HEALTH POLICY REPORT

Medicare Advantage Checkup

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The emerging role of Medicare Advantage, the private-plan alternative to traditional Medicare, is gradually changing the Medicare program in ways that have important implications for beneficiaries, providers, and spending. Fueled by policy changes adopted by both Democrats and Republicans, enrollment in Medicare Advantage plans has more than tripled since 2005, from approximately 6 million to 20 million beneficiaries. Between 2018 and 2028, Medicare Advantage enrollment is projected to rise from 34% to 42% of the Medicare population (Fig. 1). At the same time, federal spending on behalf of Medicare Advantage enrollees is projected to grow from approximately $200 billion to more than $580 billion (not including additional Medicare spending associated with coverage of prescription drugs under Medicare Part D).[1]

In this article, we begin with a brief comparison of Medicare Advantage relative to traditional Medicare. We then examine the extent to which the Medicare Advantage program is achieving goals with respect to benefits and out-of-pocket costs, plan choice, federal spending, and quality.[2,3] We highlight areas in which more evidence is needed to better understand the implications of the shift from traditional Medicare toward private-plan enrollment, and we identify ongoing challenges.

MEDICARE ADVANTAGE OR TRADITIONAL MEDICARE — OPPORTUNITIES AND TRADE-OFFS

Private health plans, now known as Medicare Advantage plans, have been an option for Medicare beneficiaries since the 1970s. (For simplicity and ease of reading, we refer to all Medicare private plans collectively as Medicare Advantage plans. Medicare private plans include Medicare Advantage plans as well as Medicare cost-reimbursed plans. In 2018, approximately 600,000 Medicare beneficiaries were in cost-reimbursed plans.) Medicare Advantage plans provide all Medicare-covered services (other than hospice) but differ from traditional Medicare in several respects. First, they are paid differently: the federal government makes capitated payments to Medicare Advantage plans on behalf of plan enrollees (adjusted for health status and other factors), in contrast to traditional Medicare, in which payments are generally based on services rendered and are not capitated. Second, Medicare Advantage plans, unlike traditional Medicare, are required to limit enrollees' out-of-pocket spending for Medicare-covered services and typically provide extra benefits, such as dental care and gym memberships. Third, virtually all Medicare Advantage plans offer prescription-drug coverage as an integrated part of the benefit package. In contrast, traditional Medicare does not cover the prescription-drug benefit directly, as it does hospital and physician services; instead, beneficiaries must enroll in a separate stand-alone prescription-drug plan to get the Medicare Part D drug benefit.

Fourth, Medicare Advantage plans generally require enrollees to use a defined network of providers, or pay more for out-of-network care. In contrast, in traditional Medicare, beneficiaries can seek care from virtually all physicians, hospitals, and other providers nationwide. Fifth, Medicare Advantage plans, unlike traditional Medicare, typically rely on utilization-management techniques, such as prior authorization, to control service use and spending. Lastly, Medicare Advantage plans have more tools at their disposal than the traditional Medicare program to manage the care of enrollees, such as reward programs to encourage healthy behaviors. Beginning in 2019, plans will also be able to provide targeted services for persons with chronic conditions, such as extra vision benefits for persons with diabetes; in 2020, plans will be able to provide nonmedical services, such as home-delivered meals.

Differences between Medicare Advantage plans and traditional Medicare present opportunities

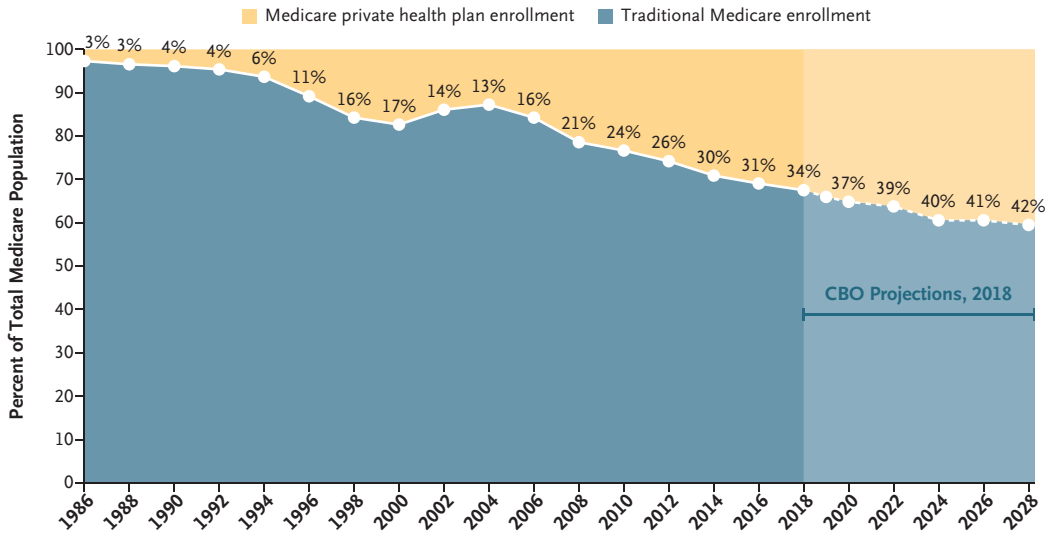

Figure 1. Medicare Private Plan (Medicare Advantage) Enrollment as a Share of the Total Medicare Population, Past and Projected.

Included are medical savings accounts, cost plans, demonstration plans, and special needs plans, as well as other Medicare Advantage plans. Excluded are beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico. Enrollment numbers are from March of the respective year, with the exception of 2006, for which data are from April. Data for 1986 to 2018 are from the Centers for Medicare and Medicaid Services, and projections for 2019 to 2028 are from the Congressional Budget Office (CBO) Medicare Baseline for 2018.

and trade-offs for the 60 million people now on Medicare, including seniors as well as younger adults with disabilities, end-stage renal disease, or amyotrophic lateral sclerosis. For instance, the extra benefits and out-of-pocket spending limits covered by Medicare Advantage plans are important financial considerations for seniors, many of whom live on fixed and modest incomes, with high health care costs relative to their income. More than one third of all beneficiaries in traditional Medicare spent at least 20% of their per capita income on out-of-pocket health-related costs in 2013.[4] In addition, Medicare Advantage plans offer the convenience of one-stop shopping by covering all Medicare benefits; in contrast, most beneficiaries in traditional Medicare have wraparound supplemental coverage (Medigap, employer-sponsored retiree benefits, or Medicaid) and, as noted above, a separate Part D prescription-drug plan.

Traditional Medicare has its own advantages that help explain why it continues to attract a majority of the Medicare population. The open provider network of traditional Medicare is important to beneficiaries who value having a broad choice of physicians and other providers. Traditional Medicare also allows beneficiaries to get care without the hassles and obstacles that can result from prior authorization and referral requirements frequently used by Medicare Advantage plans. In addition, for some beneficiaries with high health care spending, traditional Medicare coupled with supplemental insurance has the potential to be a lower-cost alternative to Medicare Advantage. For example, the most popular Medigap plans fill in virtually all cost-sharing requirements for Medicare Parts A and B services, limiting enrollees' financial exposure to their monthly Medigap premium, which is typically substantially less than the out-of-pocket limit of Medicare Advantage plans.

CHARACTERISTICS OF BENEFICIARIES IN MEDICARE ADVANTAGE VERSUS TRADITIONAL MEDICARE

Medicare Advantage enrollees appear to be somewhat healthier than beneficiaries in traditional Medicare, according to measures of self-assessed health, functional status, and cognitive status

(Table 1). Medicare Advantage enrollees have fewer years of education than do beneficiaries in traditional Medicare, on average, and are more likely to be in a low-to-middle-income group (per capita incomes between $20,000 and $40,000). They are less likely to have per capita incomes greater than $40,000, perhaps because higher-income beneficiaries are more likely to have Medigap and retiree health benefits that supplement traditional Medicare. Hispanic beneficiaries are more likely to be in Medicare Advantage than traditional Medicare, partly owing to relatively high Medicare Advantage enrollment in parts of the country with large Hispanic populations, such as southern Florida. In contrast, beneficiaries living in rural areas, where Medicare Advantage has a smaller footprint, are more likely to be in traditional Medicare.

BENEFITS AND OUT-OF-POCKET COSTS

Policymakers have articulated a number of goals for having private plans in Medicare, one of which is to provide beneficiaries access to extra benefits not available in traditional Medicare. Thanks to a number of policy and payment changes adopted over the years that have not only required plans to offer a richer set of benefits to their enrollees but also offered incentives for plans to do so, this goal has generally been achieved. Since 2011, the Centers for Medicare and Medicaid Services (CMS) has required all Medicare Advantage plans to provide out-of-pocket limits for Medicare-covered services; in 2018, the average Medicare Advantage enrollee has an out-of-pocket limit of $5,215. In addition, Medicare payment policy requires plans to use "rebate" dollars to provide enrollees enhanced benefits or lower premiums (allowing plans to keep a portion to cover administrative costs and profit). Rebates accrue when a bid submitted by a Medicare Advantage plan for Medicare-covered benefits is below the "benchmark" (the maximum federal payment to plans in that geographic area); the federal government keeps a portion of the excess and remits the remainder (the rebate) to the plan. As a result of rebates, most Medicare Advantage enrollees receive benefits not covered by traditional Medicare. For example, in 2018 approximately two thirds of Medicare Advantage enrollees are in plans that offer some dental coverage; a similar share are in plans that offer a fitness benefit (Table 2). Studies suggest that the current rebate-based method may not be an economically efficient way of providing extra benefits to beneficiaries because plans are retaining a fairly large share of the rebate for administrative costs and profit, passing on to enrollees only 54% of the rebates, on average.[5,6]

Premiums tend to be lower for beneficiaries in Medicare Advantage plans than for those in traditional Medicare; the latter often pay premiums for a separate Medicare Part D prescription-drug plan and for other supplemental insurance, such as Medigap or employer-sponsored retiree health coverage. Although all beneficiaries, whether in Medicare Advantage or traditional Medicare, are responsible for the Medicare Part B premium, beneficiaries in Medicare Advantage plans with prescription-drug benefits pay somewhat lower premiums than do traditional Medicare beneficiaries with separate stand-alone prescription-drug plans (an average of $34 and $41 per month, respectively, in 2018).[7] In fact, approximately half of all enrollees in Medicare Advantage programs with prescription-drug coverage pay no monthly premium (other than the Part B premium), partly because plans use rebate dollars to reduce plan premiums.

Surprisingly little is known about how much Medicare Advantage enrollees pay out of pocket for the services they receive overall, across plans, according to health condition, or in comparison to beneficiaries in traditional Medicare (with or without supplemental coverage). The CMS plan comparison website, Medicare Plan Finder, posts information about plan features, such as premiums, cost sharing, and out-of-pocket limits, but actual incurred out-of-pocket spending among enrollees is more difficult to discern. This is largely due to the absence of data sources that link survey and claims data for Medicare Advantage enrollees; such data are available for beneficiaries in traditional Medicare. Some of these information gaps may be filled in the near future when CMS releases Medicare Advantage encounter data, with the assumption that such data are complete and accurate.

Without much fanfare, Medicare has evolved into a program that provides benefits that are more generous to beneficiaries in Medicare Advantage plans than to their counterparts in traditional Medicare. Adding an out-of-pocket limit to traditional Medicare, as some have proposed, would

Table 1. Characteristics of Medicare Beneficiaries in Traditional Medicare and Medicare Advantage Plans (2015).*

Characteristic	All Medicare Beneficiaries	Traditional Medicare Beneficiaries	Medicare Advantage Plan Enrollees
No. of Medicare beneficiaries eligible for Medicare Advantage plan enrollment (in millions)	50	33	17
Age (%)			
<65 yr	16	17	13†
65–74 yr	44	43	47†
75–84 yr	27	26	28†
≥85 yr	13	13	12†
Sex (%)			
Male	44	44	43
Female	56	56	57
Race or ethnic group (%)			
White	75	77	71†
Black	10	9	11
Hispanic	9	7	13†
Other	6	6	6
Geographic area (%)			
Metropolitan	79	75	86†
Nonmetropolitan	21	25	14†
Education (%)			
Less than high school	18	17	20†
High school or GED	29	28	29
Some college or more	53	55	51†
Income (%)			
<$10,000	13	13	13
$10,000–$19,999	27	26	29†
$20,000–$39,999	33	32	34†
≥$40,000	27	29	24†
Health measures			
Self-reported health status (%)			
Excellent or very good	44	43	46†
Good	30	30	30
Fair	19	19	18
Poor	8	8	6†
Cognitive impairment (%)	34	35	32†
Functional impairment (%)‡	38	39	36†

* Medicare–Medicaid Plans were excluded from all Medicare Advantage Plan enrollees, and values include cost-reimbursed plans. Metropolitan areas are based on the Office of Management and Budget delineation as of February 2013. All values exclude beneficiaries in Medicare Part A only or Part B only, those not enrolled in Medicare in March 2015, and those in territories other than Puerto Rico. Data are from the Centers for Medicare and Medicaid Services (CMS) Medicare Current Beneficiary Survey (MCBS) for March 2015, with the exception of data on the number of beneficiaries, which come from the Master Beneficiary Summary File of claims from a 5% sample of Medicare beneficiaries for 2015. MCBS income data were adjusted to align with the Urban Institute Dynamic Simulation of Income Model (DYNASIM3), a predictive microsimulation model that takes into account income from all sources, including Social Security, wages, pensions, and asset income, including withdrawals from individual retirement accounts. Percentages may not total 100 because of rounding. GED denotes general equivalency diploma.

† Daggers indicate significant differences as compared with traditional Medicare beneficiaries at the 95% confidence level.

‡ Functional impairment was defined as at least one limitation in activities of daily living.

Table 2. Medicare Advantage Marketplace Characteristics (2010–2018).*

Characteristic	2010	2012	2014	2016	2018
Enrollment					
Total no. of Medicare beneficiaries (in millions)	46	49	53	56	61
No. of Medicare Advantage enrollees (in millions)	11	13	16	18	20
Percent of total beneficiaries in Medicare Advantage	24	26	30	31	34
Plan choice and market competition					
No. of insurers available per beneficiary	8	6	6	6	6
No. of plans available per beneficiary	31	20	18	19	21
Percent of beneficiaries with access to ≥1 Medicare Advantage plan	99.9	99.8	99.3	99.2	98.9
Percent of counties with no Medicare Advantage insurer	1	1	4	4	5
Percent of counties with 1 or 2 Medicare Advantage insurers	2	22	41	39	34
Percent of Medicare beneficiaries in counties with ≥50% Medicare Advantage penetration	11	15	19	20	22
Average market share of largest 2 insurers in a county (%)	60	62	61	61	63
Premiums and benefits					
Average monthly premium ($)	43	35	35	37	34
Average out-of-pocket limit for services covered by Part A and Part B ($)	4,197	4,296	4,882	5,223	5,215
Percent of enrollees in plans with no premiums	48	56	56	49	51
Percent of enrollees in plans with any enhanced fitness (e.g., gym membership) coverage	52	61	64	67	69
Percent of enrollees in plans with any dental coverage	48	55	55	61	62
Percent of enrollees in plans requiring any referral for services	87	80	82	84	79
Percent of enrollees in plans requiring any prior authorization	88	80	82	84	80
Average bonus payment to plans per member per mo ($)	NA	23	25	19	27
Total annual bonus payment (in billions of $)	NA	3.5	4.6	3.8	6.3

* Values for Medicare Advantage plans include cost-reimbursed plans. All values exclude beneficiaries in territories other than Puerto Rico. Data on the average monthly premiums, average out-of-pocket limits for services covered by Part A and Part B, and percent of enrollees in plans with no premiums exclude Medicare Advantage plans without prescription-drug coverage, special needs plans, and employer group health plans. Data are from CMS for 2010 to 2018. Bonus payments in 2010 are not applicable (NA) given that the 2010 health reform law authorized Medicare to pay plan bonuses beginning in 2012.

help level the playing field and mitigate the need for supplemental insurance; however, it would also increase total program spending and beneficiaries' Part B premiums. Given the abundance of extra benefits offered by Medicare Advantage plans, CMS through its Innovation Center could test how coverage of additional benefits, such as dental or fitness benefits, affects the health of enrollees and Medicare spending. Such information could help policymakers assess the implications of adding similar benefits to traditional Medicare.

PLAN CHOICE

During the past few decades, policymakers have generally supported the idea of expanding the role of private plans in Medicare. Virtually all beneficiaries have access to at least one Medicare Advantage plan in their area, in addition to traditional Medicare (Table 2). The average Medicare beneficiary can choose among 21 Medicare Advantage plans, offered by six insurers in 2018. In many large metropolitan areas, beneficiaries can choose from dozens of plans, with far fewer options in some rural areas. In nearly 40% of counties (which tend to be rural), beneficiaries can choose among plans offered by two or fewer insurers, including 5% of counties, accounting for 1% of the Medicare population, in which no Medicare Advantage plans are offered (Table 2).

Choosing among multiple Medicare Advantage plans can be a mixed bag for beneficiaries. Seniors

have said that they value having a choice among plans but feel ill-equipped to compare benefits, cost sharing, provider networks, and other plan features. As one 78-year-old focus-group participant succinctly explained it, "I'm too goddamn tired to investigate this." Another senior said, "There's too much detail but not enough detail at the same time."[8] Seniors also say they value having a choice of doctors and hospitals, but provider directories are difficult to find, hard to compare, and often inaccurate.[9] Beneficiaries say they are aware of the Medicare open-enrollment period but lack confidence in their ability to compare and choose a better option.[8]

In fact, the large majority of Medicare Advantage enrollees stay in the same plan year after year, with just 10% switching plans each year.[10] Beneficiaries who remain in the same plan may forgo opportunities for better benefits and lower costs. Insurers that know their enrollees are "sticky" may be less motivated to compete on the basis of costs, benefits, and quality, which can lead to higher costs and fewer benefits for enrollees, as well as higher plan bids and higher Medicare expenditures.[11,12] Thus, even with a large number of plans available, the inability of beneficiaries to easily compare Medicare Advantage plans could potentially increase costs for both beneficiaries and taxpayers.

The relatively large number of plans may also affect physicians and their practices. As more of their patients join Medicare Advantage plans, physicians (especially those in smaller practices), nurses, and other health professionals may spend more time dealing with the administrative requirements of each plan and keeping abreast of plans' formularies, prior-authorization requirements, provider networks for referrals, and other plan details that may be important to their patients' care.

To help make the Medicare Advantage marketplace work better for consumers, a number of policy options could be considered, such as providing more resources to organizations that provide one-on-one counseling, making consumer-support tools more user-friendly and accurate, and standardizing benefits to make it easier for consumers to compare plans.[13,14] Streamlining choices, by making differences among plans clearer and more meaningful, could make it easier for beneficiaries to compare plans and choose among them and could also help health care professionals stay informed about their patients' formularies, provider networks for referrals, and other plan details. Even with these changes, some caution may be warranted in designing systems that rely on older consumers to be actively engaged in health coverage choices, particularly given the high rates of cognitive impairment among enrollees in this particular health insurance marketplace (Table 1).

FEDERAL SPENDING

An initial rationale for private plans in the Medicare program was that plans could provide care more efficiently than traditional Medicare and thereby reduce Medicare spending.[2] Today, Medicare payments to Medicare Advantage plans (including bonus payments) are roughly equal to the per capita costs in traditional Medicare (101% of those costs, on average).[15] However, for many years, Medicare payments to plans were considerably higher; at their peak (in 2009), such payments were 14% higher for beneficiaries in Medicare Advantage than for similar beneficiaries in traditional Medicare, on average. In the early years, Medicare payments to plans were set below traditional Medicare (95% of per capita costs), but Congress has modified payment policy numerous times since then, often willing to pay plans more to achieve other policy priorities, such as promoting plan participation in rural areas and increasing the availability of extra benefits.[16] The Affordable Care Act (ACA) of 2010 reduced payments to plans to more closely align expenditures with traditional Medicare costs and generate savings to help offset the cost of the expanding health insurance coverage to more people.

Under the current payment system, plans submit bids to the federal government to provide Medicare-covered services to their enrollees. If a bid is below the benchmark, the plan receives a portion of the difference between the bid and the benchmark (a "rebate"), which the plan is required to use to provide extra benefits to enrollees. If the bid is above the benchmark, enrollees pay a premium to cover the difference. Benchmarks vary according to county and currently range from 115% of traditional Medicare costs in counties with relatively low per capita costs to 95% of traditional Medicare costs in counties with relatively high per capita costs.[17] Payments to plans are then adjusted for enrollees' health status and other factors. Since 2012, plans have also been

eligible to receive bonuses if they meet certain quality metrics; these bonuses are estimated to exceed $6 billion in 2018 ($27 per member per month) (Table 2).

Although Medicare payments to plans are now roughly equal to the cost of traditional Medicare, on average, some questions remain as to whether the current system is putting sufficient downward pressure on program spending and encouraging plan efficiency. First, although plans in high-cost areas are spending less than traditional Medicare, these savings are offset by higher payments (relative to traditional Medicare) to plans in low-cost areas; similarly, the lower average bids of health maintenance organizations (HMOs) are offset by the higher bids of preferred-provider organizations (PPOs).[15] These offsets promote one goal (plan choice) at the expense of another (Medicare savings). Second, and similarly, quality-based bonus payments promote two goals (quality and extra benefits) at the expense of another (Medicare savings). Third, with the current rebate system, Medicare shares savings from lower bids with enrollees and plans, rather than retain all savings attributable to low bids. Furthermore, because plans receive only a portion of the difference between their bid and the benchmark, they may have weaker incentives to bid as low as possible.[18] Even so, there is some evidence that plans in high-penetration areas may be reducing traditional Medicare spending (spillover effects), which, if true, should result in lower benchmarks, lower payments to plans in these areas, and lower Medicare spending.[19-21]

Current methods that are used to compare Medicare Advantage payments with traditional Medicare costs may overstate the true cost to plans of providing Medicare benefits. For instance, although favorable selection seems to have declined, the lack of a perfect risk-adjustment system may still confer financial advantages to plans that enroll certain types of beneficiaries, healthier or even sicker.[22-24] Moreover, Medicare Advantage plans may be boosting their payments by as much as 2% (on average) in 2018, on the basis of how they code their enrollees' health conditions, although it is unclear to what extent coding differences between plans and traditional Medicare represent more complete coding versus fraudulent "upcoding" by plans.[15,25,26]

Policymakers could face tough choices in the future as they seek to balance competing demands to reduce the growth in Medicare spending and also provide plan choice and extra benefits. To achieve savings, they could, for example, reduce plan bonus payments and rebates. Another recently proposed approach would create stronger incentives for Medicare Advantage plans to reduce their bids through a competitive bidding payment system.[13,27] Striking the right balance in payment policy from the perspective of beneficiaries, insurers, and the federal government is likely to remain a considerable challenge.

QUALITY OF CARE

Another goal for Medicare Advantage plans has been to improve the quality of patient care by increasing the use of preventive services, encouraging drug adherence, improving the coordination of patient care, reducing preventable hospitalizations and emergency department visits, and, ultimately, improving health outcomes. Since 2012, plans have been eligible to receive bonus payments on the basis of quality ratings (on a scale of 2 to 5 stars) derived from metrics for access, screenings, satisfaction, and other indicators. In 2018, 63% of plans are rated as 4 stars or better and will receive bonus payments, whereas 2% of plans are rated as 2.5 or 2 stars, which CMS defines as "below average."

Medicare Advantage plans tend to score better than traditional Medicare on some quality metrics, but the results are mixed and data are limited.[28,29] Quality of care has been found to vary greatly across plans and according to plan type (with HMOs outperforming PPOs and with plans run by hospitals or other health systems outperforming plans run by insurers), tax status (with not-for-profit outperforming for-profit), and experience (with more experience outperforming less).[29-31]

Medicare Advantage plans generally score better than traditional Medicare on preventive services and screening measures.[29,32-34] They also appear to use post-acute care less intensely with better outcomes, including lower rates of hospital readmissions. With respect to patient experiences, the evidence is mixed, with Medicare Advantage plans performing better on some measures and traditional Medicare performing better on others.[32] Somewhat counterintuitively, there seems to be no difference between traditional Medicare and Medicare Advantage plans with respect to care coor-

dination, receipt of needed prescriptions by beneficiaries, and adherence rates for diabetes and cholesterol medications.[31,32,35] These studies vary in how well they control for selection, which could influence the findings.

Little is known about the quality of care for Medicare Advantage enrollees with serious illnesses.[29] Several studies have flagged concerns about the quality of care received by high-need, high-cost enrollees, on the basis of disenrollment rates and other measures.[29,36] Relatively high disenrollment rates have been reported among enrollees in poor health,[37] living in nursing homes or using post-acute services,[38] with incident end-stage renal disease,[39] younger than 65 years of age with permanent disabilities, or dually eligible for Medicare and Medicaid.[40] For example, low-income Medicare Advantage enrollees who are dually eligible for Medicare and Medicaid disenroll from Medicare Advantage and switch to traditional Medicare at twice the rate of other enrollees (10% vs. 5%). Some evidence also suggests that Medicare Advantage enrollees are more likely than beneficiaries in traditional Medicare to be discharged to poorly rated skilled nursing facilities.[41]

Taken together, the evidence on quality may tilt somewhat favorably but not unequivocally toward Medicare Advantage plans, but with limited data, uneven performances across plans, and very little information about the experiences and outcomes of patients with complex care needs. Policymakers could review whether the quality ratings reflect the most important components of patient care, press forward in finding new ways to offer incentives for high-quality care, and monitor how well plans are serving high-need enrollees. As the Medicare Advantage population ages and has more complex medical conditions and frailties, these challenges will take on greater importance in the future.

DISCUSSION

Medicare Advantage plans are now firmly established in the fabric of Medicare. Under the assumption that Medicare Advantage enrollment will continue to climb, the Medicare of tomorrow could look much different than it does today — more like a marketplace of private plans, with a backup public plan, and less like a national insurance program. This may or may not be the program that people envision when they talk about Medicare for All.

Policymakers, both Democrats and Republicans, are generally supportive of Medicare Advantage plans because they are popular with their constituents. More and more seniors are signing up for Medicare Advantage to get the extra benefits, the financial protection of an out-of-pocket limit, and the convenience of one-stop shopping for all their coverage. Despite the substantial reductions in federal payments to plans required by the ACA, health insurers have been growing their Medicare Advantage lines of business and new insurers are breaking into the Medicare Advantage market, which suggests that it remains among the more lucrative health insurance products.

Yet, several issues are on the horizon. The current payment environment that attracts insurers and provides extra benefits to enrollees comes at a cost to taxpayers and may reemerge as an issue down the road, when federal spending becomes a more pressing policy concern. The equity issue that arises from providing stronger financial protections, with an out-of-pocket limit, for beneficiaries in Medicare Advantage than in traditional Medicare could also gain traction as an issue, particularly as seniors' out-of-pocket spending continues to rise. With respect to quality, the wide variation across plans, a paucity of data pertaining to sicker patients, and eyebrow-raising disenrollment rates among higher-need patients appear to warrant attention and oversight. Still to be determined is how the growing role of private insurance in Medicare, and the diminishing role of traditional Medicare, is likely to affect beneficiaries' out-of-pocket spending, satisfaction, and health outcomes over time.

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