

*Public Policy Monograph*

*April 2000*

Medicare Reform:  
Using  
Private-Sector  
Competition Strategies



AMERICAN ACADEMY *of* ACTUARIES

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APRIL 2000

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# Medicare Reform: Using Private-Sector Competition Strategies

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# Medicare Reform: Using Private-Sector Competition Strategies

## Executive Summary

**M**edicare plays an important role in providing health care to elderly and disabled Americans. In response to the changing health care environment in this country, fundamental changes to the program may be necessary. To that end, a number of proposals to "reform" Medicare have been introduced in Congress and put forth by candidates in this year's presidential election.

A key component of many Medicare reform initiatives is to encourage competition among health insurers, managed care health plans and health care providers. Some proposals would allow groups to submit bids to the government for providing medical services to Medicare beneficiaries. The successful bidders would be awarded contracts to serve Medicare beneficiaries in a specified geographic region. Other proposals would give each beneficiary a voucher for a defined dollar amount and let him or her choose how to use the voucher to pay for health care.

The American Academy of Actuaries Medicare Reform Task Force has examined the leading proposals to reform Medicare by increasing competition. While each proposal is to some degree different in approach, all share the premise that allowing competition will make the Medicare program more efficient and, in the long run, less costly.

The Medicare Reform Task Force believes that a well-structured program fostering increased competition has the potential to yield substantial savings. However, implementation of any of the proposed competitive systems would require decisions about a large number of technical and operational concerns. Those decisions would have a significant impact on the effects of increased competition, including the amount of savings achieved.

Increased competition would affect beneficiaries, health care providers, managed care health plans, health insurance companies, employers and taxpayers in significant ways. Many of the effects might not be apparent until after a new program is implemented.

The Medicare Reform Task Force recommends that Medicare reforms intended to increase competition include the following:

- A phased implementation, to make maximum use of available resources and to learn from the process.
- "Grandfathering" all Medicare beneficiaries above a certain age (e.g., age 80, sometimes defined as the "old old") and any beneficiaries who are functionally unable to choose a competing plan by allowing them to remain in traditional Medicare and continue to pay traditional Part B premiums. If these beneficiaries still wish to participate in the new options, they would have a one-time choice to leave traditional fee-for-service Medicare.
- Allowing sufficient time to create the necessary infrastructure before implementing the new program.
- Allowing the competitive bidding program to operate for a sufficient length of time to generate both primary and subsequent effects before it is evaluated.
- Defining carefully, before implementation, how, when, and by what criteria the competitive program will be evaluated.

Moreover, to the extent that the reforms include competitive bidding, the Medicare Reform Task Force recommends consideration of the following:

- Including a traditional Medicare fee-for-service option in any competitive bidding program to enhance competition and to provide a level playing field for all bidders.

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- Using an experienced bidding manager with the resources necessary to implement a national program.
- Minimizing legislative and regulatory restrictions to allow the bidding manager flexibility to use private sector bidding techniques.
- Insulating the bidding manager from undue political pressure, for example, through the use of an independent governing board appointed for multi-year terms.

# Introduction

Medicare provides a significant amount of support to older and disabled Americans in meeting their health care needs. Almost 98 percent of the population age 65 years or older in the United States is covered by the Medicare program.<sup>1</sup> There has been a great deal of discussion over the past few years about whether, and how, Medicare should be modified in response to the changing health care environment in this country. So-called Medicare reform proposals have been introduced in Congress, discussed by various advisory commissions and debated by candidates for public office.

To further the discussion about the Medicare program, and to help public policy-makers understand the consequences of some of the recently proposed reform initiatives, the American Academy of Actuaries is publishing a three-part series of monographs on Medicare reform. The first monograph, *Evaluating the Fiscal Soundness of Medicare*, examines how Medicare solvency is measured and discusses several proposals to strengthen the financial basis of the program. This report, *Using Private-Sector Competition Strategies*, examines ways in which competitive pricing techniques used in the private insurance market could be applied to Medicare. The third monograph, *Providing Prescription Drug Coverage for Medicare Beneficiaries*, discusses alternatives for assisting Medicare beneficiaries in paying for needed prescription drugs.

A key component of many Medicare reform initiatives is to encourage competition by health insurers, managed care health plans and/or health care providers. Some of the proposals would allow these groups to submit bids to the government for providing medical services to Medicare beneficiaries. The successful bidders would be awarded contracts to serve Medicare beneficiaries in a specified geographic region. Other proposals would give each beneficiary a voucher for a defined dollar amount and let him or her choose how to use the voucher to pay for health care.

In general, Medicare beneficiaries have their health care paid for in one of two ways. Beneficiaries may be covered by what is known as the “traditional” fee-for-service (FFS) program under which physicians, hospitals, and other health care providers bill Medicare for the services they provide at prices established by the Health Care Financing Administration (HCFA). In addition, a growing number of Medicare beneficiaries are covered by a Medicare+Choice (M+C) health plan, which is a managed care organization that contracts with HCFA to provide care. The M+C health plan administers the program, collects any required premiums from beneficiaries and pays the medical providers for health care services.

This monograph examines several types of proposals to improve the cost effectiveness of Medicare by introducing or expanding competitive concepts that appear to have been successful in managing the costs of private sector health care programs. Section I discusses proposals to award contracts for delivery of Medicare benefits by managed care organizations through competitive bidding. Section II examines giving vouchers to Medicare beneficiaries to purchase health coverage. Section III considers the awarding of contracts for delivery of Medicare benefits by health care providers through competitive bidding, and the final section addresses the possibility of Medicare preferred provider organizations (PPOs).

The critical issues faced by those advocating competitive features is whether reform will produce better coverage options for Medicare beneficiaries than are offered under the current system and what impact to expect on health care cost trends from those changes. In other words, will beneficiaries and those who pay for Medicare (both beneficiaries and non-beneficiary taxpayers) be better off than they are now? While this monograph does not provide answers to those specific questions, it does provide a framework for the debate over the issues regarding Medicare reform.

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<sup>1</sup> Medicare Payment Advisory Commission, Report to the Congress-Selected Medicare Issues, June 1999

# I. Competitive Bidding By Health Plans

## **Administrative Pricing vs. Competitive Bidding**

Under the current administrative pricing mechanism, the Health Care Financing Administration (HCFA) announces a set of payment rates each year. These rates, which vary by county, age, sex, other demographic factors and, (starting in 2000), health-based payment adjusters, are part of a complex series of rules for determining how much HCFA pays to M+C health plan contractors. HCFA allows participation in the M+C program by all health plans that satisfy minimum administrative and solvency requirements.

Under the current M+C program, profits are intentionally limited, and health plans have an incentive to provide additional benefits rather than return any savings to the government. One major consequence of using this administrative price model is that HCFA does not receive the benefit of health plan efficiency; rather, Medicare beneficiaries receive supplemental benefits (prescription drugs being the most costly) while health plans attempt to maintain satisfactory profit margins.

Many of the Medicare reform proposals require a major shift in government purchasing from a system of administratively determined rates to one in which prices are determined as a result of competitive bidding by health plans. Under most of the competitive bidding proposals, health plans would have an incentive (either through expanding their membership or increased profits) to become one of the low bidders in a local area. Savings from those bids that are less than the government's current cost to provide health care would accrue in part or in total to the government. Most of the competitive bidding proposals assume that bids from interested health plans would be based on a "standard" benefit plan (i.e., a specified set of benefits) as applied to a "standard" population (i.e., a population that represents the average Medicare enrollee in the bidding area – rather than the health plan's current enrollee group).

There are many current examples of health plans that use some aspects of competitive bidding among the under-65 population, such as the Federal Employees Health Benefit Plan and the California Public Employees Retirement System. However, competitive bidding for the Medicare program would be much more complex. Because health costs are much higher for seniors and such expenses increase with age or chronic illness, bids from competing health plans become harder to compare. In addition, since Medicare is a national program, comparisons of benefits and funding must take into account the wide variations in patterns of medical practice and health care costs across the United States.

## **Medicare Reform Competitive Bid Proposals**

The analysis in this section focuses on several major Medicare reform proposals that utilize a competitive bidding mechanism. These proposals include the premium support proposal discussed by the National Commission on the Future of Medicare, the Clinton administration's proposal for defined benefit bidding and the planned Competitive Pricing Advisory Committee (CPAC) demonstration projects scheduled to begin in Kansas City and Phoenix on January 1, 2002. A further discussion of the specifics of these three proposals is contained in the appendices to this monograph.

While there are many differences between the various reform proposals, two major factors in a Medicare competitive bidding program are how the government chooses a payment level (the payment mechanism) and whether the traditional fee-for-service (FFS) Medicare program is included as one of the bidding plans.

The payment mechanism refers to how the government determines its level of contribution, based on bid prices from health plans and, possibly, a traditional Medicare program premium. Payment rates can be determined in a variety of ways, such as:

- Low price bid from one plan
- Next to lowest bid

- Weighted average bid
- Median bid

Bids considered in a competitive bidding program can include those from:

- Any health plan in a particular market
- Only qualified plans, or those with a specified minimum capacity to accept new members
- Only plans within an acceptable range of bids (both high and low bid limits)
- All plans *and* traditional FFS Medicare

Including or excluding traditional Medicare would affect beneficiaries and program costs significantly. It could also have a very important impact on the bidding process. For example, if traditional FFS Medicare is *excluded*, many observers believe there will be much less incentive for M+C health plans to submit low bids – since there may be a smaller group of potential new enrollees if most beneficiaries stay enrolled in FFS Medicare.

In determining who is the winner of a competitive bidding program, a Reference Premium is likely to be used. The reference premium serves as either the government payment or may be calculated to create some predetermined minimum level of savings from competitive bidding. Appendix I provides a brief summary of the key components of the payment-setting mechanism for each of the three Medicare reform proposals discussed above.

## Cost Savings Estimates

Because of the magnitude of the changes involved in moving the current Medicare system to competitive bidding and the absence of many important specific program details, actuaries and other analysts are not able to provide useful estimates of the potential cost impact. Rather, it is possible only to outline the general direction and “order of magnitude” of such changes (e.g., small, medium or large cost savings). A discussion of the potential cost impact of the three reform proposals is included in Appendix II.

One of the key factors in determining the potential cost savings for any Medicare reform proposal, will be the amount of selection exhibited by beneficiaries. In most insurance markets, all things being equal, people who are less healthy will choose those health plans they perceive as providing them with the most coverage. Those individuals who are in better health generally decide to enroll in health plans that are lower cost, even if they have fewer benefits. If this selection effect were to occur, it would reduce savings from competitive reforms.

## Technical and Operational Issues

There are many other aspects of the bidding process that are essential in determining the ultimate effects of competitive bidding. The following issues would need to be addressed, and how they are addressed would have a major impact on the results of a competitive bidding program. A full discussion of these issues is beyond the scope of this report.

- *The authority and capability of the bidding manager.* Would the bidding manager be a government agency (with all the required open-meeting rules), a private-public board or a subcontracted private entity. A critical issue is the need to insulate the bidding manager from any undue political pressure involved with tough decisions regarding benefits, bidding rules, contract awards, etc. One alternative might be to structure the bidding manager as a board

appointed to multiyear terms, with explicit independence in defined areas, similar in some ways to the Federal Reserve Board.

- *Risk adjustment.* What methods and standard (reference) population would be used, and what data would be required? Risk adjusting payments would have greater importance in setting premiums than in the current administrative price system, because price positioning, out-of-pocket costs and enrollment growth may be affected. Risk adjustment could help deal with selection issues. In addition, risk adjustment would become significantly more important under a competitive bidding model – since it would be a key part of determining the competitive position of a M+C contractor (or traditional Medicare). Practical concerns about data availability must be considered when implementing a risk adjustment methodology.

- *Geographic adjustment factors.* How would the bidding manager adjust payments to recognize the geographic differences in health care costs?

- *Differences in utilization of health care services.* Would the bidding manager allow or attempt to reduce current wide variations in costs due to different health care practices and utilization (separate from geographic adjustments)?

- *Bidding in noncompetitive areas.* Would special rules apply in rural areas or other markets where competition does not exist today?

- *Terms under which traditional FFS Medicare would compete.* Would the traditional Medicare program compete as is or would it have more flexibility to use utilization management or other contracting tools?

- *How bids would be evaluated.* What factors would be considered in evaluating bids? What requirements or incentives would bidders, including HCFA (assuming it is a competitive bidder offering traditional Medicare FFS), have to submit an accurate bid?

- *Coordination of state and federal regulation.* How would the bidding manager, HCFA, and state regulatory agencies work together to regulate competing health plans, without duplicating requirements or issuing contradictory regulations?

- *“Low-ball” bidders.* Should the bidding manager exclude bidders that fall below a minimum bid, and how would that minimum be set? The bidding manager may need to prevent bidders from submitting artificially low bids as part of a strategy to drive out competitors and later raise prices.

- *Standards with respect to health plan financial strength and adequacy of provider networks.* What standards would be used by the bidding manager to determine which health plans are qualified to bid? Because Medicare beneficiaries may have difficulty interpreting the qualifications of competing M+C contractors, the bidding manager may need to set minimum standards for health plan financial solvency, access to health providers or health care quality that are different from those currently used.

- *Treatment of cash rebates to Medicare beneficiaries (not currently allowed for M+C plans).* Would rebates to individual Medicare beneficiaries be allowed, which would add an entirely new dimension to marketing, contractor strategy and purchasing manager monitoring of activities? Contractors and the bidding manager would need to evaluate Medicare beneficiaries’ elasticity of demand and their ability to recognize trade-offs between benefits, premiums and rebates.

- *Standard benefits.* Would a standard set of benefits be necessary and, if so, what would those benefits include? Such determinations would be controversial. Attention would need to be paid particularly to whether a standard benefit is applied nationally or regionally, and if prescription drug benefits should be part of the coverage.

- *Optional benefits.* Would optional benefits, in addition to the standard benefits paid for by beneficiaries through additional premiums, be permitted? Benefit variation is one of the cornerstones by which health plans currently distinguish themselves, and benefit options give beneficiaries an opportunity to select the plan they think is best for them. However, having optional benefits makes it more difficult for beneficiaries to compare health plans. Policy-makers would need to evaluate the trade-off between the need for variations and difficulties in making comparisons.

- *Pre-existing conditions.* To what extent, and by which health plan, would the costs of treating a condition that manifested itself before enrollment be covered?

- *Continuity of care.* How would medical treatment be handled if a beneficiary switches health plans and his or her medical provider is not a member of the new health plan's panel of providers.

- *Catastrophic claims.* There may need to be some mechanism to help health plans and FFS Medicare deal with catastrophic claims, such as a high cost medical condition or treatment. Would these claims be pooled and the costs shared by all participating health plans and FFS Medicare? Would a risk adjustment payment mechanism be used to recognize those individuals with higher than usual health claims?

- *Communication with Medicare beneficiaries* - how would health plan options and the implication of those choices be communicated to health plan members? These communication issues are often more difficult with a senior population, than with a younger population.

- *Enrollment Requirements.* What, if any, restrictions should be placed on the ability of M+C health plans to enroll new members? For example, should the successful health plan bidder be required to have mandatory open enrollment for a period of time? Should only "young" beneficiaries (e.g., those age 80 or less) be enrolled to lessen the problems of communicating health plan options? Should beneficiaries who reside outside a health plan's service area be permitted to enroll? What restrictions, if any, should be imposed on a Medicare beneficiary's right to change health plans? For example, would they be required to stay with a plan for at least a year (as in some employer health plans)?

- *Beneficiary Mobility.* How would the needs of beneficiaries who maintain residences in different areas of the country be met?

- *Setting up the bid system.* How would practical problems, associated with the size of the Medicare program, be dealt with? Some of the issues include:

- The vast array of counties for which bids must be sought and reviewed
- The size of the competitive bid system that would have to be set up
- Geographic variations in benefits, premiums and approaches to bidding
- Hiring enough people with practical experience in administering a competitive bidding system

- Possible use of private-sector contractors for administration (similar to the use of fiscal intermediaries under the current Medicare program)

- Possibility of a phased implementation of the program, rather than universal simultaneous implementation, to reduce logistical problems

- *Program Evaluation.* How, when, by whom, and by what criteria would the competitive bidding program be evaluated? Regardless of the specifics of the evaluation process, it is likely that at least two years of program operation would be necessary before any reliable evaluation could be made.

## **Possible Effects of a Competitive Bidding System**

As noted earlier, estimating the influence of a competitive bidding system is very difficult, since no comparably sized model exists. The following is an outline of the possible impact of moving to a competitive bidding system on various segments of the health care system:

*Medicare Beneficiaries.* Individuals covered by Medicare may experience:

- Changes in benefits or out-of-pocket premiums as a result of bidding competition
- A need to choose a new health plan or to change providers periodically
- Difficulty in evaluating marketing materials from multiple competing health plans
- Possible reduction in the number of health plans serving the market as they exit from marginally profitable or small enrollment counties
- Potential increase in competition resulting in greater choice of health plan options in profitable health care markets
- Fewer providers taking new Medicare patients
- Fewer providers, due to hospitals closing or physicians leaving the practice of medicine

*General Public.* The general population may view the change as:

- Providing coverage similar to their current employer health plan
- A partial fix to concerns about intergenerational transfer concerns (i.e., younger workers paying for the health care needs of the elderly)
- Providing savings, which reduce the pressure for new payroll taxes or allow for the funding of non-senior health care needs (e.g., uninsured children)
- Taking away promised benefits for seniors

*Health Care Providers.* Hospitals, doctors and other health care providers may experience:

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- Administrative changes they perceive as either positive or negative
- Further pressure on reimbursement levels
- An inability to survive financially, or the opportunity to thrive, depending on their circumstances and skills
- Difficulty maintaining continuity of care, if seniors change plans annually
- A need to look for new sources of funds to support medical education and research programs that are currently funded through Medicare

*Health Plans.* Insurers and managed care organizations may have to:

- Learn how to bid in a new environment
- Face additional administrative costs due to more work, or find less cost because of more efficient systems
- Decide whether to exit from additional Medicare markets, or expand into new markets
- Strengthen their provider networks in order to offer benefits required by Medicare participants
- Translate their experience with large private sector plan bidding to competitive bidding for Medicare
- Have greater focus on county-by-county bids, since less margin will be left to expand membership into marginally profitable areas

*Medicare Supplement Insurers.* Insurers and health plans that market Medicare Supplement insurance products may:

- Need to exit markets where competitive bidding is implemented if the Medicare+Choice health plans are providing supplemental benefits not covered by Medicare and a majority of Medicare beneficiaries choose coverage from those plans
- Develop new markets or products to meet beneficiary needs

*Federal Government Expenditures.* The Medicare program may have higher administrative costs due to the implementation of a competitive bidding system and oversight of the health plans. To the extent that there are savings from such a system, some of the issues that policy-makers may face are:

- Should the federal government capture all savings for use in protecting the financial position of Medicare, or
- Use some of the savings for a quality incentive pool for providers, or
- Increase payments to providers, or
- Increase benefits for beneficiaries to encourage enrollment in M+C plans, or
- Return some of the savings to beneficiaries who choose lower cost plans?

## Unintended consequences

It is highly likely that a new competitive bidding system will result in a number of unintended consequences. One of the primary lessons learned from the Medicare program changes contained in the 1997 Balanced Budget Act is that Congress cannot possibly anticipate all the consequences of such legislation. Some potential consequences of a competitive bidding system may include the following:

- In some markets, the top one or two plans might provide health coverage for nearly all Medicare beneficiaries. The successful bidders would be those health plans (including FFS Medicare if permitted to bid) that can provide the most desirable package of benefits for the lowest cost.

- Easier for HCFA to manage
- Easier for seniors to understand
- Fewer choices for seniors
- Remaining plans may exit or reduce marketing
- More leverage for health plans in contracting to provide Medicare coverage, which could lead to fewer hospitals offering charity care and a reduction in teaching and research activities at medical facilities, to the extent that those costs are no longer subsidized through Medicare or another government funded program
- Increases in marketing and administrative expenses could negate some or all the savings generated through competition since health plans would need to reach large numbers of individual Medicare beneficiaries.
- Real or perceived decreases in quality of care might occur as more competitive pressures are brought to bear.

## Conclusions

Based on actuarial considerations and an overall goal of increasing Medicare's long-term financial strength, the American Academy of Actuaries Medicare Reform Task Force suggests that the following be considered if competitive bidding by health plans is incorporated into the Medicare program:

- Including traditional Medicare FFS as an option/participant in any competitive bidding program to enhance competition and to provide a level playing field for all bidders
- Using a bidding manager that has considerable experience with competitive bidding and the resources necessary to implement a national program
- Using a phased implementation, to make maximum use of available resources and to learn from the process
- "Grandfathering" all Medicare beneficiaries above a certain age (e.g., age 80, sometimes defined as the "old old") and any beneficiaries who are functionally unable to choose a competing plan by allowing them to remain in traditional Medicare and continue to pay traditional Part B premiums. If these beneficiaries still wish to participate in the new options, they would have a one-time choice to leave traditional fee-for-service Medicare.

- Minimizing legislative and regulatory restrictions, allowing the bidding manager flexibility to make use of private sector bidding techniques
- Insulating the bidding manager from undue political pressure, for example, through the use of an independent governing board appointed for multiyear terms
- Allowing sufficient time to create the necessary infrastructure before implementing the new program
- Allowing the competitive bidding program to operate for a sufficient length of time to generate both primary and subsequent effects before it is evaluated
- Defining carefully, before implementation, how, when, and by what criteria the competitive program will be evaluated

## II. Medicare Vouchers

**M**edicare vouchers could replace or supplement the current Medicare program with a system that provides Medicare eligible beneficiaries with an amount of money or a voucher to purchase health coverage from private competing health plans. This change would move the Medicare program from the current environment to a system that relies on competition and choice. While this approach could provide greater control over the cost of Medicare, there is no guarantee that the amount of the voucher would be sufficient to purchase the level of health care deemed appropriate for those covered by Medicare.

### Design Issues

The voucher concept is based upon competing health plans providing coverage to the Medicare population. Therefore, all the design issues discussed in Section I would need to be addressed in a voucher system. A related issue is whether traditional FFS Medicare coverage would continue to be available. Traditional Medicare could be one of several options that could be purchased, but it might cost more than the amount of the voucher.

Determining how traditional FFS Medicare would fit into a voucher system raises a number of important issues. Many beneficiaries currently receiving coverage through the FFS program depend on those benefits and may be resistant to shifting to a M+C health plan. However, care must also be taken to guard against adverse selection resulting when those beneficiaries in poor health stay with FFS Medicare and the relatively healthy participants move to M+C health plans. This change would dramatically increase the per patient cost to the FFS Medicare program.

Another important issue is whether benefits currently provided through Medicare Supplement insurance coverage would be covered by the competing health plans and made available to beneficiaries who are willing to pay for more coverage than provided by the amount of the voucher. It may be necessary to standardize the additional types of health care coverage that are available, as is currently the case in the Medicare Supplement insurance market. Such combined benefit plans could result in the elimination of significant administrative costs involved in the current Medicare FFS program plus Medicare Supplement insurance arrangements. This issue is complicated by the fact that existing Medicare Supplement insurance contracts are non-cancelable, so any roll-ups into voucher programs could abrogate existing contractual guarantees. In addition, many Medicare Supplement policies are medically underwritten if an individual applies for coverage after the initial six-month enrollment period (individuals can first be covered when they are eligible for Medicare). It would need to be determined if Medicare Supplement contracts will be guarantee issue and under what circumstances, if any, underwriting will be permitted.

Another issue is whether beneficiaries will be allowed to use any unspent voucher amounts to purchase other types of insurance coverage.

### Voucher Amounts

The voucher amount may be set at the cost of providing a prescribed set of benefits. This, of course, may be dependent on the bids submitted by the competing health plans that participate in the voucher program. The amount of the voucher could be set equal to the average bid price in each market area. The voucher amounts might be designed to achieve some overall budgetary target for the Medicare program.

The calculation of the voucher amount may have to include rating variables such as age, sex, geography and health status. The variables could be similar to those included in the current Medicare+Choice program. Because the health care expenses for various rating groups vary greatly, voucher amounts would need to be designated for each group of Medicare participants by using risk adjustment methods.

### Other Issues

Other issues that would need to be addressed in a voucher system include the following:

- The voucher system is dependent on competitive health plans being available. The current fee-for-service Medicare program would need to remain an option in areas where no alternative health plan coverage is available and as a backup in the case of a health plan insolvency or removal from the program because of poor quality of care.

- As noted in Section I, presenting seniors with choices and communicating potential health plan changes would be challenging.

- Subsidies may be necessary for some beneficiaries to ensure a basic level of health care coverage. These subsidies could possibly be provided through state Medicaid programs, to those at a certain percentage of the federal poverty level. The subsidies would need to be accounted for when determining the voucher amounts, so that the overall cost of the Medicare program meets its budgetary target.

## **Unintended Consequences**

Many of the unintended consequences of a competitive bidding system, discussed in Section I could also apply to a voucher system. In addition, some seniors could be left without adequate health insurance, since the amounts available to them through the vouchers and their own funds might be insufficient to purchase sufficient coverage. This would require careful attention to the provision of safety-net protection for those individuals.

## **Conclusions**

Based on actuarial considerations and an overall goal of increasing Medicare's long-term financial strength, the American Academy of Actuaries Medicare Reform Task Force recommends that the following be considered if a voucher system is incorporated into the Medicare program:

- Including traditional Medicare FFS as an option so that Medicare beneficiaries could use their vouchers to select traditional Medicare coverage, possibly at an additional cost to the beneficiary

- Structuring voucher amounts to recognize the differences in risk characteristics among Medicare beneficiaries

- Using a phased implementation, to make maximum use of available resources and to learn from the process

- Building into the voucher system a process for keeping voucher amounts consistent with health care cost trends

- Providing safety net protection for those Medicare beneficiaries whose voucher amounts plus their own funds are insufficient to purchase adequate insurance coverage

- Allowing sufficient lead time to create the necessary infrastructure before implementing a voucher system

- Allowing the voucher system to operate for a sufficient length of time to generate both primary and subsequent effects before it is evaluated

- Defining carefully, before implementation, how, when and by what criteria the voucher system will be evaluated

# III. Competitive Bidding for Providers

One approach with the potential to achieve cost savings and increase the quality of medical care would call for competitive bidding between the providers of health care services in a defined geographic region. The bidding could take the form of simple price competition on a fee-for-service basis or might define a set of services to be bid on an at-risk or capitated basis. For purposes of this discussion, we assume that provider entities would bid for the beneficiaries enrolled in the current FFS Medicare program and that Medicare beneficiaries would continue to have the option to enroll in any available M+C health plan. Inherent in this approach is the potential for significant increases in market share for the successful provider in the bid process and limitation in the choice of providers. From a beneficiary perspective, limitation of choice of providers would be a significant change and may, in fact, be politically unfeasible.

## Fee-for-Service Option

HCFA currently pays providers for medically necessary health care, using a variety of fee-for-service reimbursement structures. As examples, hospital inpatient services are paid using diagnostic related groups (DRGs), hospital outpatient surgery services are reimbursed using case rates, and physicians are paid using fee schedules based on a resource-based relative value scale (RBRVS) and HCFA common procedure coding system (HCPCS). Under a competitive bidding approach, it might be advisable to define uniform types of reimbursement structures to be used to pay for different types of health care services, in order to keep administrative costs down.

## Capitated At-Risk Option

One payment option is to have the provider networks submit bids to provide the full range of services to a defined group of Medicare beneficiaries for a set amount per beneficiary per month (capitation). This essentially becomes a provider services organization (PSO), which is similar to a provider-owned health maintenance organization (HMO).

An option that is not as comprehensive would be to capitate multispecialty physician networks for professional and diagnostic services, and structure incentives for the efficient management of utilization of institutional and other services. The least comprehensive option would be to capitate for single specialty physician services or targeted health care services such as diagnostic testing, durable medical equipment or home health care.

## Estimated Savings

Savings from this program could be derived from several sources. First are lower unit costs; providers may agree to accept lower reimbursement per unit of service if they know that more patients will be channeled into using their services. A second source is lower utilization; selecting providers who have more favorable utilization patterns may provide the program with additional savings. In addition, there may be providers who are able to provide treatment or who institute successful disease management programs that result in a lower level of overall cost.

The savings derived from competitive bidding by providers depend on HCFA achieving some level of control over which providers deliver care to Medicare beneficiaries in a given market. For example, in a relatively small market with only one hospital, it would probably be necessary to include that hospital and the majority of the physicians in any Medicare network, resulting in minimal additional savings. However, for complicated procedures that have to go out of the market, there would be a potential for savings gained from tertiary care centers.

There is little or no data available that can be used to estimate savings from a Medicare provider competitive bidding program. However, depending on the number of competing providers and the amount of excess capacity in a market, based on our professional judgment and private sector experience, we believe that substantial savings could be achieved through such a program.

## Technical and Operational Issues

There are formidable issues to be addressed in establishing a Medicare competitive bidding program for providers. Among them are the following issues, many of which are identical to a competitive bidding program for health plans. How these issues are addressed would have a major impact on the results of a competitive bidding program. A full discussion of these issues is beyond the scope of this report:

- *The authority and capability of the bidding manager.* Would it be a government agency, a private-public board or a subcontracted private entity? A critical issue would be the need to insulate the bidding manager from undue political pressure. One alternative might be to structure the bidding manager as a board appointed to multiyear terms, with explicit independence in defined areas, similar in some ways to the Federal Reserve Board.

- *Population-based risk adjustment or patient-based severity adjustment.* What methods would be used, what standard (reference) population would be used, and what data would be required? Risk adjusting would have a significant impact in a competitive bidding program, because the risk adjustment process would be essential to protect providers from the adverse financial effects of serving a disproportionately high-cost population.

- *Geographic adjustment factors.* How would the bidding manager adjust payments to recognize differences in health care costs?

- *Differences in utilization of health care services.* Would the bidding manager allow or attempt to reduce the current wide variations in costs due to different health care practices and utilization (separate from geographic adjustments)?

- *“Low-ball” bidders.* How would the minimum bid be set, and should the bidding manager exclude bidders that fall below that minimum bid? The bidding manager may need to prevent bidders from submitting artificially low bids as part of a strategy to drive out competitors and later raise prices.

- *Standards with respect to provider network adequacy and financial strength.* What standards would be used by the bidding manager to determine who qualifies as a bidding provider?

- *Communication with Medicare beneficiaries.* How would this kind of fundamental change in the Medicare program be communicated to beneficiaries?

- *Continuity of care.* How would discontinuities of care be dealt with? Discontinuity in care would likely result in a competitive program, involving the inclusion of some providers and the exclusion of others.

- *Coordination of Care.* How would the program coordinate care for beneficiaries who have multiple medical providers? Would the lack of effective coordination of care result in higher overall cost?

- *Beneficiary mobility.* How would the needs of Medicare beneficiaries who maintain residences in different areas of the country be met?

- *Setting up the bid system.* How would the Medicare system deal with the practical problems of its size, including:

- The vast array of counties from which bids must be sought and reviewed

- The size of the competitive bid system that will have to be set up
  - Geographic variations in health care networks and consequent differences in approaches to the bidding system
  - Possible use of private-sector contractors for administration (similar to the current Medicare program's system of fiscal intermediaries)
  - Hiring enough people with practical experience in competitive provider contracting
  - A phased implementation of the program, rather than universal simultaneous implementation, to reduce logistical problems
- *Program Evaluation.* How, when, by whom, and by what criteria would the competitive bidding system be evaluated? Regardless of the specifics of the evaluation process, it is likely that at least two years of program operation would be necessary before any reliable evaluation could be made.
- *Payment Methods (fee-for-service only).* What methods would be used so that providers are rewarded for managing utilization of services, rather than for increasing the volume of services?

## Potential Effect of Changes to a Competitive Bidding System

- *Federal government/HCFR.* Competitive bidding by Medicare providers could have a positive fiscal effect if the potential savings are realized. Nevertheless, such a program would likely be highly controversial. A successful system would require a politically insulated bidding manager.
- *Medicare beneficiaries.* Beneficiaries would benefit from the strengthened financial status of the Medicare program, but would lose some freedom of choice of health care provider. Some beneficiaries could also experience discontinuity of care.
- *Providers.* Such a program would likely place additional strain on many providers' income levels. It would also put a premium on expertise regarding competitive bidding in a risk environment. For the winning bidders, income may be increased, but capacity may be stretched to accommodate the volume of Medicare recipients. Losing providers who are not successful in the bidding process may find it difficult to retain sufficient volume of patients to continue to operate.
- *Health plans.* To the extent that networks of physicians and hospitals are limited in standard fee-for-service Medicare, managed care options might begin to look increasingly attractive. If a portion of the savings realized from competitive bidding is used to add benefits, especially coverage for prescription drugs, then the revised Medicare program may appear to be similar to a health plan's benefits.

## Unintended Consequences

As with other possible Medicare reforms, it is highly likely that a new competitive bidding system for providers

would result in a number of unintended consequences. Potential consequences of a competitive bidding system may include the following:

- Medicare is such a large payer for health care that awarding contracts to selected providers may cause those selected to focus exclusively on Medicare. Other providers who were not selected would be forced to focus on commercial business. This could deteriorate into a two-tier health delivery structure similar to the so-called “Medicaid mills” found in California in the 1970s.

- The process could force some providers to close their doors. This could take needed competitors out of the market, thereby increasing costs for all. Or it may reduce redundant capacity, thus increasing the efficiency of the overall health care system.

- There may be a real or perceived deterioration in the quality of care.

- There would be additional pressure on those providers whose income is affected by their participation in medical education and/or research activities. Unless these expenses were funded separately, such activities could be curtailed.

- The federal government may be subjected to medical malpractice claims if a Medicare beneficiary believes he or she were harmed by a health care provider selected by the bidding manager.

- The federal government could incur higher costs due to administration of the bidding process and oversight of the providers who participate in the program.

## **Conclusions**

Based on actuarial considerations and an overall goal of increasing Medicare's long-term financial strength, the American Academy of Actuaries Medicare Reform Task Force suggests the following for consideration:

- A system of competitive bidding by providers may offer the possibility of substantial reductions in the cost of health care financed by the Medicare program.

- Although the savings potential of such a program is substantial, any comprehensive competitive bidding program would face considerable obstacles - especially problems of limited public acceptability and implementation.

- It may be more appropriate to experiment with pilot projects limited to a few selected markets and to specific health care services, rather than attempting a more comprehensive program at this time.

- If the pilots are considered to be successful, more comprehensive bidding programs could be implemented, broadening either the health care services included or the market areas included.

- Before any pilot programs are launched, evaluation criteria and processes should be carefully defined.

- Sufficient lead time should be allowed to create the necessary infrastructure before any pilot is launched.

- Any pilot program should be operated for a sufficient length of time to generate primary and subsequent effects before it is evaluated.

## IV. Medicare PPOs

**P**referred provider organizations (PPOs) are a mid-range alternative to full managed care products in the employer health insurance market. They have frequently served as an introductory or transitional product for employers moving from traditional indemnity insurance to HMO coverage. In addition, they have become a choice for employers who have moved away from both traditional indemnity health insurance and managed care gatekeeper plans. They are often one of several options for employers offering multiple health insurance plans to employees and their family members. The existing Medicare+Choice program has recently been expanded to allow for Medicare PPOs.

PPOs have been successful in the employer market because they appeal to employees and employers. The less restrictive managed care features (perhaps just hospital admission certification and catastrophic claim management) appeal to insured employees. The cost savings from discounted fee schedules or negotiated case rates (DRGs) obtained from the preferred providers appeal to employers.

The 1997 Balanced Budget Act permitted the operation of PPOs as part of the Medicare program. So far, there has been little interest on the part of preferred provider organizations in participating in Medicare. The low participation rate may be due, in part, on the regulatory restrictions on Medicare PPOs and their unfamiliarity with the Medicare market.

### Commercial PPOs

There is not a unique definition of a PPO, only defining characteristics. A PPO is fundamentally a network or networks of providers who agree to offer health services at preset prices or fee schedules and, in some cases, abide by certain utilization and quality assurance programs. Typically, these networks include physicians (primary care and at least the more common types of medical specialists) and hospitals. The panels may be narrow, with just physicians and hospitals, or they may be broad, including pharmacies, medical laboratories and other ancillary service providers. An insurer or an independent third party administrator may organize the PPO. The members of the networks are selected based on the willingness to accept the fees being offered and other requirements imposed by the organizer. PPO products are frequently, although not universally, regulated under insurance statutes.

Although there have been some recent changes, benefits offered under PPO products usually follow the indemnity health insurance pattern with deductibles and percentage coinsurance, rather than, flat dollar copay amounts for specific services. Full benefits (with larger insurer coinsurance payments and/or lower deductibles) are payable when medical services are furnished by providers within the network. Reduced benefits are payable for services furnished by non-network providers. As is generally required for network products, emergency or urgent care services, or services not available within the PPO network, are reimbursed at the higher benefit amounts. PPO benefit packages typically include physician, hospital and ancillary services. Prescription drug benefits may or may not be included.

Initially, the primary utilization control feature was reduced benefits for out-of-network services. (Presumably, network providers are selected, in part, for efficiency as well as lower cost.) Several basic utilization management programs, such as hospital admission certification, mandatory outpatient procedures, and catastrophic claim case management are now often included. Recent variations have included gatekeepers as part of the utilization controls. Gatekeepers are primary care physicians who direct the patient's care by authorizing services from network providers. Unlike closed panel HMOs, in PPO products the patient may receive care outside the network and receive some, albeit reduced, reimbursement for the medical care.

The normal price spectrum for commercial products has health indemnity insurance at the high end and HMOs generally at the low end. Typically, prices for PPO products have been somewhere in the middle—typically 5 percent to 15 percent below those for fee-for-service indemnity health insurance. Exactly where PPOs fall within the price spectrum depends on several factors, in addition to the level of provider discounts—the richness of the benefit packages, the out-of-network limitations or reductions, and the effectiveness of the PPO utilization management programs.

## Adjustments Necessary for PPOs to Serve Medicare Beneficiaries

Medicare PPO provider panels must be structured to recognize the medical needs of Medicare beneficiaries, as contrasted with a commercial population. There may be differences in terms of specialty types, (fewer pediatricians and pediatric subspecialists will be necessary), as well as in the depth of the panels in certain specialties (more cardiac specialists and oncologists). Such provider panels will be necessary to provide the required services and to be appealing to senior Medicare beneficiaries.

Coverage of health care services obtained from the PPO network would likely have to be richer than those offered under traditional fee-for-service Medicare, either through lower coinsurance amounts or additional benefits such as outpatient prescription drugs in order to attract members. In addition, an effective Medicare PPO may also need to have out-of-network benefit differentials that are greater than those currently allowed under Medicare. For example, cost sharing may need to be increased to 30 percent or 40 percent to effectively channel enrollees into the PPO network.

Gatekeepers may be necessary in order to manage utilization for the financial viability of Medicare PPOs, with penalties (higher out-of-pocket payments or lower reimbursement) applicable when the gatekeeper is not used. Other utilization management programs, as well as increased medical oversight compared with the commercial products, are likely to be required. These utilization management programs may tend to be closer to those in a commercial HMO environment than those in a commercial PPO.

One part of an effective PPO is the use of financial incentives to control utilization of health care services. Therefore, physician incentive payments that are prohibited or curtailed under the current Medicare PPO program may need to be reconsidered.

Developing procedures to comply with HCFA's restrictions on the enrollment and disenrollment of members in a Medicare PPO could be expensive for a PPO just entering this market. These restrictions and other requirements, such as those relating to reconciliation and attestations of member enrollment, are examples of the significant adaptations of a successful commercial PPO to the Medicare+Choice environment.

The degree of enforcement of existing Medicare PPO regulations could be a major consideration in the success or failure of Medicare PPOs. PPOs are new to the Medicare+Choice environment and how strictly regulations will be enforced is yet to be determined.

## Revenue Sources

Under the 1997 Balanced Budget Act, the main source of revenue for Medicare PPOs is government funding. The revenue will be member based, and it is calculated by HCFA in the same (or a similar) manner as for Medicare+Choice HMOs (see Section I, "Administrative Pricing vs. Competitive Bidding"). The basis of calculation is geographic, incorporating the move toward nationwide blending. The per-member revenue reflects member demographics, and will be further modified using the risk adjusters being adopted by HCFA.

The payment restrictions contained in the Balanced Budget Act caused many Medicare+Choice HMOs to reduce benefits or begin charging premiums to their members. Assuming that the commercial price relativity holds, PPOs are likely to be more costly than HMOs, requiring either greater member premiums and/or smaller additional benefit offerings. This will require very careful analysis by the PPO organizers to assure financial and marketplace viability. The analysis should focus on both the demographics and, where possible, the health status of the expected members. This analysis is especially important if the PPO will be the only Medicare+Choice product available in a county.

## Geographic and Market Considerations

Preferred provider organizations, much like commercial HMOs, are located primarily in urban areas. However,

PPOs are in some cases more prevalent in rural areas than their HMO counterparts. It is likely that Medicare PPOs will be initially located in urban areas. The reimbursement scheme in the Balanced Budget Act encouraged the development of HMOs in rural counties in order to provide more choices to rural beneficiaries. Thus far, the increased Medicare reimbursement has not been a sufficient inducement for health maintenance organizations to become established in most rural areas. There is a possibility that PPOs may be more viable than HMOs in rural counties. Many carriers have existing commercial PPO networks in rural counties, which could serve as the base for a Medicare PPO. Such PPOs have already made arrangements for services not available within the county. These could be used as starting points for developing the services necessary for a Medicare PPO.

## Implementation and Operational Issues

Although preferred provider organizations have been successful in the commercial market, their novelty in the Medicare market suggests that a phased-in introduction may be advisable. This could be done through a series of pilot projects. PPOs could be approved for introduction only in designated test sites, with program features designed to measure the effects of certain variables in each site. Another approach would be to approve initially only a particular limited number of PPOs, but allow the market to determine the location and program features in each one.

Whichever approach is used, the initial preferred provider organizations must be allowed to be attractive to providers, organizers, insurance carriers and beneficiaries. This may suggest, within constraints necessary to protect the beneficiaries, that regulations initially should be relaxed or loosely enforced. Those features that have led to that commercial success should be allowed to operate in the Medicare market.

Under either scenario, there must be a sufficient number of PPOs established in order to provide adequate measurement of financial viability (especially over a multiple-year period), beneficiary acceptance and satisfaction, and quality of care. They should operate for a long enough time frame for any unintended consequences to emerge and be remedied. If possible, they should be operated within urban, rural and suburban sites. Finally, since there are likely to be many lessons learned from the initial offerings, provision should be made for changes and for the effects of those changes to be observed.

## Conclusions

Preferred provider organizations are becoming more prominent in the commercial sector. To allow similar movement in the Medicare area will require allowing insurers and health plans to have more input into policy-making and flexibility in design.

Based on actuarial considerations and the overall goal of increasing Medicare's long-term solvency, the American Academy of Actuaries Medicare Reform Task Force recommends encouraging the development of viable Medicare PPOs as an alternative to traditional fee-for-service Medicare or M+C health plans, by considering the following:

- Relaxation or more flexible enforcement of regulatory restrictions during initial pilot tests
- Permission for the development of both PPOs (all provider types) and limited PPOs (restricted provider types), as appropriate for the geographic area
- Provision of sufficient time (perhaps multiple year contracts) for Medicare PPOs to operate and fine tune benefits, reimbursement rates, member premiums and utilization controls
- Allowance for market forces to determine the most appropriate combination of incentives and penalties in order to encourage use of the most cost-effective providers

# Appendix I – Key Elements of Competitive Bidding Proposals

**T**his monograph includes a discussion of key elements of three recent proposals to utilize competitive bidding among health plans (and in some cases including the traditional Medicare fee-for-service plan) to provide health care services to beneficiaries.

## **Bipartisan Commission (Premium Support)**

The Balanced Budget Act of 1997 established the National Bipartisan Commission on the Future of Medicare (sometimes referred to as the Medicare Commission). Senator John Breaux (D-Louisiana) and Representative Bill Thomas (R-California) jointly chaired the Commission which had 17 members drawn from the U.S. Congress, private industry and public policy organizations. Sen. Breaux and Rep. Thomas proposed a premium support plan under which private health plans would bid along with Medicare fee-for-service to provide Medicare benefits.

Although the Commission considered the Breaux-Thomas plan, it was never formally approved, and the Commission ended its work in March 1999 without any final decision on a Medicare reform plan. The two Congressmen subsequently introduced their proposal as the “Medicare Preservation and Improvement Act of 1999” (S.1895) in the Senate and the “Medicare, Medicaid and State Children’s Health Insurance Program Balanced Budget Refinement Act of 1999” (H.R. 3426) in the House of Representatives. Copies of the two bills can be obtained through the Library of Congress Web site (<http://thomas.loc.gov>).

## **President Clinton’s Proposal**

On June 29, 1999 the Clinton administration announced its “Plan to Strengthen and Modernize Medicare for the 21<sup>st</sup> Century.” This proposal also uses competitive bidding between health plans and would add a new voluntary prescription drug benefit for Medicare beneficiaries. An outline of the proposal is available from the White House web site ([www.whitehouse.gov](http://www.whitehouse.gov)).

## **Competitive Pricing Advisory Committee Demonstration Projects**

The Balanced Budget Act of 1997 required the Health Care Financing Administration (HCFA) to implement at least four competitive pricing demonstrations, starting on January 1, 2000. Due to the need to develop and obtain comments on the demonstration model, that starting date was first deferred until January 1, 2001. Subsequently, as a result of political opposition to the demonstration projects, the Balanced Budget Reconciliation Act of 1999 further delayed implementation of the first two demonstration sites until the later of January 1, 2002 or receipt of a report on the projects from HCFA.

Earlier proposed demonstration projects in Baltimore and Denver were abandoned after considerable effort. While the Baltimore demonstration was quickly stopped by political action, the Denver demonstration went as far as receiving bids from health plans, before judicial action stopped further implementation. In all cases, stakeholders in the areas under consideration objected to being targeted for the projects and took sufficient action to eliminate or defer the demonstration projects.

The following table compares how the three Medicare reform proposals utilize competitive bidding by health plans and the traditional Medicare FFS program to provide health care services.

**Table 1: Comparison of Bid Payment – Medicare Reform Proposals**

<b>Medicare Reform Proposal</b>	<b>Traditional Medicare Included</b>	<b>Reference Price (RP)</b>	<b>Beneficiary Payment/Savings</b>	<b>Status of Traditional Medicare FFS</b>
Bipartisan Commission (“Premium Support”)	Yes	88% of weighted average premium (which includes the FFS plan)	If chosen plan is below the RP, beneficiary keeps all savings.  If chosen plan is above the RP, beneficiary pays the excess.	Competes like any other plan, possibly requiring senior to pay more than Part B premium to maintain enrollment.
Clinton Proposal	No	96% “FFS cost” (however defined)	If chosen plan is below the RP, beneficiary keeps 75% of savings (maximum of Part B premium).  If chosen plan is above the RP, beneficiary pays the excess.	Senior never pays more than Part B premium.
Modified CPAC Demo	No	Higher of weighted average or median bid of M+C plans (excluding FFS)	If chosen plan is below the RP, beneficiary keeps savings, up to Part B premium.  If chosen plan is above the RP, beneficiary pays the excess.	Senior never pays more than Part B premium.

# Appendix II – Cost Impact of Competitive Bidding Proposals

## **Congressional Budget Office Comments on Competitive Bidding Models**

The Congressional Budget Office (CBO) responded to requests to review both the premium support plan suggested by Sen. Breaux and Rep. Thomas and the Clinton administration proposal. This discussion summarizes the CBO analysis of those two proposals and adds additional comments from the Academy's Medicare Reform Task Force. The comments from CBO on the Medicare Commission premium support model proposed by Sen. Breaux and Rep. Thomas are contained in a letter to Sen. Breaux from Dan L. Crippen, Director of the Congressional Budget Office dated February 18, 1999.

The analysis of the Clinton proposal is contained in the statement of Dan L. Crippen before the Senate Finance Committee on July 22, 1999. Both documents are available from the Congressional Budget Office or through its Web site ([www.cbo.gov](http://www.cbo.gov)).

## **A. Analysis of Breaux-Thomas “Premium Support” Proposal**

- CBO comment: Medicare savings would emerge if a competitive model is tied closely to private sector plans, which then reflect today's competitive forces. In part, the private sector gained from a one-time reduction in costs as most employers rapidly shifted employees and dependents to tightly managed-care plans during the 1990s.

*Medicare Reform Task Force Analysis:* If Medicare beneficiaries shifted to managed care plans in comparable numbers, it would seem likely that a similar one-time gain might be realized. If the shift were accomplished over a period of three to five years, then it might be similar to a shift of similar magnitude of *people* that occurred in the private sector during the 1990s. However, the *dollar amount* of the shift would be at least three times as large due to the higher per capita costs of seniors and may cause massive secondary changes to providers and suppliers.

- CBO comment: It is uncertain whether long-term spending will be held down by managed care, due to the recent rapid increase in premiums in the private sector.

*Medicare Reform Task Force Analysis:* There is little basis to think that a Medicare competitive bidding system would be any different. However, there is reason to speculate that a more massive spending change could cause bigger structural changes in the health care system, which might greatly reduce capacity (resulting in closure of hospitals and incentives for physicians to retire or leave practice) with a resulting one-time reduction in spending.

- CBO comment: A current trend to consolidation among health care plans may reduce the incentive to compete.

*Medicare Reform Task Force Analysis:* Consolidation would appear to be increasingly likely, driven both by market forces (to have health plans better leverage deals with providers) and the enormous investments in information technology needed to bring the health care industry up to standards in other parts of American industry. However, there may be continuing opportunities for new players, such as units of large provider systems, or incursions from other powerful players, such as very large financial institutions, that would bring established management and information systems to bear on the problem.

- CBO comment: The ultimate success in reducing cost trends may result from how aggressive a Medicare competitive bidding manager is and whether it is allowed to negotiate with the traditional Medicare program.

*Medicare Reform Task Force Analysis:* We fully agree that the most successful private sector models generally have managers (private or public sector) that have free rein to be tough negotiators. If Congress does not allow this freedom to a competitive bidding manager, then the system will be unlikely to achieve its goals.

## **B. Estimates of Savings from the Clinton Proposal**

Since no dollar estimates are provided above, it may be useful to discuss briefly the estimates of Medicare cost savings that might be realized under the Clinton proposal. The CBO commented about the absence of specific details needed to provide a robust estimate. Instead, the CBO stated that the Administration's estimate of \$8.9 billion in savings over the period from 2004 through 2009 was not unreasonable. To put this estimate into context, yearly savings of approximately \$2 billion per year should be compared with overall Medicare expenses of approximately \$200 billion per year.

*Medicare Reform Task Force Analysis:* Savings appear to be relatively small, in light of the magnitude of such a change, which would affect at least the current 6.5 million beneficiaries. In particular, the Clinton proposal does not greatly affect traditional Medicare, since all seniors continue to be eligible to receive traditional Medicare benefits for the price of the current legislation's Part B premium (approximately \$50 per person per year).

## **C. Estimates of the CPAC Demonstration's Impact**

No direct estimates of the cost savings resulting from the CPAC demonstration in either Phoenix or Kansas City have been made. In fact, one of the goals of the demonstration is to determine the impact of competitive bidding. Several observations may be of interest:

- There was a great outcry from both health plan seniors and providers that any competitive bidding demonstration would reduce their benefits. Many seniors in these relatively high payment areas appeared to believe that they were entitled to these higher benefits, especially a prescription drug benefit.
- The aborted earlier demonstration in Denver reportedly would have achieved small reductions through its bids. Informal conversations with several health plan representatives indicated that plans might have reduced bids in a range from 1 percent to 5 percent of the payment rate. If a 3 percent reduction were possible in all currently competitive areas (reflecting over 80 percent of Medicare's beneficiaries), a rough estimate of annual savings would be about \$5 billion per year—much larger than the administration's estimate of savings in its proposal.
- Imperfect incentives to bid low and the absence of traditional Medicare as a bidder probably reduce the likely savings effect under the CPAC demonstration.

Since current proposed legislation appears to defer this demonstration until January 1, 2002, it is unlikely that the CPAC demonstration will be available to provide better estimates. It may, however, provide practical lessons about how to implement such a radical change.

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