CHAPTER 4

What next for Medicare+Choice?

RECOMMENDATION

The Congress should set payments to Medicare+Choice plans at 100 percent of per capita local fee-for-service spending as soon as possible, and an adequate risk-adjustment mechanism should be phased in at least as rapidly as called for in current law.

***YES: 12 • NO: 2 • NOT VOTING: 1 • ABSENT: 2**

***COMMISSIONERS' VOTING RESULTS**

CHAPTER 4

What next for Medicare+Choice?

In this chapter:

- Problems with the Medicare+Choice payment system
- A better payment system
- Could competitive bidding improve a financially neutral payment system?

The Balanced Budget Act of 1997 established the Medicare+Choice program to increase choices available to Medicare beneficiaries, address perceived regional inequities caused by payment rates that varied widely across the country, and reduce overall Medicare spending. Unfortunately, the payment system governing it is a complex patchwork that creates inequities between Medicare+Choice plan payments and traditional fee-for-service spending in local areas, leading to unsustainable underpayments and unnecessary overpayments to health plans. To preserve the Medicare+Choice program for the long run and correct some of the current problems, the Medicare Payment Advisory Commission recommends moving as soon as possible to a financially neutral payment system in which payments to Medicare+Choice plans are set equal to local spending in traditional fee-for-service Medicare, with adequate risk adjustment. The Commission also examines how competitive bidding might work in conjunction with a financially neutral payment system, although we make no recommendations about moving to competitive bidding at this time.

The Balanced Budget Act of 1997 (BBA) established the Medicare+Choice (M+C) program with a payment system designed to correct some perceived problems with the pre-BBA payment system for health plans, such as payment rates that varied widely across the country. The M+C program was also intended to increase the plan choices available to Medicare beneficiaries and to reduce overall Medicare spending. Unfortunately, the M+C payment system has been unsuccessful in addressing the perceived problems with the pre-BBA system and has made some worse. It has not solved the problem of unequal plan distribution across the country, nor has it reduced the costs of the Medicare program. In fact, market forces that have increased costs and reduced enrollment in health maintenance organizations (HMOs) in general, combined with lower growth in plan payments in certain areas, have caused many M+C plans to exit the program, leaving beneficiaries with fewer choices instead of more. Finally, in trying to solve geographic inequities, the M+C payment system created inequities between M+C payments and spending in traditional fee-for-service (FFS) Medicare within local areas. To improve equity between M+C payments and traditional FFS spending and avoid unsustainable underpayments and unnecessary overpayments to plans in local areas, the Medicare Payment Advisory Commission (MedPAC) recommends moving as soon as possible to a financially neutral system in which Medicare pays the same risk-adjusted amount for beneficiaries enrolling in M+C plans as it pays for beneficiaries remaining in traditional FFS Medicare. In making this recommendation, we are expanding on a recommendation we made last year (MedPAC 2001).

Problems with the Medicare+Choice payment system

Four years after the implementation of the M+C program, few are happy with the results. Medicare beneficiaries generally have access to fewer private plans and less generous benefit packages than they did before the BBA, in part because of recent market forces affecting the entire HMO industry and in part because of M+C restrictions on the growth of plan payments in some areas. The M+C program has not resulted in cost savings for Medicare, nor has it addressed the continuing geographic disparities in access to plans and plan benefits. Private plans contend they cannot participate in Medicare in many areas of the country under the current payment structure, and health policy analysts object to the inappropriate incentives that result from payment inequities in local areas.

Reduced access to plans and decreased benefits

The number of plans participating in Medicare has fallen since the implementation of the M+C program, and the additional benefits offered have decreased steadily. The number of M+C contracts peaked at 346 in 1998. By January 2002, this number had fallen to 148.[1] In the past four years, between 300,000 and 1 million M+C enrollees annually have lost access to the plan they were in and had to switch to another plan (if one was available in their area) or return to traditional FFS Medicare. Beneficiaries returning to traditional Medicare could purchase a Medicare supplemental insurance policy (known as medigap), but generally faced higher premiums for medigap coverage than they had paid for their M+C plan and were limited in their choice of coverage.[2] Such disruptions can take a financial and emotional toll on beneficiaries, who may have to switch health care providers or face larger out-of-pocket costs for health care services and outpatient prescription drugs.

In many cases, plans that have not withdrawn have reduced the overall value of their benefit packages. Before the inception of M+C, Medicare HMOs were popular in certain areas of the country because they offered extra benefits—such as coverage for outpatient prescription drugs and lower copayments for hospital admissions and physician visits than traditional Medicare—at little or no additional cost to their enrollees. M+C plans provided a less expensive alternative than medigap insurance for beneficiaries in many areas of the country. In response to rising health care costs and slow growth in M+C payments in certain areas, however, plans have steadily increased the premiums they charge beneficiaries and reduced the benefits they offer. The percentage of beneficiaries living in areas where at least one zero-premium plan is offered has fallen by about half (60 percent to 32 percent) since 1999. While 51 percent of beneficiaries still have access to at least one plan that offers prescription drug benefits in 2002, the dollar value of these benefits has declined significantly. Plans have been increasing beneficiary copayments, limiting the total dollar amount of coverage, restricting coverage to a formulary, or covering only generic drugs.

Reduced plan participation and declining benefit packages are not unique to the M+C program. The commercial HMO market has experienced similar trends in recent years; one study suggests that overall HMO market share is lower now than at any time since 1993 (Gabel et al. 2001). Analysts cite several reasons for these trends. First, health care consumers

1 The reduction in contracts was due in part to a number of HMO contract consolidations over the same period.

2 Medigap plans are privately purchased insurance plans that cover some of the costs of health care not covered in traditional FFS Medicare, including some portion of beneficiaries' deductibles, coinsurance, and copayments for traditional Medicare services. Current medigap plan options include 10 standardized plans and a number of other plans that either pre-date or are otherwise exempt from adhering to the federal standards. Few medigap plans offer any prescription drug coverage, and those that do generally have much higher than average premiums and limited coverage. The General Accounting Office reported that, in 1999, the average annual premium for medigap plans was more than $1,300 (GAO 2001). Beneficiaries whose M+C plans leave the program are only guaranteed to be able to purchase some of the standardized plans; none of these guaranteed options offers prescription drug coverage.

are increasingly rejecting many techniques that HMOs use to control costs, such as restricted provider networks, specialty referral requirements, and preauthorization for services. In response, HMOs have loosened some of these restrictions, causing costs and premiums to rise (Gabel et al. 2001). Also, consumer demand for large, stable provider networks and consolidations of providers have increased providers' bargaining leverage enough that they generally no longer offer the deep discounts that helped HMOs lower costs in the past. The combination of rising costs and declining enrollments has caused the entire HMO industry, not just Medicare HMOs, to consolidate, restrict benefit offerings, and charge higher premiums.

Lack of cost savings

Although the number of exits suggests that M+C payment rates may currently be too low to sustain plan participation in some areas, the M+C program has not resulted in cost savings for Medicare. In fact, MedPAC has estimated that average spending for beneficiaries in the M+C program was about 4 percent higher than spending for demographically similar beneficiaries in the traditional Medicare program in 2001.[3] This estimate does not adjust for the relative health of beneficiaries in M+C plans or traditional Medicare.

Payment inequities between Medicare+Choice and fee-for-service Medicare in local health care markets

In trying to solve the pre-BBA problem of wide differences in plan payment rates across the country, the M+C payment system created a new problem: payment inequities between M+C and traditional FFS within local health care markets. The BBA constrained M+C payment rates in many areas of the country in which FFS spending was higher than average, while setting M+C payment rates far above local FFS spending in many areas with lower-than-average spending (see Chapter 1, p. 31). Ironically, this policy, which has caused M+C payments to lag behind FFS costs in some areas, may make it more difficult for private plans to serve areas where they would otherwise be most effective in negotiating provider discounts, managing use of health care resources, and providing health services to beneficiaries more efficiently than traditional FFS Medicare. At the same time, the system subsidizes private plans for operating in areas of the country in which market conditions make it difficult to manage care or operate more efficiently than traditional Medicare.

Areas of the country with relatively high concentrations of health care providers and beneficiaries and high FFS spending (often an indicator of above-average health care use) have generally been amenable to HMO cost-control methods. In these areas, private plans typically have more success negotiating with health care providers for volume discounts and using resource management tools to control use of services. In addition, many of these areas have above-average M+C payment rates, either because beneficiaries' use of health care resources is higher than average or because prices are higher than average, or both. By taking advantage of higher payment rates and more cost saving opportunities, plans generally have been able to offer additional benefits in these areas at little or no additional premium. In some cases, plans have used the extra revenues they generate to subsidize services in less profitable adjoining areas. However, by restraining payment increases, the M+C payment system may have reduced the incentives for M+C plans to operate in these areas.

The M+C payment system also introduced floor payment rates (subsidies) to encourage plans to operate in lower-payment areas. Many of these areas, though not all, have few providers and relatively few Medicare beneficiaries spread over large distances, making them unfavorable to HMOs.[4] The limited number of health care providers makes it difficult for plans to negotiate volume discounts or establish adequate provider networks. The limited number of beneficiaries increases the financial risk to plans and generally makes serving these areas financially questionable. Although the floor payment rates have been unsuccessful in attracting many managed care plans to enter these areas, private FFS plans are beginning to recognize a profit opportunity.[5] The first such plan, called Sterling Option 1, has more than 19,000 enrollees in 24 states. Sterling serves mostly floor payment rate counties, where it receives M+C payment rates set far above local FFS spending while paying providers essentially FFS rates (based on the Medicare fee schedule). In addition to being costly for the Medicare program because of the subsidy, the plan offers beneficiaries little beyond the basic Medicare benefit package and charges enrollees a monthly premium of $78. The floor payment rates inappropriately provide incentives for private plans to enter areas where they are least likely to influence market behavior or contain costs.

The Medicare+Choice payment system needs to be changed

The current M+C payment system does not encourage more health plan choice or save Medicare money. It also discourages plan entry in areas where M+C plans are most effective at competing with

3 To estimate relative spending in M+C and traditional FFS Medicare, MedPAC first calculated M+C spending using M+C payment rates, weighted by enrollment. Next, we used the Centers for Medicare & Medicaid Services' national growth factors for 2000 and 2001 to update the 1999 estimates of per-capita FFS spending (without graduate medical education payments and standardized for demographic factors) for each county. We weighted aggregate FFS spending by M+C enrollment and compared it with M+C spending.

4 Some areas, such as Portland, Oregon and Minneapolis, Minnesota, are exceptions to this generalization in that they have relatively large provider and beneficiary populations and high HMO penetration, even though they have lower-than-average M+C payment rates.

5 Private FFS plans pay providers for each covered service they deliver and allow enrollees to obtain services from any provider willing to accept the plan's payments (which are typically based on the Medicare FFS payment schedule).

traditional FFS Medicare and encourages plan entry in areas where they are least effective. In addition, the current system has not been successful in solving the geographic equity problem of beneficiaries in some areas having access to additional benefits, generally at lower cost than medigap coverage, while beneficiaries in other areas do not. However, as long as FFS spending varies substantially across geographic areas, the geographic equity problem is difficult to solve without introducing serious inequities in M+C payments and traditional FFS spending at the local level. For these reasons, the current M+C payment system is unsustainable in the long run and may ultimately result in few plans operating in areas other than floor payment rate counties.

A better payment system

Notwithstanding problems with the payment system, the M+C program itself is popular. Many beneficiaries value the option of receiving Medicare benefits through private health plans. Believing that private plans may do a better job of delivering cost-effective, high-quality health care to beneficiaries than a government-run system, many policymakers support Medicare reform proposals that would rely heavily on the private market to provide Medicare benefits.

To preserve and sustain the M+C program for the long run without substantially increasing Medicare spending, the Commission recommends a financially neutral payment system that would equalize Medicare payments between beneficiaries in M+C and in traditional FFS Medicare within local areas, adjusted for differences in risk. This system would provide beneficiaries with the choice of enrolling in an M+C plan or remaining in traditional FFS without directing beneficiaries toward one option or the other. Furthermore, the Commission believes that if the M+C program provides a choice of delivery systems and additional value for beneficiaries, it should do so without costing Medicare more than it would otherwise pay to provide the basic benefits package to enrollees through the traditional FFS program.

RECOMMENDATION

The Congress should set payments to Medicare+Choice plans at 100 percent of per capita local fee-for-service spending as soon as possible, and an adequate risk-adjustment mechanism should be phased in at least as rapidly as called for in current law.

The Commission would prefer to see payment rates moved to 100 percent of per-capita local FFS spending over a short transition period to avoid undue disruption in the M+C program. Eliminating the floor payment rates and the minimum updates immediately could create too much instability in local plan payments, especially because the floor payment rates and minimum updates have insulated some counties from significant rate reductions.

For example, if rates were moved immediately to 100 percent of FFS spending, areas such as Manhattan and Portland, Oregon would experience large decreases in payment rates that would likely force plans to leave immediately. Plans in other areas—such as Las Vegas—would see large increases in payment rates. To lessen these effects, the Commission considered a four-year phase-in of the new financially neutral payment rates (Table 4-1). In 2003, the rates would be a blend equal to 75 percent of the 2003 M+C payment rates under current law and 25 percent of local estimated FFS spending. The portion of rates determined by local FFS spending would increase each year until rates are set at 100 percent of FFS spending in 2006. This transition should produce more manageable rate changes. Even in areas

TABLE 4-1

Illustrative effects of moving to a financially neutral payment system, assuming a 4-year phase-in period

Selected payment areas	2002 per capita FFS costs	2002 payment rates	Payment rates under phase-in 2003	2004	2005	2006	GME/IME per capita spending in 2006
2 percent update areas							
Manhattan, NY	$654	$795	$775	$764	$762	$772	$104
Miami, FL	805	834	843	865	900	950	16
Los Angeles, CA	672	694	702	721	751	793	20
Las Vegas, NV	676	583	618	665	724	798	8
Floor payment areas							
Portland, OR	408	553	527	514	499	481	25
Phoenix, AZ	515	553	554	572	590	608	15
Current law as percent of total payment			75%	50%	25%	0%	
Per capita FFS as percent of total payment			25%	50%	75%	100%	

Note: FFS (fee-for-service), GME (graduate medical education), IME (indirect medical education). All dollar figures are per capita per month. This illustration assumes that: FFS costs and GME/IME spending grow at 2% in 2003 and 5% annually from 2004–2006, payment rates in 2% update areas grow at 2% annually, and payment rates in floor payment areas grow at 2% in 2003 and 5% annually from 2004–2006. Estimated FFS costs in 2002 exclude GME and IME spending. GME and IME spending represent amounts paid directly to teaching hospitals that serve Medicare+Choice enrollees.

Source: CMS, 1999 FFS expenditure data by county, and 2002 Medicare+Choice payment rates.

A brief history of risk adjustment in Medicare+Choice

The Balanced Budget Act of 1997 (BBA) directed the Secretary of Health and Human Services to begin making payments to Medicare+Choice (M+C) plans on January 1, 2000, using a system that accounts for differences in health status among enrollees. As a first step in meeting the BBA requirement, the Centers for Medicare & Medicaid Services (CMS) began phasing in the principal inpatient diagnostic cost group (PIP-DCG) model on the required date. The PIP-DCG model measures enrollees' health status using their:

- age,
- sex,
- Medicaid status the previous year,
- original reason for eligibility (aged or disabled), and
- principal diagnoses from any hospital inpatient stays in a defined prior 12-month period.

For 2000 through 2003, the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) mandated that the new risk-adjustment system apply to 10 percent of the payment for M+C plans, and that the remaining 90 percent be based on a demographic model already in use. For 2004, the BIPA specifies that risk adjustment be based on a multiple-site model that uses data from hospital inpatient and ambulatory settings. The BIPA also requires that such a model apply to 30 percent of payments in 2004, and that this percentage be increased annually until it reaches 100 percent in 2007.

Considerable uncertainty exists over the form the risk-adjustment system will take in 2004. Before the BIPA was passed, CMS had plans to replace the PIP-DCG model with a multiple-site model that takes into account diagnoses from physician and hospital outpatient visits as well as hospital inpatient stays. CMS intended for M+C plans to submit all diagnoses from all hospital inpatient, hospital outpatient, and physician office encounters, as well as data elements that would have made auditing easier and would have allowed for eventual use of encounter data to calibrate the risk-adjustment model. Plans argued that collecting and submitting the full encounter data would be an excessive burden. In response, the Secretary suspended collection of full encounter data from ambulatory sites in May 2001 and directed CMS to investigate alternative methods that would not require plans to submit full encounter data.

CMS intends to reduce the burden on plans by requiring them to submit only the data elements necessary to run a risk-adjustment model: beneficiaries' identification number, diagnosis codes, beginning and ending dates of service, and type of provider (inpatient, outpatient, or physician's office). CMS is also considering decreasing the burden on plans by reducing the number of diagnoses it will use to risk-adjust payments. Plans would be required to submit only information on those diagnoses used in the risk-adjustment model, but they would also be allowed to submit information on other diagnoses if they choose. Finally, plans will have flexibility in how they submit the data. They can submit either full encounter forms or summary forms with only the required data elements.

CMS will announce the variables to be used in the risk-adjustment model on or before March 29, 2002. It will announce which multiple-site risk-adjustment model it will use on or before January 15, 2003, and will begin using the model to adjust payments beginning January 1, 2004. ■

like Manhattan—which currently has an M+C rate that is $141 per month above FFS spending—the annual adjustments over the transition period are likely to be $20 per month or less.

Similarly, the Commission recommends phasing in as quickly as possible a reliable risk-adjustment system to account for the relative health status of beneficiaries in M+C plans and in FFS Medicare. Such a system is necessary for the proper functioning of a financially neutral payment system. If M+C plans were paid based on the estimated cost of treating average beneficiaries in traditional FFS Medicare without adjusting for the relative health status of M+C enrollees, plans could be paid too much or too little for the health care needs of their Medicare enrollees. This could give beneficiaries who join M+C plans access to very generous benefits at the expense of other beneficiaries and increase Medicare spending (if plans are paid too much), or it could make it impossible for plans that enroll more costly beneficiaries to operate in Medicare (if plans are paid too little).

However, current risk adjustment—the principal inpatient diagnostic cost group (PIP-DCG) model—does not work well enough to differentiate adequately among beneficiaries based on health status.[6] Therefore, MedPAC continues to support moving to a system, such as one of those currently being considered by the Centers for Medicare & Medicaid Services (CMS), that would include data from some outpatient settings (see text box above). The data do not presently exist to allow us to determine the distributional

6 MedPAC recently examined these issues in more depth (MedPAC 2000).

consequences of moving to an adequate risk-adjustment system. We believe that some plans probably have healthier-than-average populations of enrollees and that other plans probably have less healthy enrollee populations, but whether use of a more accurate risk-adjustment system would ultimately result in an increase or a decrease in plan payments, on average, is uncertain.[7]

In addition to risk adjustment, Medicare faces three technical issues in setting rates: the appropriate size of payment areas, how to treat the interaction of the Medicare program with spending on behalf of beneficiaries who are also eligible for benefits through the departments of Defense and Veterans Affairs, and how to account for payments related to graduate medical education (GME). The first two issues have been raised in previous reports by MedPAC and one of MedPAC's predecessor commissions, the Prospective Payment Assessment Commission (MedPAC 2001, ProPAC 1997); these issues are not discussed here. The Commission believes that the current M+C payment policy with regard to payments for GME should be continued (see text box, right).

Effects of moving to a financially neutral payment system

The Commission believes that a financially neutral payment system is a prudent way to preserve and improve the M+C program in the long run. Such a system would improve equity between M+C payments and traditional FFS spending and eliminate unsustainable underpayments and unnecessary overpayments to plans. It would not necessarily improve geographic equity across areas, reduce overall spending, or increase plan choices, but neither will the current M+C payment system.

A financially neutral payment policy would improve equity between M+C enrollees and traditional FFS beneficiaries within local payment areas. By design, the Medicare program would spend the same risk-adjusted amount for M+C enrollees and beneficiaries in the traditional FFS program within each local market, something that is not true under the current M+C payment system. Beneficiaries would be free to choose between enrolling in an M+C plan or remaining in traditional FFS Medicare, without Medicare paying more for either.

A financially neutral payment system also would avoid the problem of unsustainable underpayments and unnecessary

The reduction in Medicare+Choice payments for graduate medical education

Prior to the Balanced Budget Act of 1997 (BBA), payment rates to Medicare health maintenance organizations (HMOs) were based on county-level fee-for-service (FFS) costs, including graduate medical education (GME) and indirect medical education (IME) payments to teaching hospitals (among other payment add-ons). Thus, plan payment rates were higher in counties where FFS beneficiaries obtained care from teaching hospitals and lower in counties with less use of teaching hospitals.

The Congress changed this policy with the creation of Medicare+Choice (M+C) because some policymakers believed that reflecting GME and IME payments in plan payment rates was inappropriate to the extent that there was a belief that managed care plans used teaching hospitals less often than traditional FFS Medicare and paid them less. Thus, current law requires that M+C payment rates be computed without the GME and IME payments and that these payments be paid by Medicare directly to teaching hospitals for the M+C enrollees they treat. The Congress intended for this change to be phased in over a 5-year period ending in 2002, but GME payments have not been fully removed from M+C payment rates in many areas because the floor payment rates and minimum updates have prevented rates from declining. However, teaching hospitals began receiving some GME payments from Medicare immediately after implementation of the BBA and will receive the full amount of the GME payments for M+C enrollees in 2002.

To help ensure that M+C plans have incentives to direct enrollees to use teaching hospitals when appropriate, the Commission supports excluding GME and IME payments from plan payment rates. This exclusion is sometimes referred to as the carve-out. In the absence of a carve-out, M+C plans would receive additional payments that could be used to pay for the higher cost of care in teaching hospitals, but they might elect instead to contract with community hospitals and use the additional funds for other purposes, including additional benefits. Continuing the carve-out, however, allows teaching hospitals to compete with lower-cost community hospitals. Under the carve-out, teaching hospitals only receive the additional GME and IME payments directly from Medicare if they treat M+C enrollees; they therefore have incentives to lower their rates to encourage plans to contract with them. If teaching hospitals' rates are competitive with those of community hospitals, plans have an incentive to use teaching hospitals when their enrollees would benefit from the care that teaching hospitals provide. ■

7 CMS analyzed the potential impact of the current risk adjuster, the PIP-DCG, and found that overall plan payments would decrease. However, it is unclear whether any existing risk selection would have changed between then and now as a result of higher plan premiums and less generous benefits.

overpayments. Plans would be paid what it costs to treat beneficiaries in traditional FFS Medicare and would have incentives to operate in areas in which they could provide services at lower cost than FFS. Similarly, plans would no longer be subsidized for operating in areas where they cannot compete with traditional Medicare.

A financially neutral payment system would not improve geographic equity across areas. Geographic variation in spending in FFS Medicare precludes improving both geographic equity across areas and equity between M+C payments and traditional FFS spending within local areas at the same time. The Commission believes that changes to M+C payment rates are the most effective way to improve equity within areas, while changes to FFS payment systems and practice patterns would be needed to improve geographic equity across areas.

It is unclear whether the payment policy MedPAC recommends would change overall spending relative to the current M+C payment system. Eliminating floor payment rates could reduce spending, but payment rates to other areas would increase under a financially neutral payment system. The change in overall payments relative to current spending would depend on the relative magnitudes of the two effects.

Even under the current payment system for M+C, which was designed to encourage choice in more areas of the country, many areas still lack plan choices. Moving to financially neutral payment rates would likely lower M+C payment rates in most areas currently without plans, especially in floor payment areas. Thus, the new rates probably would not result in new plans entering areas that have no plan choices now. However, the system could help to maintain or even increase the choices available in areas where choices already exist.

Could competitive bidding improve a financially neutral payment system?

Some policy analysts suggest that implementing a financially neutral payment system through competitive bidding might encourage greater plan participation, reduce Medicare costs, and improve geographic equity across areas. In evaluating this proposition, we assume the notion of competitive bidding that is embodied in the private market for health insurance. Insurers develop products that differ in the benefits they offer and other characteristics of interest to potential enrollees. Insurers' offerings can be thought of as bids. Buyers—in this case, beneficiaries—face different prices for the different offerings and make tradeoffs among price, quality, and convenience when choosing to enroll in a particular plan.

In fact, many elements of this form of competitive bidding already exist in the M+C program. Plans compete against one another on the basis of supplemental benefits and premiums. They also compete against the FFS Medicare program (often combined with medigap), although they are sometimes limited in the ways in which they can compete. For example, M+C organizations currently cannot offer plans that are less expensive than traditional FFS Medicare; they may only offer plans with richer benefits. This means that M+C enrollees are required to pay the same Part B premium as beneficiaries who remain in traditional FFS Medicare, even if their M+C plan would like to charge them less and offer fewer supplemental benefits. A provision in the BIPA takes effect in 2003 that will ease this restriction and will allow plans to refund all or part of the Part B premium to their enrollees.

However, current law differs significantly from most models of competitive bidding in that market competition does not affect the government contribution to M+C plan payments. (The payment an M+C plan receives for each enrollee is the government contribution, typically referred to as the M+C payment rate, plus any additional premium the plan charges beneficiaries.) Some proponents suggest that using competitive bidding to set the government contribution could help lower overall program costs. For example, if some plans bid lower than traditional FFS Medicare, and if beneficiaries choose lower-cost plans to avoid paying the additional costs of more expensive plans, then overall Medicare spending could be reduced.

An illustrative model of competitive bidding

In this section, we analyze an illustrative model of competitive bidding and examine how the results could be generalized to other system options. Although there are many possible models for competitive bidding, the Commission has focused on those that would be compatible with a financially neutral payment system (which we define as one that requires the government's contribution in a local area to be equal for beneficiaries in M+C plans and those in traditional FFS Medicare). We also assume that the benefit packages on which plans bid would be the same in traditional Medicare and M+C plans. We made this assumption to avoid the question of how to distinguish differences in plan costs from differences in benefits. If plans were allowed to bid on different packages, it would be difficult to determine which benefits the government contribution was actually supporting.

In our illustrative model, plans' bids would be based on the basic Medicare benefits package, although they might be able to offer richer benefits. (Plans do this now when they submit their adjusted community rate proposals, which report the benefits they offer and the premiums and copayments they charge.) Traditional FFS Medicare would be one of the plans in the market, and its bid would equal estimated FFS costs in the local area. Other plans would be free to bid whatever they wanted to provide the defined set of benefits. The amount of the government contribution to plan payments in each

local area could be determined in a number of ways. For example, it could be based on the lowest bid, the average bid, or some percentage above the lowest bid. However, because traditional FFS Medicare would submit a bid and because we focus on models which are consistent with a financially neutral payment policy, we assume the government contribution would never exceed local costs for traditional FFS Medicare.

Two different types of local markets would exist under this competitive bidding model: those with only traditional FFS Medicare and those with traditional FFS Medicare and at least one private alternative. In markets with only traditional Medicare, the government contribution would be equal to local estimated FFS costs, as it is under current law, and beneficiaries would pay the Part B premium, as they do now (Table 4-2).

In markets with at least one alternative to traditional Medicare, the government contribution could be set in any number of ways. In Table 4-3, we illustrate a market that has at least one M+C plan, in addition to traditional Medicare. We assume that the government contribution for market B has already been chosen, using any of the possible methods, and that M+C plan X's bid happens to equal the government contribution, which in this case is lower than traditional FFS Medicare's bid. Beneficiaries living in this market who choose to remain in traditional Medicare would have to pay the Part B premium plus the difference between the cost of traditional Medicare and the government contribution. For example, if expected costs were $500 under traditional Medicare and the government contribution were set at $450, beneficiaries choosing to remain in traditional Medicare would pay the $54 Part B premium plus $50 (Table 4-3). Beneficiaries enrolling in plans with higher bids would pay the Part B premium plus an additional premium equal to the difference between their plan's bid and the government contribution. (Additional premiums collected from beneficiaries could be used to lower the national Part B premium, increase the level of benefits in the standard benefit package, or lower the overall cost of the Medicare program to taxpayers.) Beneficiaries enrolled in M+C plan X would pay no additional premium beyond the Part B premium because the plan's bid would be equal to the government contribution.

TABLE 4-2 **Payments under illustrative competitive bidding model**

Markets	Medicare pays	Beneficiary pays
Market with traditional FFS only	providers as usual in FFS	Part B premium only
Market with traditional FFS plus 1 or more private plans	providers as usual in FFS	Part B premium
	government contribution to private plans	Plus – people in plans with bids above the government contribution pay the difference between bid and government contribution – people in FFS pay the difference (if any) between expected local FFS costs and government contribution

Note: FFS (fee-for-service).

TABLE 4-3 **How rates and premiums would be set in the illustrative competitive bidding model, in markets with only the traditional fee-for-service plan available and in markets with an alternative lower-cost Medicare+Choice plan**

Markets	Plan bid	Government contribution	Beneficiary premium
Market A			
Traditional FFS plan	$510	$510	$54
Market B			
Traditional FFS plan	500	450	54+50
M+C plan X	450	450	54

Note: M+C (Medicare+Choice). FFS (fee-for-service). Illustrative market A has only traditional FFS Medicare as an option. Illustrative market B has traditional FFS Medicare and at least one M+C plan alternative. The traditional FFS plan's bid is set equal to traditional FFS plan costs in the local market. The government contribution has already been set at $450 in market B. $54 is the 2002 Medicare Part B premium.

Effects of moving to competitive bidding

This section compares outcomes under the illustrative competitive bidding model with the current M+C payment system and a financially neutral payment system that does not use competitive bidding based on the criteria introduced earlier in

this chapter: geographic equity across areas, choice of plans, and overall spending.

The illustrative competitive bidding model would offer a different sense of geographic equity across areas than either the current M+C system or a financially neutral payment system without competitive bidding. All beneficiaries nationwide would have access to a basic benefit package (not necessarily provided through traditional FFS Medicare) at the same Part B premium, and would have to pay more if they wanted to join a more costly plan. This differs substantially from the current situation: all beneficiaries nationwide have access to traditional FFS Medicare at the same Part B premium, and beneficiaries in some areas have access to plans with extra benefits for no additional premium. Because the illustrative model adheres to the financially neutral payment policy, equity between M+C enrollees and traditional FFS beneficiaries in each local market would be improved.

Would setting the government contribution using the illustrative competitive bidding model expand choice of plans? Unless the model allowed the government contribution to exceed the expected local costs of traditional FFS Medicare (which would violate the policy of financial neutrality), plans would have no greater incentive to participate than they would under a financially neutral payment system without competitive bidding. In areas with no plans, a plan that was not already participating would still be unlikely to participate, given that rates could only be lowered under our illustrative model relative to financial neutrality without competitive bidding. In areas with alternatives to traditional FFS Medicare, the fact that beneficiaries would have to pay more to remain in traditional FFS Medicare could encourage more beneficiaries to enroll in M+C plans and create opportunities for additional plans to compete in these areas. However, a recent study using a simulation model to predict the outcomes of different competitive bidding models concluded that significantly greater enrollment in M+C plans is unlikely under any of the models examined (Thorpe and Atherly 2001). The simulations were based on previous studies that found that beneficiaries tend not to switch health plans unless presented with significant financial incentives.

Medicare spending under competitive bidding is difficult to predict because it depends on how the government contribution is set and whether some plans would bid lower than traditional FFS Medicare. Nonetheless, our illustrative model would likely not increase Medicare spending, at any point in time, relative to a financially neutral payment system without competitive bidding. In fact, spending could decrease depending on how the model is structured. For example, the authors of the competitive bidding study cited above estimated that a model with the government contribution set equal to the average bid would generate savings to the Medicare program of close to 10 percent of total Medicare spending (Thorpe and Atherly 2001). Savings would arise primarily from the additional premiums paid by beneficiaries remaining in traditional Medicare, and to some extent from lower government contributions paid to M+C plans.

Issues with moving to competitive bidding

Several complications would likely arise in the actual implementation of a competitive bidding model. Because the premiums beneficiaries would pay for traditional FFS Medicare could vary more under a competitive bidding model than they do under the current system, risk selection issues could be more serious. In addition, competitive bidding would change the nature of the Medicare entitlement. Finally, policymakers would need to consider tradeoffs in the actual design of a competitive bidding model.

Adequate risk adjustment would be essential to ensure the stability of traditional FFS premiums in any competitive bidding system like the one we illustrate. Under the current M+C system, beneficiary premiums for the traditional FFS program are fixed in the short run. In a competitive bidding system without adequate risk adjustment, however, premiums for traditional FFS Medicare could increase rapidly in some local markets if healthier beneficiaries chose M+C plans and less-healthy beneficiaries stayed in traditional Medicare. Once premiums began to rise, increasing numbers of healthier beneficiaries could decide to trade the broad choice of physicians available in traditional FFS Medicare for less expensive health plan alternatives, further raising the average costs of beneficiaries remaining in the traditional program and perpetuating an unsustainable series of premium increases for traditional Medicare.

In addition, under this illustrative model of competitive bidding, beneficiaries would no longer be entitled to get care through traditional FFS Medicare for the same premium nationwide. Beneficiaries would still be entitled to receive the standard Medicare benefits package, but not necessarily through the broad choice of providers available in traditional FFS Medicare. Beneficiaries would always have the traditional FFS option, but they could be required to pay more for it if less expensive alternatives were available in the market.

Finally, two types of tradeoffs need to be considered in implementing a competitive bidding system in which the government contribution might be lowered and beneficiaries in some areas could be required to pay more to remain in traditional Medicare. One tradeoff is between higher premiums paid by some beneficiaries and cost savings. The savings could be distributed either to taxpayers or to all Medicare beneficiaries nationwide through lower Part B premiums or an improvement in the standard Medicare benefits package. The other tradeoff occurs among geographic areas. In areas of the country where M+C plans currently provide extra benefits at minimal cost, such bargains probably would not exist after implementation of competitive bidding. Beneficiaries in these areas who chose to remain in traditional FFS Medicare would face

additional premiums. Beneficiaries in areas of the country that currently have no M+C plans would either be unaffected or would benefit if overall savings were used to lower Part B premiums or enhance the basic Medicare benefits package.

Overcoming the challenges and reaching a political consensus on these tradeoffs would be difficult. In the meantime, the Congress should move to a financially neutral payment system, incorporating adequate risk adjustment, as soon as possible without creating undue disruption to the M+C program. It is not necessary to wait to see if competitive bidding will be enacted; the use of competitive bidding to set M+C payment rates would be compatible with financial neutrality as long as traditional FFS Medicare is included as one of the bidders. Competitive bidding would simply determine the level of the government contribution, and thus could be done at a later time. ■

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