the syllogism runs like this. The more freedom people have the better off they are. There's one thing you can't have too much of, it's freedom. This is a sacrosanct value in American society. If you accept this as virtually all of us do, the question is what does it mean to have freedom and the answer is you don't have freedom unless you have choice. If you want to enhance freedom you should enhance choice. More freedom means more wellbeing and more choice means more freedom. How could this not be true? Of course it's true and if it's true what follows? What follows is that the more choice people have the better off they are.

We have certainly operated over the last two generations as if this is self-evidently true. This is my supermarket, which is not a very big one, so you must admit there's even more choice than this clicker is allowing me to show you. There is a lot of choice when we go shopping for groceries; 275 different kinds of cereal. What could be better than that? Now, there's always been choice in supermarkets now we just have more of it and you could claim this is merely a quantitative change, although it seems to me 275 isn't nearly quantitative, but there are other areas in life where we used to have no choice where we now have significant choice.

My favorite example is with regard to phone service. There doesn't seem to be anybody here old enough to remember the time when there was one phone company and it made one phone, but that was once true. It's not true anymore. These are the cell phones of the future; the one in the middle is my favorite. This leads people to go into their store and ask this question, and of course the answer to this question is now, no. There's only one kind of phone you can't get and that’s a phone that’s just a phone. Actually there is one, it's called a Jitterbug, it's for very old and myopic people. Each button is about the size of your head and all it is, is a phone but you can't actually buy it in a store because what sane person would choose it.

Here's a case where there used to be no choice and now there is significant choice. Given what we're talking about today the healthcare domain has changed dramatically, both the provision of services and also the provision of insurance. The ethic of modern medicine is the ethic of patient autonomy, which basically means that doctors don't tell patients what to do. Doctors give you the options and you choose. Chemotherapy, surgery and you look at the doctor like, what? The doctor says, listen, I can't tell you what to do. These are the benefits and risks of chemotherapy, these are the benefits and risks of surgery, what do you want to do? This is—it's not always honored in practice by doctors but this is the way doctors are supposed to treat patients; doctors propose, patients dispose.

In connection with insurance there is Medicare. There are a variety of Medicare plans as you just heard. There's also Medicare Part D, these drug plans, which offer people somewhere between 20 and 82 different plans to choose from and having made this decision they get to do it all over again the next year when everything has changed. Now, with the Affordable Care Act people are once again being confronted with lots of different options about how to get their healthcare.

Retirement plans, the company pension is a thing of the past. Instead we have 401(k) plans and benevolent employers

will offer us 50, 100, 200 different mutual funds into which we can put our meager pension investments.

The world used to look like this and now it looks like this, and now it looks like this, and the question is, is this good news or bad news and the answer, as I'm sure you can tell, is yes. We all know what's good about it so I'm going to talk to you about what's bad about it. When people have a lot of choice three different kinds of bad things happen.

The first bad thing that happens is instead of being liberated by all this choice people are paralyzed. The first demonstration of this done by the real world expert on choice, Sheena Iyengar, was the famous jam study where a fancy food store in Palo Alto had a new product. It put it on a display table, 30 different flavors of expensive imported jam. You could stop by the table, taste the jam, and if you did you got a coupon that would save you a dollar on any jam you bought. A few days later, same jam but instead of 30 flavors, six flavors. What Sheena found is that when there were 30 flavors more people were attracted to the jam than when there were six but one tenth as many people actually bought jam. One tenth as many people actually bought jam. Why? Because they couldn't figure out which damn jam to buy.

The same thing is true with 401(k)s. Sheena did a study of 500 companies, a million employees and they all were

serviced by Vanguard, but they differed one from another in how many mutual funds they offered employees. Some offered a few, some offered 20, some offered 50, some offered over 100, and what Sheena found is the more mutual funds that were available the less likely people were to choose any. Roughly 2-percent decrease in take-up for every 10 funds that were offered and what's stunning about this is that by not signing up in most cases employees were passing up matching money from the employer. They were basically taking a $5,000 bill and tearing it up because they couldn't decide. This is problem number one, paralysis.

To overcome paralysis and choose, you face problem number two, which is that people make worse decisions when there are lots of options and this is especially true when the things people are deciding about are multi dimensional and complicated as for example choice of a prescription drug plan or a health insurance plan. Medicare Part D has been studied, both in the field and also in laboratories where they simulate the kinds of decisions that consumers are going to have to make and they found quite consistently, since they knew what drugs people were taking, they found quite consistently that people made suboptimal choices of prescription drug plans and the more plans they were given to choose among, the more likely it was that they were going to choose a suboptimal plan.

Here's another example of this, it shows you why choice is a problem. This is work done by Daniel Kahneman and Amos Tversky, so you give people a choice between surgery and radiation therapy and they get these statistics? Ninety survive surgery, 68 live to the end of the first year, 34 live to the end of five years, radiation, everybody survives that, 77 survived to the end of the first year, 22 survived to the end of five years. Which would you choose given these statistics, radiation or surgery?

Contrast that with this version, which is exactly the same thing except that instead of 90 people surviving the surgery, 10 people die. With me? Exactly the same but now you're focusing on the negative rather than on the positive. In the first case 78-percent choose surgery and in the second case 42-percent choose surgery. This points out the problem that you raise for people when you decide you're going to give them choice. What's the right way to describe this choice for a patient, in terms of their mortality, their survival, both? Both will surely confuse them. This is not an easy problem to solve. That’s problem number two.

Problem number one is paralysis, problem number two is bad decisions. The third problem, which is what I focused most of my attention on, is that people are less satisfied when they choose from a large set of options than when they choose from a

small set of options, which makes no sense. It's like you go to a restaurant and you order the grilled salmon. If you've ordered the grilled salmon from a set of five entrées you will like it better than if you ordered the same exact grilled salmon from a set of 20 entrées. That's what this research shows.

There are several reasons for this. One is regret. Is the salmon perfect? Has anyone ever had salmon that was perfect? It's not perfect and it's easy to imagine that one of the options—one of the alternatives would have been better and it's easier to imagine that when there are 20 alternatives than when there are five.

The second problem is missed opportunities. You choose the grilled salmon and it's the right—it's good. You made the right decision but there were all these other attractive things that you didn't choose and as you put each forkful of salmon into your mouth, you're thinking about how nice the duck would have been, and how nice the shrimp would have been, and how nice the risotto would have been. Each of these alternatives subtracts from the satisfaction you get out of the salmon even if you think you made the right decision. This is true of ordering in restaurants and may also be true of deciding who to marry, so here's an example of that. Apparently this doesn't need explanation. It's not—parking problems are not unique to

New York and he's another example, my favorite cartoon. When I show this to young people I do it to try to convince them that despite what they think you can really only do one thing at a time and whatever it is you're doing there are many, many other things you're not doing and if you think about all the things you're not doing, you're not going to get as much satisfaction out of what you are doing.

The third thing is when there are large choice sets, what happens is our expectations about how good the decision we make will be go up. When we get a result, inevitably, we compare the result not to some objective standard but to our expectations. If you expect a mediocre result, you might be pleasantly surprised. If you expect a great result, the best that can possibly happen is you'll break even with expectations and chances are pretty good that things won't be as good as you expected them to be. Large choice sets raise people's expectations about how good the choice will turn out to be so they end up disappointed, even with good decisions.

I don't want to romanticize the past but the sense in which this is true is that when things were worse expectations were lower, and when expectations are lower people have the opportunity to be pleasantly surprised. We have basically eliminated that as a possibility in modern affluent societies like ours.

Okay, so how can choice be good and bad, because remember I did say that choice was good. We make an assumption that if some of something is good, more of it must be better. What I call the monotonicity of assumption. Three options are good, five will be better, 10 will be better, 15 will be better still. This assumption, it turns out in connection with choice is false.

This is my conception of the relation between wellbeing and choice as zero is neutral, plus is good, minus is bad. When you have no options in life, life is infinitely bad. As you start giving people options you make their lives better but the curve is a curve. There's diminishing marginal benefit to additional options. Eventually, the curve flattens out. This captures the fact that is undeniable, that choice is good, but choice is also bad. The regret, the paralysis, the bad decisions are all captured by the second curve. The more options you offer, the greater the magnitude of the bad stuff. How does it feel to have any given amount of choice? The answer is you simply add these two curves together algebraically and when you do you get a curve that looks like this. Going from no choice to some makes people's lives better. Going from some choice to more, bends the curve. We all want to bend the cost curve, unfortunately, now we're bending the satisfaction curve and if the choice set is large

enough you can actually make people miserable; move them to the wrong side of neutral. That's what the negative aspects of choice do.

The trick is to find the sweet spot. How much choice is the right amount of choice for people to benefit from the freedom that this choice offers and not pay the prices that I've been describing. I'll just say one word about what we can do to deal with the choice problem, and it comes from work by Cass Sunstein and Richard Thaler. It's captured in a book they wrote called *Nudge* and their argument in this book, and then I'll finish, is we're not really going to stop people from making choices. Certainly not in supermarkets and probably not when it comes to things like healthcare. The trick is to organize the architecture of choice so that when people are in fact paralyzed because there are so many options, they get automatically what's in their best interest. This has a lot to do with taking advantage of structuring choice so that the default, the thing you get if you do nothing, is actually good for you.

You don't have to take the default. You could always opt out but if you don't opt out you end up with health insurance instead of without it, with money in your 401(k) instead of not having money in your 401(k). It preserves our

commitment to liberty pretty well, and it also tries to mitigate the negative consequences of too many options.

Okay, so, concluding, this cartoon captures the essence of what I've tried to tell you. You can be anything you want to be no limits, says the parent fish to the baby fish and we look at this and we say, what is he talking about? There's nothing—they're aren't any options in there, right? This is a world of diminished opportunity and that's true, but what is also true is if you shatter the fishbowl what you've created for the baby fish is a monstrosity and a nightmare, not nirvana. Every human being needs a fishbowl. Every human being needs to choose within constraints and the difficult task is to figure out which constraints, how many constraints, so that people are enabled to choose and they're enabled to choose wisely because we haven't given them a problem that is impossible for them to solve. Thank you.

TRICIA NEUMAN: Okay, this is your turn to ask questions and if you don't have questions, I have plenty but it's sort of fun to hear from the audience. Does anybody want to start with a question? All right, I will ask a question and I'll give you a little bit of time to think about this. One of your solutions is to have a default and that way people are sort of protected. There's a good choice available for people and then they can move beyond that. Short of a default, which

has been something that in the policy world people have shied away from, how would you—what else would you do to both bring on more happiness and to help people make better choices?

BARRY SCHWARTZ: That's a great question, the critical thing for people to appreciate that I think a lot of critics of the nudge idea don't is that there's really no neutral way to present anything. Consider the survival rate/mortality rate in the example I gave of radiation versus surgery. What's the neutral way to present that information? It doesn't exist, so anytime you put anything into words you're going to be pushing people in one direction or another. The question is what's the best way to put things into words so that when you're pushing people, you're pushing them in the right direction?

There are some domains where we don't know the answer to that. We don't what cereal to push people towards. There are other domains where we do know the answer to that because there's overwhelming evidence that people, for example, approve of organ donation. We can make it easy for them to be organ donors. They approve of being able to pay their bills when they retire. We should make it easy for them to put money away.

Forced choice is an alternative to defaults. You can't get your driver's license unless you decide whether you are or are not going to be an organ donor. You can't start work

unless you decide whether you are or are not going to be putting money into a 401(k). This satisfies some libertarian critics of defaults about half as effective to force people to make choices as it is to create a default. It's still much better to force people to choose than it is to have the wrong default, so you can do that. Then there are a whole continua. You can force people to choose but make it easier for them to choose the better option and harder for them to choose the worse one and the specifics will almost certainly depend on the domain that you're trying to create architecture for.

TRICIA NEUMAN: Can you just stand up and introduce yourself.

Barry Brauth: Barry Brauth, CMS. Actually this is more of a comment than really a question but as you were talking there I was thinking of Google and I remember when I would put in a search term and you get back there were 1.5 million hits, but Google presented to me a screen with five, or six, or seven. They sort of recognize what you're talking about.

BARRY SCHWARTZ: Right, so, online there are lots of possibilities for solving the problem because you can structure the choice set tailored to each individual. You can also make recommendations. Amazon makes recommendations to me about what books I should buy based on what books I've bought. They're

remarkably good at that. I don't buy everything they recommend but everything they recommend is relevant and worth thinking about. What they're doing is, they're taking my past behavior and tailoring a set of options for me in the future. Amazon is a nightmare if you're browsing but it's great if you know exactly what you want because whatever it is you want they've got it. The way they solve the problem of having an infinite number of options, is that they don't present you an infinite number of options. They present you with a half-dozen.

I think there are lots of possibilities there. It's harder for the state to do that because the state isn't meant to play favorites. Even if the state knows exactly what you want it probably can't tell you because there would be enormous backlash. I think there's a way in which the state has to find a way to do this with one hand tied behind its back and the private sector doesn't have to worry about playing favorites.

TRICIA NEUMAN: Howard.

HOWARD BEDLIN: Howard Bedlin with the National Council on Aging, is there a methodology by which we might attempt to find the sweet spot?

BARRY SCHWARTZ: Is there a methodology by which—yes, I think the answer to that is yes but unfortunately I don't think it's a general methodology that will give you a generalized sweet spot. My sense is that the sweet spot depends on the

domain in question. Some domains people may want a small number of options and the sweet spot may be six or seven, and in other domains it may be 20. I don't think there's any way of avoiding the hard work of doing the research in your domain of interest. Then you give people hypothetical choices, you can evaluate the quality of the decision they make, the time it takes them to make the decision and their own reaction to whether they're satisfied with the choice process and in that way try to figure out what the sweet spot is for Part D prescription drug plans, for cereal purchases, and so on. I don't think there's a general answer, the magic number seven or something like that for how many choices is the right number.

TRICIA NEUMAN: We have a question over there but before we go to it, I'm going to sneak in a question, which is, is this conundrum product-neutral? In other words, does this apply equally to jams, to cereals, to retirement plans, to cars, to any other products people are choosing? Or is it more specific to certain types of decisions than others?

BARRY SCHWARTZ: Is it product-neutral? I think the evidence we have is that it is pretty much product-neutral. There's a product by person interaction, so you may be a real car buff. In which case, the right answer to the question how many car options for me is infinite because I like to roll up my sleeve, get in the weeds, look at all the details. I can

never have too many options. When people say this to me, I say, fine, do you feel the same way about cereal, and about jam, and about Medicare plans? They go, no, I see what you're getting at. I think it's the probably the case. Every domain that has been studied there is a choice overload problem but it won't be our choice overload problem for every person who faces it. I think that's a fair—and if you know what you want, there is no such thing as too many options because if you know what you want the task is to find it and with a large choice set, it's more likely to be in there than with a small choice set. The problem is we seldom know exactly what we want. We know approximately what we want and that's when the fun begins.

TRICIA NEUMAN: We have time for one more question and I think we have a question over there.

STEVE Scango: Steve Scango, , with GlaxoSmithKline. Thinking about the baby boomer population that's about to come into the marketplace, specifically the healthcare marketplace, have you seen in any of the data that's out there the comparison between the older sector versus the younger sector and how they approach this issue?

BARRY SCHWARTZ: The little bit of evidence we have is that this is less of a problem for older people than it is for younger people, paradoxically, because you'd think the cognitive challenge of finding the right choice would be a

bigger issue, but the reason why is that older people are not interested in finding the best option. They are interested in finding a good enough option and if that's all you're looking for, all of a sudden the choice problem gets much more manageable because you don't need to look at every option. You look at one, you look at another, you look at another, ah, that's good enough. Your search is done. I think experience teaches people, this we don't know because we haven't done a longitudinal study, either it's a cohort effect in which case current seniors have learned this, but future seniors won't, or it's an experience effect in which case as you age one of the most important lessons you learned is that good enough is almost always good enough. That makes the choice problem much less debilitating. That's the best guess I can make but we don't really have much in the way of data.

TRICIA NEUMAN: I hear my mother now, like isn't that good enough? I'd like to go through this again.

BARRY SCHWARTZ: Let me tell you, trying to convince college students that good enough is good enough is hopeless but it's not hard to convince people my age that good enough is good enough.

TRICIA NEUMAN: Can you all join me in thanking Professor Schwartz.

BARRY SCHWARTZ: Thank you very much.

TRICIA NEUMAN: Thank you so much.

BARRY SCHWARTZ: Thank you.

TRICIA NEUMAN: Okay, great. Now, we're going to do something that's more typical of the Barbara Jordan Conference Center, we're going to invite our health policy experts and wonks to the stage, leading off with Gretchen Jacobson, who is the Associate Director here at the Kaiser Family Foundation in our Program on Medicare Policy. Everybody, please come, join me. Gretchen leads or work on Medicare Advantage and is going to be talking to you about some focus group work that we've done here.

I'm also pleased to welcome Josh Raskin, who I think it's his first trip to the Kaiser Family Foundation. We're very happy to have him. He's a Managing Director and Senior Analyst in the Equity Research Department at Barclays and he is an expert on the managed care industry and the healthcare industry more generally. Joe Antos is no stranger to this audience or to this building. He is the Wilson Taylor Scholar in healthcare and retirement policy at the American Enterprise Institute and we are thrilled to have him here. Last but certainly not least, is Judy Stein who is the founder and currently the Executive Director at the Center for Medicare Advocacy. She is a lawyer and a fierce advocate for consumers and I'm looking forward to hearing everybody speak. They're

going to offer their remarks but now I'm going to give you a warning. You have time to think about your questions for this panel after they each make a few opening remarks.

GRETCHEN JACOBSON: Thank you. It's great to see such a large crowd here today. As Tricia said, people on Medicare have a lot of choices among private health insurance plans, whether it's Medicare Advantage plans, Part D plans, or the Medigap plans. The question arises of how are beneficiaries actually choosing among plans and what are the factors most important to them? Is it the premium, the plan's quality ratings, the cost of different services, or some other factors? What is it that prompts them to actually switch plans, if anything? There is some quantitative research looking at this question and the bulk of it shows that many beneficiaries are not in the lowest cost plans. Some research suggests that beneficiaries may be attracted to plans with higher star quality ratings but we do not know if they are picking their plans based upon the ratings.

Further, relatively few beneficiaries ever switch plans, even their plan's premium, benefits, and even provider networks change each year. Since there seems to be a lot of factors affecting beneficiaries plans choices that you can't quantify we worked with PerryUndem to conduct focus groups with seniors during the Medicare open enrollment period in four

cities; Baltimore, Tampa, Memphis and Seattle. Before I get to the findings, I would first like to thank my co-authors and colleagues, Christina Swoope and Michael Perry, for their work on this report.

Here's what we learned that's underneath the numbers, not surprisingly seniors said that cost is one of the most important factors to them but they defined cost differently. For some, particularly healthier seniors, that meant the premium, while others were most focused on the out-of-pocket limits or costs for particular services such as hospitalizations. Some who took particularly costly medications were focused on what they would pay for those medications.

There were also a lot of factors other than costs that were important to beneficiaries. Many seniors want to be sure that they had access to particular providers. Some in Medicare Advantage plans were concerned about access to specialists and certain hospitals, while people in stand-alone Part D plans said that access to their pharmacist was very important to them. Reputation of the insurance company also really mattered to seniors in the focus groups and some seniors stayed with the same company through which they had insurance prior to going on Medicare.

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Seniors were also looking at coverage, whether that meant coverage for particular services provided by Medicare Advantage plans or coverage for particular drugs. Finally, to our surprise, some seniors thought it was very important to be in the same plan as their spouse, even if their spouse had more healthcare problems. This wasn't as true among people in Medicare Advantage plans who wanted the same set of doctors. It was also true among some who had stand-alone Part D plans. One woman in our focus group explained that it's much easier for her if her husband is in the same Part D plan because when she went to the pharmacy to pick up their medications she knew what her plan covered and how much it would cost for medications. She just could not imagine having two sets of rules for two different plans.

When we asked seniors about the star quality ratings most of them didn't know about them. Those who did questioned their validity because it wasn't clear to them how they were calculated. Seniors said that their own experience with the plan was more important to them than the plan's quality rating. When one woman in the focus group was told that her plan had fewer than three stars, she shrugged and said, so be it. It didn't reflect her experience with the plan and she had no intention of changing plans. It seems as though overall that

the star ratings did not seem to affect beneficiaries' overall plan choices.

Seniors said that they found it very difficult to change plans and to choose plans. They liked having many options but the process of choosing plans they found frustrating, confusing, and exhausting. They received a ton of information but they found it difficult to use it to actually compare plans. Some of them, many of them actually, read the Medicare handbook but they didn't find it to be very helpful. Some of them tried to use Medicare Compare on *Medicare.gov*, but they said it was difficult because you had to scroll, then scroll down, then scroll up again, if you wanted to compare different features of plans.

We did have one retired aerospace engineer in our focus group and he said that every year he made a spreadsheet of all his options but he said that he still found it to be frustrating and confusing.

To help sort these options, many seniors relied upon insurance agents to help them pick a plan and the idea of having this in-person help was so appealing to seniors that oftentimes after the focus groups we would find that seniors were providing their insurance agents contact information to other seniors that wanted it. People also talk to their pharmacists, their friends, and their doctor's offices to help

pick a plan. Overall, people tried to compare plans and really wanted to understand their options but they didn't have the tools that they wanted.

Because the initial process of choosing a plan was not an easy experience many seniors were reluctant to re-visit their initial decisions and change plans. Many seniors said that they would try various workarounds before changing plans including changing their drugs, getting samples from their doctor, or even changing their primary care physician. Seniors said that they expected that premiums and out-of-pocket costs would increase and they thought that if their premium was increasing other plan's premiums were increasing as well. Along the same lines, seniors said that if their costs ever decreased they'd be suspicious and wonder what benefits of theirs were being cut.

However, seniors said they would change plans and some in our focus groups did if costs increased a lot. They also said that they would change plans if their plan dropped a particular pharmacy or a doctor or a hospital that they valued. For most seniors, changing plans was a last resort option but they were willing to do so if necessary.

When we asked seniors what could be done to make it easier for them to change plans and compare plans, many, and particularly those who did not have insurance agents, wanted

more in-person help. They liked the fact that agents that come to their home, review their options with them, and help them to pick a plan. They also thought they would be more inclined to review their options if they were told how much they could save by changing plans. Some seniors also wanted an online tool, although they did not find *Medicare.gov* to be particularly helpful.

Finally, seniors were intrigued by the star quality ratings and wanted more information about them. However, at the end of the day, they would probably value their own experiences more than the plan's quality ratings. Overall, seniors said they liked having many options but they wanted more help sorting through the options based upon the criteria that was important to them, which was sometimes often cost but oftentimes also other factors that are harder to measure overall. Thank you.

TRICIA NEUMAN: That's great. Thank you. You will have a chance to ask questions to Gretchen in a bit, but we're going to go to Josh Raskin.

JOSHUA RASKIN: Great, thanks, and good morning, everyone. First and foremost, thanks to Kaiser for inviting me. I was flattered when I got the call considering most of my research is just simply citing their surveys. I didn't know what I would be talking about here but I've made a couple of

notes. I'll just sort of talk to three points around a couple of interesting things in the Medicare world that we see and certainly more than willing to answer some questions.

First is, sort of this whole idea of too much choice; 88 plans in Dade County and all of that. We look at the Medicare Advantage. I'll start with Medicare Advantage I'll talk about PDP and then we'll talk about the stars.

Medicare Advantage, there are something in the ballpark of 350 to 400 plans nationwide that seniors could select based on their county. It's really misleading in my opinion to say that there's that much choice. If you look at the top 15 plans in the country overall, those top 15 plans have grown faster than the overall market the last four years. What we're saying there is that if you look from 2010 to 2013, the average of the top 15 plans has grown just over one million lives each year. That means since the program is only up about 950,000 lives on average over the last four years, that means that the remaining—so plan 16 through 400, have actually lost about 90,000 lives per year.

There's this thought that, oh my gosh, I'm inundated with choice when the reality is seniors in Medicare Advantage are continuing to pick the most efficient and in many ways I don't know if they're the absolute optimal case for every individual but they're certainly in that good enough category

where seniors are ending up in what I would consider to be the right bucket at least. That trend, by the way, is accelerating. Like I said, they've made up about 108-percent of the growth over the last four years and that trend in terms of growth continues to accelerate so that's the first thing.

Second thing is if you look at the PDP plans, I remember doing the initial analysis in the fall of '05 when all of the plans were introducing and no one knew what to look for and everyone said, well, you just kind of stick with the Blues or the AARP because brand matters, right? The first thing on PDP, is brand doesn't matter. I remember there's a company still around, Universal American, based up in Rye, they decided that they were going to go full bore into Part D. They signed an agreement with CVS at the time to be their sort of back engine PBM, got them to a very low cost structure, they introduced plans called American Progressive Life Insurance Community Care Rx, Pennsylvania Life and Trust. Not only were they new brand names, they were terrible. I mean, they were just nothing you would ever pick, but they aggregated towards to the top. You went on CMS on *Medicare.gov*, you sorted by premium; they were one of the first couple of plans. You put in your drugs and you saw if they were covered.

They built up one of the five biggest PDP plans on literally ridiculous brand names and I talk to the CEO about it

all the time and we joke about. They did a little market research. They knew that really all that mattered was column B, which was premium. In December of '06, so by the end of the first year, if you looked at the PDP landscape and again, hundreds of plans available, the top five plans have over 11 million lives. That was 67-percent of the total. The top 10 plans had 81-percent and the top 15 plans had 89-percent. I've never in the history of managed care seen any aggregation of share in a one-year period that looks like that. When you fast-forward to April, the April data that just came out that top five share has gone from 67-percent to 75-percent so think about that. Five companies are controlling three-quarters of the PDP market nationwide. The top 10 are at 91-percent that's also up a lot and then the top 15 is up at 95-percent.

I think what you're seeing in the PDP market is, again, it's aggregation of share to the largest plans, which is based solely on cost structure. If you want the cheapest plan, everyone knows it's the Humana Walmart plan and that's in all 34 regions and that's what most people are buying, or the largest percentage are buying year in, year out.

Then the third point I'll make is just the star bonuses. I think there's been a lot of discussion around how there's not much correlation between growth and enrollment in MA plans and star bonuses, and that's probably a generous way

to put it. I looked at the '13 data. I can tell you the '12, the '11, and the '10 growth, all of these numbers if you looked at just the calendar year 2013 the five star plans grew 6.5-percent. The overall program grew at 8.5-percent, so the fives were up 6.5-percent, the four star, 4 and 4.5s were up 9-percent, the 3 and 3.5s were up 12.5-percent, so you're actually seeing growth continue to increase as you go down the star bonuses.

My last point on this is, this will actually start to change. There's two different things that are going to matter. One is CMS is actually getting more active around it. They're sending letters and phone calls to individuals that are enrolled in not such great plans, so giving a choice as to switch especially if you're below three stars. Then the second thing is there's a pilot in terms of the bonus payments has expired and so only plans with four stars or better are eligible to get rate increases.

Again, my supposition on Medicare Advantage is it's a low cost structure that wins so if you're getting five percentage points of additional pricing relative to your competitors it means you can offer the eyeglasses and the hearing aids and the transportation services and fill in the donut hole and all that sort of stuff, so by definition your product actually looks more attractive. I think that becomes

self-fulfilling. People are more satisfied in plans that have better product and the better products sell so more people get into them and again, that becomes that virtuous cycle.

I would say, just in summary there, that the star bonuses have meant absolutely nothing. I don't think seniors care about the ratings or even look at them but it's going to matter for product design and ultimately that's what's going to win.

TRICIA NEUMAN: Terrific. Thank you. Joe.

JOE ANTOS: Thanks. Actually I take a slightly different lesson about the star bonuses, which is that the seniors are actually much better policy analysts than Washington policymakers because—

TRICIA NEUMAN: That's a low bar.

JOE ANTOS: It's a very low bar but the point is that—

TRICIA NEUMAN: I should have asked that. Is that a low bar?

JOE ANTOS: —indeed we do know that the star bonuses don't really tell you anything about quality and furthermore who decides what quality is for me? I think that's really a big question here. Now, everybody has seen the commercial about Progressive Auto Insurance ads on TV with Flo, the lady in white. You know why that ad is instructive? It's because that isn't the way Medicare sells anything. People who sell

insurance, know how to sell insurance. People who regulate insurance companies and people who regulate the Medicare program do not know how to sell insurance. It's pretty straightforward. It's not too surprising that—actually I thought that the results that Gretchen gave made perfect sense to me.

This says that seniors, at least those people that you've somehow selected, are very rational people. They're not going to go through a lot of effort to try to figure something out when it can't be figured out. As Barry said, good enough is good enough. That's partly based on maybe the fatigue of age speaking personally now, but it might also have something to do with experience. One of the reasons why young people might in the case of insurance or almost anything else, might want to get more into the details and think about a lot of stuff is that they don't know which details are important or not.

Whereas the older you get the more you realize that most of those details don't really matter at all. I thought that the results that you had, Gretchen, really were very positive. It raises some questions in my mind. The ultimate question that most people in policy ask is, can seniors actually make good decisions but they always define a good decision as the decision that I think you should make rather

than the decision you think you should make, and the reason is very simple. I know what I think. I have no idea what you think.

This is ultimately the problem, not just in Medicare, the problem with ACA, it's the problem generally with government supported health insurance. Somebody's going to make a decision and the market will somehow work itself out within whatever the restraints are, the fishbowl, except I think this fishbowl that we tend to talk about in Medicare and in the ACA, it's a pretty narrow fishbowl because it ignores one thing. It generally ignores the fact that a lot of people would rather have less health insurance. They'd rather have more of something else. This is one of the big problems. This is really not a Medicare issue. People have sort of gotten used to the idea that we're just going to have Medicare but for younger people, the ACA raises this important question, which is if I'm a low income person would I rather have more access to more doctors and more hospitals, or would I rather have more money in my pocket to spend for food, the kid's clothes, or a night on the town.

This whole question of choice really is a difficult one in health policy and maybe even more important now that we have the Affordable Care Act. Now, the next question that comes to mind is how many people actually have to be active switchers in

order for there to be an affective consumer voice in the market? I think this is a really good question. I think Josh's point about this consolidation in the Part D market is a pretty positive point. I think what it says is that you don't need everybody to be perfect and you certainly don't need most people to actively go through the agony, especially the way the HHS websites are, go through the agony of trying to figure out what the choices are this year. That's pretty hard to do, but you don't need that.

Now, you can't really say and economists can't really tell you how many or what share of the market needs to be sort of a threat to the active sellers. There has to be some threat but it doesn't have to be 100-percent. Does it have to be 20-percent? I don't know but 50, I doubt it. This whole question of do people make a good decision in the first place and we're there enough active switchers, I think again, sort of misses the point.

It's to me, this is asking for perfection when to repeat you again, good enough really is good enough and it ought to be good enough in health policy too.

TRICIA NEUMAN: Terrific. Thank you. Judy.

JUDITH STEIN: Yesterday afternoon I received a copy of Kaiser's, again, Kaiser's fine report about Medicare and choice and does it matter, and I think the latter question is really

very interesting. I was extremely worried because I had already sent in my slides. I had taken the liberty of making a Kaiser-like chart all on my own. I was very proud of this and Tricia may not be surprised because she said, well, we only have five minutes so don't worry too much about slides. I said, I already did this cute thing here.

TRICIA NEUMAN: It is adorable.

JUDITH STEIN: I can't give it up. My presentation is really based on what I know as a Medicare attorney for over 30 years and an advocate for beneficiaries. We have no skin in this game and I'm glad to be in DC and use some of these terms, except for what's best for beneficiaries, I always say to my crew, and what can we afford as a community. I did this chart based on my extremely non-scientific analysis of what we have seen over the many years I've been doing this work since Medicare Plus Choice and Medicare Advantage came in, re-branding, which I'll say a little bit of something about. I'm thrilled to say that I think it's not too bad a match for what the much more scientifically-based such charts would look like if you did one based on what your focus groups just showed.

The big piece of the puzzle, and I don't know how to do these things very well, so I wanted the left side by the way to be of the—and I only wanted three or four slides, of those who choose. That's what this is. Of those who choose, our

experience is that people do make a choice when they first become eligible for Medicare and as you know over the last decade-plus people became eligible for Medicare Plus Choice or Medicare Advantage and then Part D while they were already on Medicare so at the first opportunity to make a choice people tend to make a choice.

It may not be the smartest choice but they tend to make a choice and that's extremely important because if you think of your toothpaste, I can tell you I still use Colgate. When I was between five and eight there was this super dental man and he had what was a screen and that was the guard against tooth decay and Colgate was what you needed to get that invisible screen for your teeth because what we really needed was fluoride but I think insurance companies know that people make the choice at this time and it's important to both the consumer and the seller because they rarely make a change and so I still use Colgate toothpaste. I'll bet that if you used Crest as a kid, you may be using it now, et cetera.

I know for example when Part D came in Humana, not to name it, was I think $6 and something cents premium a month, got a huge market share and that very first year when I was graced to be on this stage at that time, the head of CMS at the time, the next year said, if you're happy with the plan you made, you may recall CMS was saying, you don't need to do

anything and of course everybody quickly knew that was not good advice but people don't change. It's very important what you choose the first time.

One of the things I take a little bit of exception to only from what Professor Schwartz said is that sometimes good enough will turn out not to be good enough. Then there are other reasons, if you choose, you make these other choices. Plan reduces the network, it's insufficient to you, it doesn't have your drugs, it doesn't have your doctors, you have a new special enrollment period, but those things are much less likely to cause change.

There's too much complexity. These are lessons from the field. Too much personal information is needed. Now, this is a place where I should really be able to make friends with some of the libertarian colleagues because in order to make the right choice—I'm going to run out of time, you need to tell people now where you live, what your income is, what your health is. I did not know my mother was taking certain medications until I needed to help her with choosing traditional Medicare, a drug plan choice. It's too much personal information to provide easily to someone you don't know.

I used to be able to talk about Part A and B and help people in a group. You really can't do that anymore and

whether it's insurance agents or the state health insurance plans, the SHIPs, there aren't enough objective resources to help people do this. It leads to also branding. Medicare Advantage is a very clever name. We find people think it means on top of Medicare, it's better than. Very often, come March, April we start getting calls from people who didn't understand that they were leaving traditional Medicare and not getting something on top of Medicare. Medicare Advantage PD is the only one-stop shopping and that is another reason. It's simpler to go to a Medicare Advantage plan and get your drug benefit there.

If you stay in traditional Medicare you need to get both—you need to shop anyway for a PDP plan and I think that is against people's sense. It's not as easy. Here's a tale of two relatives 18 months ago, my mother, 86 at the time, her brother, my uncle, 92, 91 at that time. They were very, very healthy elderly age in this cohort. For 10 years they're both incredibly smart and cognitively intact. I've been suggesting my uncle switch to traditional Medicare. No, because it's less expensive to be in Medicare Advantage. My mother, being my mother, is in traditional Medicare with a PDP plan.

She said to me a couple of years ago, I know this won't make you happy but I'm going to stick with the ARP plan and I said, mom, your drug's not on it this year and because, only

because of that, she switched. My uncle never did get out of his Medicare Advantage plan. They've both had a terrible last six, eight months. My uncle could not choose to go to the hospital that my cousins wanted him to go to. My mother was able to get her rehab here in my community because she's in traditional Medicare.

I think these are things people need to think about. The plans tend to be good enough when you're relatively well. They may not be when you're not relatively well. So less is more, choice people want is a physician, a choice of physician, their healthcare providers, not insurance plan and so you need to help them steer to think about what if they get sick, what if they get injured? It happens to all of us. It happened to me. Often don't think about specialists, hospitals, until you are sick or injured as I just described, people aren't experienced at choosing health insurance.

I have had the most incredible number of calls over the last year from colleagues who are turning 65. One friend with two PhDs and a law degree told me he had a Medicare emergency and we know a very expert health economist who said, I don't know how to choose my plan, because most of us in my cohort have gotten employer group health plans. I know how to choose a plan because I choose it for my employees but most people don't have experience with this.

Also basic consumer protections are missing. The plans can change their networks and do, and this is the part that I would say doesn't make any difference because in Connecticut and around the country there was huge amount of change in the biggest MA plan, we lost 2,250 physicians and hospitals in Connecticut, small state, from people who had chosen UnitedHealthcare. It leaves people with a sense of why bother because it's I bought a car and now it's a bike.

All in all, I think that it's a very complex area and people need to choose based on thinking, like all of us, they will get sick, they might get injured. Thank you very much.

TRICIA NEUMAN: Terrific. Thank you so much. Alright, I do have plenty of questions but I'm hoping you do as well so I'm going to start with the audience rather than myself. If you could, again, stand up and introduce yourself that would be great.

Dimitar Naydenov: My name is **Dimitar Naydenov**. I am a consultant. I have two questions, one of them is directed toward the KFF associate. You mentioned something about how overwhelming the number of choices are and how even when they were all in a spreadsheet and someone was still not happy. My question here is was it actually really a spreadsheet, like an Excel spreadsheet where you can actually sort the data. It's a column, where that column actually fits your needs so you can

choose and easier way, because if that's not the case then probably the overwhelming part is not addressed.

The other question is for the AEI scholar. You're talking about how Medicare should be more, definitely more choice in Medicare that the government shouldn't be on the driver's seat, and I actually side with you on that. However, is it actually like, we people tends to not take responsibility for our actions, so if we have a plethora of choices instead of saying, I made a bad choice, we tend to say, there are too many choices. How can you actually bring me so many choices to overwhelm me? We tend to blame it on someone else, in this case the policymakers, isn't it more like accountability and responsibility, the transfer of those two, to blame rather than the plethora of choices that people now have including Medicare?

TRICIA NEUMAN: Thank you. Gretchen, I'm going to start with you.

GRETCHEN JACOBSON: Yes, I can answer the question first. He was a retired aerospace engineer so of course he used an Excel spreadsheet and he explained that he had it set up so that the rows were all of his different plans and that he had his columns of all the factors that were important to him. You could see how in his mind he was organizing all of this but the part that was just frustrating for him was the fact that he

had to put this together every year and from all the various sources and the different mailings that he got. Then order it based upon all the different factors, whether it's a premium, and deductibles and different co-pays for different services, so he was very organized with his thinking but it was still just that sheer quantity and figuring out what factors he wanted to weigh more than others.

JOE ANTOS: May I ask, do you know whether he was aware that CMS has a really dysfunctional website that probably had all that information?

GRETCHEN JACOBSON: It's organized differently. It wasn't organized the way that other people wanted it. We even had people in the same group who went to *Medicare.gov* and they wanted a spreadsheet because it's not organized in that way. It's organized so that you have the least expensive plan at the very top but if you want to look at things other than cost, then you need to start scrolling up and down and trying to compare things that way.

JOE ANTOS: Anyway, so on your question of individual responsibility. Yes, sure, I'm the first to blame almost anybody else for any mistake that I make, there's no question about it. The Medicare program encourages people to imagine things that are not economically possible. The traditional Medicare programs that offers infinite choice in a sense. It's

not really true but it looks that way and until you actually start using Medicare benefits seriously you may not fully realize that there are restrictions and limitations, in particular post-hospital services often come as a surprise, a shock to people who have no idea.

In fact, Medicare has changed dramatically over the last 40 years and will continue to change and it will not be, whatever anybody thinks Medicare is today, it will not be that way in 10 years, probably sooner. It's going to be a much tighter program. I think the concern here is that people will have to start making more active choices and they need better information in order to do that, but as you said, they also have to realize that there are consequences.

The theory that many of us have including people who have employer-sponsored coverage is that health insurance is free, or it really doesn't cost me anything. Of course, that's not true either. As long as we sort of have that in our mind emotionally rather than intellectually we're going to act on that basis and that has led us in the case of Medicare to a cost outlook that is not very favorable.

GRETCHEN JACOBSON: One more thing also that I should add is the people in Medicare Advantage plans sometimes found it difficult to use *Medicare.gov* because it doesn't have

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provider networks in there so you can't see if your provider is in different plans, which is often important to them.

PHIL GALEWITZ: Hey there, Phil Galewitz, with Kaiser Health News, Josh, I wonder if you could address this. How have companies, the top 10 who have most of the market, how have they sort of taken advantage of the fact that knowing that seniors won't change, knowing there's a lot of inertia, knowing there is this paralysis, what have companies done to either cause that and how have they reacted to this fact that they know it exists?

JOSHUA RASKIN: Yes, I think the companies are certainly aware of this phenomenon. They call the senior the stickiest of the members, so the average length of Medicare Advantage members is about 7.5 years and the number one cause for disenrollment is involuntary terminations, as we call them. What they do is they make benefit design changes based on the most attractive benefits to keep those members in, so they know full well that adding a premium, for example, is the single biggest way to get a senior to go back to market and look for a plan.

That's different than incrementally increasing a premium. If you're charging $15 and you move that to 20, that's a lot different than going from zero to five. They will, in markets where they have a large existing base is the

last thing they'll do is change that benefit design. I think they're certainly cognizant of it. I think they're very reticent to make obvious changes to benefit design. What United did this year, which was mentioned, was just sort of cut the network, which is alright, we're going to lose a couple of members if they lose their primary care physicians and we'll send them to market, et cetera, but holistically in that market we can maintain the same level of benefit design, et cetera.

They are absolutely aware of it. There is huge cost for losing members but commission rates are extremely high, especially in the first year and then they tail off. I think historically the plans have done a lot to make sure that they maintain those members for the full life of the individual.

TRICIA NEUMAN: Let's go to that side of the room.

JACK HOADLEY: I'm Jack Hoadley from Georgetown University and I want to go partly to what the last question raised but also to Joe's comment on do we have enough people moving around in the market to make a difference, to actually have an impact. I guess what I'm concerned about, I'm interested in reactions to, is the phenomenon that we've seen, at least on the Part D side, is a lot of the companies coming in with inexpensive plans. Judy mentioned the first year Humana plan that was very inexpensive. Joshua, you mentioned the Humana plan on the market now that's inexpensive. I think

right there is the sort of contrast. The companies have come in with an inexpensive plan and then count on people to be sticky to raise the premium on the old plan and ending up with a sicker, older, stickier part of the market bring in a new plan in the market cheap, attract the new people and you get this kind of segmentation.

I guess my question is really, both how do you react to that but also are there things we can do to try to prevent this sort of exploitation of the stickiness?

JOSHUA RASKIN: I'll jump in and I'm not sure this is all—I'm not sure everything there sort of all matches up because if you think about it, the rate increases that you've seen—if you look at the top five plans in any given year, and you look at the average rate increase. What we do every September when the bids hit, there's 2,500, 3,000 plans across the country, I line up every single one and figure out what the rate increase is. It's a little apple to oranges because they could change formularies and things like that but if you look at the five most popular plans in the country, for four of the last five years the rate of increase in those premiums has actually been lower than the overall and they've been decreases.

It's not one of these bait-and-switch where they try and get the member in and then jack up the rates over time.

You're actually not seeing that and I think it's the opposite. I think what the plans know is that if they provide a low priced product with a relatively lean set of benefits, i.e., something that's not very attractive, they're going to get positive selection buyers. The individual that has one prescription that gets it mail order, a 90-day supply, that person is a very easy member, very cheap drug cost, et cetera, they want that individual to come into those lower cost plans.

I haven't seen and CMS promotes this every year, you've seen actual rates of growth in premiums for Part D. They've been below budget since the onset of the program and they've actually been I think average to maybe low single-digits in terms of rate increases on an annual basis.

JOE ANTOS: There's another aspect to Part D marketing, which is that a lot of companies also wanted to use the Part D as a way to convert people to their Medicare Advantage plan. It's a much more complicated story really than you can really tell just by looking at that D.

JUDITH STEIN: I think one of the things CMS has done well over the last couple of years is to make meaningful difference a standard for calling something a plan within a sponsor so that we have some lessening of the number of plans to look at but we still have such a variety and it's so hard for non-statisticians to compare, or engineers, or aerospace

people. Unlike Medigap, where we have for years had a chart that we could adjust every year and A is this and who's offering it and what are the prices and then B and C and D.

I think we should definitely to the extent that we're going to continue to have Medicare Advantage and PDPs, they ought to have true meaningful differences between the plans and some movement towards standardization so that people can choose by making charts, CMS and beneficiaries and SHIPs, advocates should try and do that and truly be able to compare apples and apples to the best possible. Now, that's not doable because there are so many variations and people do want to try to do that and help one another to help out beneficiaries. Standardization and meaningful difference is very important.

TRICIA NEUMAN: I want to follow-up and drill down a little bit because what I'm hearing and what we all know exists, this is a really sticky market. People sign up for their plan maybe when they first come on Medicare and they stay on their plan unless premiums really jump through the roof. It takes a big deal for people to make a change and insurers know that so they can kind of raise their premiums but not so much if they want to keep people in their plan. I'm kind of going back with this good enough, what's the difference concept that Professor Schwartz raised earlier, what difference does it make? Let's go back to this question about why does it matter.

Does it matter if people are sticky? Does it matter to, we think it matters to insurance companies, does it matter to Medicare? More broadly, how does it matter to consumers? I think we're talking around this issue but I'd like for everybody to really comment on that and maybe you have different perspectives on whether it matters or not.

JUDITH STEIN: Let me try that from three perspectives, not the insurance companies because we know the answer there, right? When you first looked on your report said and does it matter, my mind initially went to this issue that I think is very important for us to think about and that is if people make a choice—we all know United made huge changes this year. In Connecticut it was very big deal including they terminated the contract with Yale-New Haven Hospital and full disclosure. As it happened my mother needed spinal surgery at Yale-New Haven Hospital and was able to have that done, but 2,250 providers, mostly physician specialists, primary care, and hospitals were terminated.

That doesn't make a difference, no, sometimes no, but what I mean by that is that people make a choice and don't get what they think they chose. That I think is very detrimental to trust ironically in Medicare and the government. There's not a sense that this plan is private. It's still Medicare to people and it's a great deal of consternation and grief and

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anger when I've been to a lot of senior centers with Congress people in Connecticut about this, and it's directed at they counted on something, they made a choice, and now it's not a car it's a bike.

People have feelings about that and maybe it's something we're studying from your perspective and where they lay the blame and what it means for whether they'll ever make a choice again. That's one reaction to beneficiaries. Then on the other hand that it doesn't matter because it might change. On the other hand it matters—it can end up mattering a lot because if you become ill or injured during the year and you didn't choose something that's rather broad and gives you a lot of options for providers and drugs you may actually not be in something that's good enough for you, so therefore those are the two sides of that.

For taxpayers, the more people who go into Medicare Advantage the more expensive all of Medicare is becoming and that's a problem as well. I think those are three various takes on, and does it matter.

JOE ANTOS: I think we're in a transition. It's a very slow transition but it's a transition. The generation of current Medicare beneficiaries is not used to making choices. They got insurance from an employer. The employer didn't give you any options. It was Blue Cross. Pretty straightforward.

When they entered Medicare, they got Blue Cross. That model is gone. Even in Blue Cross they don't offer that kind of Blue Cross anymore. The next generation, the baby boomer generation, they're a little more used to choice. They have smart phones now, they may not know how to use them very well, but they have smart phones, the older ones. The younger baby boomers are much more into understanding that you can use information in a fairly efficient way to understand what your options are.

That's a generation that is going to be much more active in making choices and the generation after that, well, it's a little scary, they're my kids. I think we are moving more towards a Medicare program that is typified by choice and by necessity because as they say, Blue Cross can no longer exist like it used to.

Now, does it matter? I think what Judy was talking about is really expectations and you said this in your formal remarks as well. A lot of people thought they were going to keep Blue Cross when, in fact, they never really had it. They were shocked when they actually ended up needing something that might have been out of the ordinary and in turn—well that actually isn't what they signed up for. That's a real issue but it has to do with expectations. It doesn't have to do with the feasibility of offering an infinite number of choices; you

can't do that, or offering absolutely everything; you can't do that either.

JOSHUA RASKIN: I guess my perspective is the idea that people bought a car and got a bike is I think they bought a bike and they thought they were driving a car. If you ask what United is selling, is they're providing a health insurance benefit at a much lower out-of-pocket cost to the individual with a less broad set of providers. If you were the type of person that needs to get your procedures done at Yale-New Haven you should pay for that. I think what United's answer is we're going to give you an alternative and I think what's more frustrating from the insurance and from Medicare's perspective is that individuals think they know better than the insurance company.

There was an article, I don't know if it was *The Journal* or *The Times* this morning that talked about advances that had been made through data analytics and different patterns that have been identified to help find different causes, et cetera, the insurance company, when you ask United why did you pare back your network. They made decisions based on two factors. One, is this individual providing outcomes that is not on par with what their brethren are? They're getting that outcome, so then you've got to go. Or two, are

you providing the same level of quality and/or maybe even slightly higher but charging an egregious amount for it?

Their answer is we can't provide you with an additional set of benefits and give you the additives above and beyond Medicare Fee-for-Service if you're going to make us pay for sort of these high cost procedures, et cetera. You see these variations. I was looking at a colonoscopy schedule recently, the cheapest in a specific market, you can get one for $275.00 in one place and literally 10 times that in another place. There's literally no difference in outcomes for any of this sort of stuff. I think that's the issue is consumers really think of Medicare Advantage as Medicare on top of the Fee-for-Service program. That's not what they're getting. They're getting a limited set of providers that can provide them a higher set of benefits.

JUDITH STEIN: Just one quick nuance. They shouldn't be able to change once you're purchased and that was what I was referring to because people did now purchase a plan based on what the network is announced as. Then it will change during the year. That was my point.

JOSHUA RASKIN: I think if your primary care physician has been thrown out of the network you should have the ability to change it, but—

JUDITH STEIN: Yes and now you don't.

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JOSHUA RASKIN: —but if they throw a hospital out they're providing you with an alternative they can get that procedure done at [interposing].

JUDITH STEIN: That may be the case, but this was primary care doctors in large part.

TRICIA NEUMAN: See, I wanted this to happen. Barry Schwartz wants to say something. Gretchen, do you want to respond quickly?

GRETCHEN JACOBSON: I'll say quickly that, I mean, it does matter what choices beneficiaries or seniors are making because on the one hand these are federally subsidized plans, so if they want to be in some sense and can be in lower cost plans, that's a federal budget issue. On the other hand if beneficiaries are doing all these workarounds to try to make the current plan work because it's just too arduous to change their plan that's a problem from the beneficiary perspective. It's also helpful to remember that in a marketplace system like we've set up where people will choose the plans that they want to choose it's not always going to be based upon cost. It will be based upon other factors as well.

TRICIA NEUMAN: Barry Schwartz.

BARRY SCHWARTZ: I wanted to say something about stickiness. It's not just senior citizens in Medicare. This is one of the most robust findings in decision-making. People

are very change-averse and we know why they're change-averse. Typically when you make a change, there's a trade-off. You get some benefit and you pay some cost. I used to have this covered, I don't anymore but now I have that covered. What we know about people is that losses hurt roughly twice as much as gains help, which means that almost any change you make that involves a trade-off the loss, what you're giving up will be more salient and painful to you than what you're gaining. That's why people don't change.

It's not that it's too complicated, though that contributes, you see this among PhD professors changing their plan for paying for their parking on campus. It's quite pervasive. Now, whether stickiness matters it seems to me really depends on how much of an assurance you have that there is no bad decision and here's where it seems to me, it's not that I bought a car and it turned out to be a bike. It's rather, when I go to buy a car do I have to make sure that the ignition won't turn off while I'm driving. What level of detail do I need to worry about? Unless there's some assurance that somebody, the state, is looking out to make sure that certain minimum standards are met by everything that's available on the market, well then you've got a problem that you can't possibly solve. You have no trust in anybody.

These people are trying to sell you something. They're not trying to help, they're trying to sell you something. It's caveat emptor and now it becomes a simply impossible task for anyone, health economist or not, an impossible task for anyone to manage. There has to be a minimum standard of acceptability and if there is, then I think stickiness is really not such a big deal. If there isn't, as you pointed out, it can be a catastrophe.

TRICIA NEUMAN: We are going to take one last question and it will go to the gentleman in the back, George Strumpf.

GEORGE STRUMPF: I'm George Strumpf with Emblem Health Plan and I think I've heard a recurrent theme from a few of you that the way the elderly choose is in large part because they're old and I wonder if you've considered the parallel with the Federal Employee's Health Benefits Program. With all these choices and yet the choices, just like in Medicare Advantage, are clustered in a handful of plans, people don't change, you see continuity year after year, so are the determinants of choice any different for the elderly than they are for the non-elderly?

JUDITH STEIN: I'm not basing it on—far be it from me. I've dedicated my career to representing older and disabled people. It has nothing to do with age. I think it has to do with Professor Schwartz's various wonderful models. Maybe a

little bit that that cohort is of current older people is not accustomed to choosing and doesn't care as much about as many choices, but not because they're older but because of their life experiences. I don't think it's—anyway, that's my answer.

JOE ANTOS: I would just say that buying health insurance is a pretty complicated affair for everybody. You're absolutely right. I think that's a large part of the problem. I don't think it's in the Medicare program. I certainly don't think it's that the federal government isn't there trying to make sure the ignition switch will stay on. You're in the health insurance business. It's pretty complicated. Unfortunately the Medicare program makes it even harder to figure out. At least with the Federal Employee's Health Benefits program you can go to—I guess I shouldn't [inaudible 01:31:22] it, but it's the one source that I know about. The *Checkbook Magazine* study that comes out every single year, which if you're an analyst is extremely useful and if you're not, well, you know, it's more information.

TRICIA NEUMAN: All right, I want to thank you all for coming here today. I want you to join me, please, in thanking our panelists. I think it's fair to say that the role of private plans and Medicare has grown and appears here to stay and I think the key issue for us all to consider is, why does it matter, how much does it matter, and what more can we do to

make sure that this program is working well, both for the Medicare program itself but most importantly for the people who rely on it for their health coverage. Thanks again for coming. Thanks again to our panelists and I'll see you next time.

Judith Stein: Thank you. Thank you.

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