



STRENGTHENING MEDICARE FOR

2030



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**Could Improving Choice and
Competition in Medicare Advantage
be the Future of Medicare?**

Alice Rivlin and Willem Daniel

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Alice Rivlin, Leonard Schaeffer Chair in Health Policy and Economics, Director, Center for Health Policy and Senior Fellow, Economic Studies, Brookings Institution
Willem Daniel, Former Senior Research Assistant, Economic Studies, Brookings Institution

I. Introduction

The last several years of ferment over health care reform have witnessed a curious political anomaly. Democrats enacted the Affordable Care Act (ACA), which features consumer choice among competing private health plans combined with government subsidies to make the insurance affordable. Republicans vociferously attack the ACA and vote repeatedly to repeal it. At the same time, they proposed converting Medicare to a premium support model, which would combine consumer choice among competing private health plans with government subsidies to defray the cost of Medicare coverage. Republicans, while rejecting the ACA, believe that giving Medicare beneficiaries a subsidized choice among competing health plans could result in higher quality care, more efficient delivery, and lower costs. Democrats, while supporting the ACA, believe just as strongly that converting Medicare to a premium support model, which they call a voucher program, would lead to deteriorating care, hardship for low-income beneficiaries, and the eventual destruction of “Medicare as we know it.”

In fact, however, as the background papers for this conference make clear, changes to “Medicare as we know it” are necessary to ensure that this popular, successful program is able to deliver higher quality care at sustainable cost to the much larger

population of older beneficiaries who will be eligible by 2030. Moreover, these changes will not involve a stark choice between a choice/ competition model and improving traditional Medicare, but will combine elements of both. Many changes in Medicare are already underway and papers written for this conference explore possible next steps in several dimensions of Medicare reform. Proposals for modernizing the benefit and payment structure of Medicare are explored by Aaron and Reischauer. Ginsburg and Willensky discuss the potential for payment reforms, such as Accountable Care Organizations (ACOs), and bundled payments, designed to move traditional Medicare away from paying for volume of services toward paying for higher quality, more effective care.

This paper will attempt to cut through the partisan ideological rhetoric surrounding premium support proposals and explore the advantages and disadvantages of strengthening competition in Medicare Advantage (MA). MA already offers beneficiaries a choice among private plans and currently enrolls about 30 percent of the Medicare population, so it is a natural starting point for introducing more competition into Medicare.

First, we examine the feasibility and consequences of changing the bidding process in Medicare Advantage so that the

government payment to the health plans is the result of a competitive bidding process among qualified plans in local areas, rather than the current benchmark system. We conclude that such a system could reduce the costs of MA plans, especially in high cost urban areas. At the same time it could cause a drop in private offerings and MA enrollment in low-cost areas, especially in sparsely populated rural areas where there are few providers and health plans generally will not enter the market without subsidies.

Second, we explore the pros and cons of the more drastic step of having traditional fee-for-service (FFS) Medicare compete with MA plans. This step would put all Medicare beneficiaries in a position to choose a plan (including an FFS plan) on an exchange. The government contribution (which would be risk-adjusted to allow for the beneficiary's age and health status) would be determined by a weighted average of the bids in the area, or alternatively by the second lowest bid, as in the ACA. This proposal would preserve the Medicare entitlement to a defined package of benefits, and the government contribution would be determined by the cost of delivering that package in the area.

Beneficiaries would be able to obtain the Medicare benefit package without paying a premium on top of the normal Part B premium. This proposal is a type of premium support, but it would not include a provision common to recent premium support proposals that would put an arbitrary cap on the rate of growth of the government contribution at, say, the growth of per capita GDP. If competition among plans and other reforms are successful in keeping the growth of health spending moderate, such an added control would be unnecessary and if health costs accelerate

rapidly, the arbitrary cap would be unsustainable.

II. Summary

Evidence shows that MA plans, especially if they are Health Maintenance Organizations (HMOs) can deliver Medicare benefits more cost effectively than traditional FFS Medicare, especially in higher cost urban areas where a large fraction of Medicare beneficiaries live. Hence, we believe that the competitive model could have substantial benefits in eventually reducing costs and sustaining quality. Four substantial implementation challenges, however, would have to be overcome.

First, there is the problem of sparsely populated rural areas, which is also proving a problem for the ACA.

Second, there is the problem of improving risk adjustment. Very substantial improvements in the current risk adjustment process would be necessary to overcome the tendency of sicker people to migrate to traditional Medicare, balloon its costs, and make it unaffordable for low-income people.

Third, there is the problem of concentration and insufficient competition in insurance markets, which could derail the expected benefits of the competitive model.

Lastly, insurance firms typically respond to cost pressures by increasing the out-of-pocket costs charged to their beneficiaries or by reducing the breadth of their provider markets; this might reduce the value of Medicare to beneficiaries.

If these hurdles can be overcome, competition among private insurance plans—especially HMOs—has the potential to make Medicare Advantage more cost

effective. In some areas of the country, especially those with largely urban populations, MA could soon become the dominant Medicare model. Meanwhile, moreover, if payment reforms are successful, traditional Medicare could be moving toward provider led integrated systems paid on a capitated basis. These integrated systems might accept many of the risks now borne by insurance companies. The distinction between health insurance plans and fully integrated delivery system might begin to fade.

In addition, over time, if the ACA exchanges work effectively and private exchanges spring up as well, choosing a health plan on an exchange may become the normal way to acquire health insurance. At the same time, risk adjustment may become more accurate as techniques for analyzing patient-level cost data improve. In this scenario, a blend of payments to incent value and competition among integrated plans could become normal for all age-groups in both public and private sectors.

III. A Brief History of Medicare Advantage

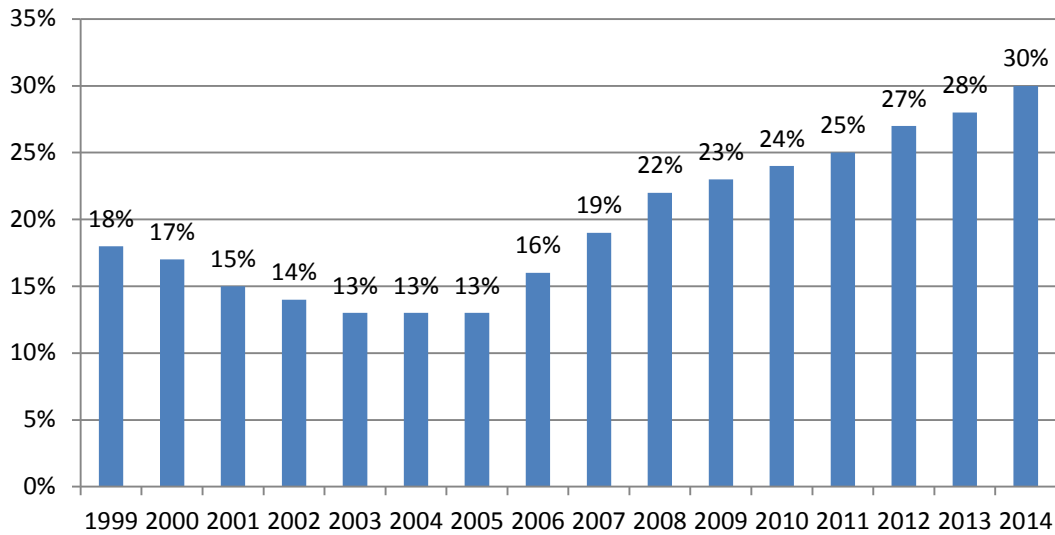
When Medicare was established in 1965, capitated health plans, such as HMOs, already existed and there was some evidence that they delivered more effective, better coordinated care at lower cost. Capitated plans participated in Medicare from the beginning, but it was not easy to fit them in to the evolving Medicare payment system, which was primarily geared to FFS payments. Starting in 1982, capitated plans were paid 95 percent of risk adjusted FFS cost of Medicare population in the area. A basic problem emerged that is still true today: capitated plans could

compete well in higher cost, primarily urban areas, but not in lower cost, primarily rural areas. Continuing tension between efforts to subsidize payments so that capitated plans could compete more effectively and desire to limit costs led to repeated changes in payment rules. Enrollment in capitated plans moved up and down in response to subsidies that resulted from changes in payment rules.

The Medicare Modernization Act of 2003 created the program we know as Medicare Advantage. The new program featured complex payment formulas designed to encourage capitated health plans to compete in more markets and resulted in very substantial subsidies for these plans, especially in low cost areas. Average payments per Medicare beneficiary were higher in MA than traditional Medicare. Also MA plans were able to attract healthier, lower cost patients. Attempts to improve risk adjustment and block overt efforts to attract healthy patients were only partially successful. MA enrollment increased substantially, but varied greatly by state.

The Affordable Care Act (ACA), which passed in 2010, reduced the subsidies to MA plans and used the savings to help fund ACA. These payment rules are still being phased in. Enrollment rates in MA were expected to fall as a result of the lower subsidies, but have held up surprisingly well. Currently about 30 percent of Medicare beneficiaries are enrolled in MA (see **Figure 1**), although MA enrollment varies enormously by state. At the extremes, 51 percent of beneficiaries are enrolled in MA in Minnesota in 2014, compared with only three percent in Wyoming.

Figure 1: Penetration of Medicare Advantage, 1999 - 2014



Source: Kaiser Family Foundation, Medicare Advantage Spotlight

Figure 2: Penetration of Medicare Advantage by State

Alabama	24%	Missouri	26%
Alaska	N/A	Montana	17%
Arizona	38%	Nebraska	13%
Arkansas	19%	Nevada	33%
California	38%	New Hampshire	6%
Colorado	36%	New Jersey	15%
Connecticut	24%	New Mexico	30%
Delaware	7%	New York	35%
District of Columbia	11%	North Carolina	28%
Florida	38%	North Dakota	14%
Georgia	28%	Ohio	38%
Hawaii	46%	Oklahoma	16%
Idaho	33%	Oregon	43%
Illinois	16%	Pennsylvania	39%
Indiana	22%	Rhode Island	36%
Iowa	14%	South Carolina	22%
Kansas	13%	South Dakota	15%
Kentucky	24%	Tennessee	32%
Louisiana	28%	Texas	29%
Maine	20%	Utah	34%
Maryland	9%	Vermont	7%
Massachusetts	20%	Virginia	15%
Michigan	30%	Washington	29%
Minnesota	51%	West Virginia	24%
Mississippi	13%	Wisconsin	35%
Total US: 30%		Wyoming	3%

As shown in **Figure 1**, the enrollment trend in Medicare Advantage is a rollercoaster. In 1999 in the aftermath of the Balanced Budget Act, about 18 percent of the Medicare population was enrolled in Medicare Advantage. However, enrollment immediately declined. This coincided with the mass exodus for Medicare Advantage plans, particularly from rural areas. In 1998 there were 346 plans operating in Medicare Advantage; by 2003 there were only 146 plans. Once the Medicare Modernization Act subsidized private plans to enter the market then both the number of plans and the enrollment in Medicare Advantage rebounded.

III. How Medicare Advantage Works Now

Currently, four types of capitated plans participate in MA. The predominant type is the Health Maintenance Organization (HMO), which typically manages patient care and restricts service to a fairly narrow network of providers, with which it has negotiated favorable prices. HMOs account for about two thirds of MA beneficiaries. Two types of Preferred Provider Organizations (PPOs) also participate—local and regional PPOs—accounting for about thirty percent of enrollees. They are looser networks, which impose some penalties on patients who seek care outside the network. Some private FFS plans also participate but they account for a small and diminishing share of MA enrollees, currently only about three percent.

Medicare Advantage plans are paid a fixed capitation rate in order to provide the Medicare Part A and Part B (and sometimes D)¹ benefit packages. Ideally, since they do

not have FFS incentives to produce additional services, plans will develop methods of coordinating care, reducing waste and duplication, and emphasizing disease prevention in order to deliver quality care as efficiently as possible. If MA plans are successful at lowering costs, they are allowed to return a portion of the cost-savings to the beneficiaries in the form of supplemental benefits or reduced cost-sharing.

The Centers for Medicare and Medicaid Services determines the geographic reference area for Medicare Advantage plans. For the most part, the geographic reference areas are counties but for some types of plans, larger geographic areas are used. The Medicare Advantage plans then submit bids to the Centers for Medicare and Medicaid. The bids submitted are supposed to represent the cost of covering the average beneficiary within the geographic reference area. The bids represent the per-person, per-month revenue needed to provide Medicare Parts A and B benefits, Medicare Part D benefits, and supplemental benefits or cost sharing reductions.

Medicare Advantage plans can offer extra benefits in order to induce the Medicare beneficiaries to enroll in Medicare Advantage rather than traditional Medicare. Since the majority of private plans are HMOs with narrow networks or intensive care-management, Medicare Advantage plans design their supplemental benefits in order to offset the disutility of the HMO networks. The supplemental benefits can take the form of reduced cost-sharing for

¹ Medicare Advantage plans are given the option of offering Medicare Part D benefits but are not required to do so. If a Medicare Advantage plan chooses to cover Part D then the bid that plan submits to CMS includes the cost of doing so.

beneficiaries or—famously in one case—gym membership.

The Centers for Medicare and Medicaid Services compares the bids submitted by the Medicare Advantage plans to a benchmark in order to calculate the monthly capitated payments made to the plans. The Affordable Care Act simplified the method used to calculate the Medicare Advantage benchmarks, and reduced, but did not eliminate the previous subsidy to MA plans. All counties are divided into quartiles according to the cost of fee-for-service Medicare in that area. The Medicare Advantage benchmark will be equal to a fixed percent of the fee-for-service in that county. The lowest cost fee-for-service counties will receive 115 percent of the fee-for-service costs; the other quartiles will receive respectively 107.5 percent, 100 percent, or 95 percent of the fee-for-service costs. Thus, MA is still subsidized in half the counties, although these counties are sparsely populated and account for only one-third of the Medicare population.²

Each plan's bid is compared to the calculated benchmark. If a Medicare Advantage plan's bid is lower than the county-benchmark, the government and the private plans share the savings that result from the difference in payment rates.

² Since the previous system was more generous to MA plans, in some counties, the difference between the previous benchmarks and the new benchmarks is quite substantial. In order to soften the change in payment rates, the new benchmarks are phased. The new benchmarks are phased in over two, four, or six years depending on how large the change in the benchmarks will be. The new benchmarks were first introduced in 2012, so those counties with a two or four year phase in will be fully under the new benchmark in the next plan-year. For the counties with a six year phase in, the actual benchmark for each county is equal to a weighted average of the old and the new benchmarks: one sixth of the previous benchmark is added to five sixths of the old benchmark to calculate the blended rate.

The Medicare Advantage plan gets to keep 75 percent of the difference between its bid and the benchmark; the Medicare program retains 25 percent of the difference. Plans are required to spend their share of the cost-savings on supplemental benefits or reducing cost-sharing. On the other hand, if the plan's bid exceeds the country-level benchmark, the beneficiaries in that plan are required to pay a premium equal to the difference.

Each month the Centers for Medicare and Medicaid Services (CMS) pay the Medicare Advantage plans. Primarily, the payments are based on the bids submitted by the plans. However, several additional adjustments are made to the bids in order to calculate a final payment rate. Individuals in Medicare Advantage are risk-adjusted in order to account for differences in expected health expenditures. The Centers for Medicare and Medicaid Services estimates expenditure for each individual using an econometric model. The model estimates a beneficiary's expected costs based on age, demographics, and health conditions.³ The capitation rate for Medicare Advantage beneficiaries is adjusted based on the predicted expenditures.

Over time, research has shown that Medicare Advantage plans “upcode” their beneficiaries.¹ Beneficiaries in Medicare Advantage tend to have higher risk-scores than equivalent individuals in fee-for-service Medicare because Medicare Advantage firms have a financial incentive to diagnose as many conditions as possible

³ Medicare has begun to collect data on the actual services performed during each beneficiary's encounter with the healthcare system. Under the Medicare Modernization Act, risk-adjustment is based on an individual's diagnosed conditions. For 2016 and beyond, the Secretary of Health and Human Services has suggested calculating the risk-adjustments based on the encounter-level data.

in their beneficiaries. Additionally, as beneficiaries in Medicare Advantage grow older, their risk-scores increase faster than equivalent beneficiaries in fee-for-service Medicare. Starting with the Deficit Reduction Act in 2005, the risk-scores for Medicare Advantage beneficiaries are deflated by a coding intensity adjustment in order to account for the upcoding problem. The Affordable Care Act increases the coding intensity adjustment.

The Affordable Care Act also required the Centers for Medicare and Medicaid Services to adjust the payments made to the Medicare Advantage plans according to the plans' quality – thus another adjustment is made to the plans' payments. Each Medicare Advantage plan is assigned a quality rating on a scale of one to five stars. The star rating affects both the rebate rate and the plans benchmark.⁴ For example, a Medicare Advantage plan that received four stars would be given 65 percent of the difference between its bid and the county benchmark; additionally, the benchmark itself would be increased by 5 percent for the purposes of calculating the benchmark for that plan. On the other hand, a plan that received only three stars would receive only fifty percent of the difference between its bid and the benchmark; and the benchmark itself would not be adjusted. To some extent, the quality payments may have compensated MA plans for the declining subsidies resulting from the ACA.

IV. Which costs more: Medicare Advantage or Fee-for-Service?

Medicare Advantage was supposed to reduce the cost of delivering Medicare

⁴The star rating effects *only* the portion of the benchmark determined by the Affordable Care Act, and not the portion determined under the old process.

benefits in two ways. Capitated plans would be able to manage and coordinate patient care more effectively, thus reducing the waste and duplication that can occur in a FFS system, and competition among plans for patients would provide incentives for plans to control costs. Nevertheless, opponents of MA are quick to point out that average per beneficiary cost of MA has been higher than average per beneficiary cost of FFS Medicare. This is true, although the difference has recently been closing. Supporters of MA counter with the equally valid fact that the average MA plan bid (which is supposed to represent their cost of providing Medicare benefits) was not only below the benchmark, it was below FFS Medicare costs. How can both be true?

This paradox is explained by three factors. First, the bidding system is designed to give MA plans strong incentives to offer additional health services beyond the required Medicare benefit package and these services add to their costs. Second, MA plans have been deliberately subsidized in an effort to induce more plans to enter the market, especially in lower cost areas. Third, despite the differential subsidies, MA plans have been much more successful in attracting enrollees in higher cost, normally urban areas than in lower cost areas. Hence, even though MA plans have lower costs within individual areas (especially high-cost areas), more MA beneficiaries are located in high cost areas, so their average cost is higher.

A recent large-scale study of MA and FFS Medicare costs by county illustrates these points.² The authors excluded the MA plan rebates in order to obtain estimates of the cost of delivering the Medicare benefit package alone. When the authors compared costs of MA plans and traditional Medicare

nationally and in urban and rural counties, they found that at the national level the costs were the same (MA cost were 99 percent of traditional Medicare). For rural counties the MA costs were 15 percent higher than fee-for-service costs. When they arrayed the counties by cost of traditional Medicare, they found a consistent cost advantage for MA plans in the higher cost counties (see the exhibit 3 in Biles et al). They also analyzed the costs by type of MA plan and found that HMOs had substantially lower costs than non-HMO plans, especially in the highest cost counties (see exhibits 4 and 5 in Biles et al).

An analysis of MA bids illustrates the same paradox. The total per capita cost of Medicare Advantage is higher than the total per capita cost of traditional fee-for-service Medicare, but the average bid submitted by Medicare Advantage plans was actually lower than the costs of traditional fee-for-service Medicare. According to MedPac,³ the average benchmark for Medicare Advantage plans was 107 percent of fee-for-service costs and the bids submitted by Medicare Advantage plans averaged 94 percent of the average fee-for-service costs. Since the actual payments to Medicare Advantage plans is determined by *both* the benchmark and the bids, the average payments made to the Medicare Advantage plans averaged 102 percent of the fee-for-service plans in 2014.

These differences used to be larger, but the ACA significantly lowered the payment rates to Medicare Advantage, which caused the benchmarks, bids, and payments to fall. In 2010, MedPac⁴ estimated that the benchmarks averaged 117 percent of fee-for-service costs. The bids submitted by Medicare Advantage firms averaged 104 percent of fee-for-service costs and overall

payments to the firms averaged 113 percent of the fee-for-service costs.

There is significant variation in relative costs of Medicare Advantage and fee-for-service Medicare, which suggests some scope for reducing MA payments. According to MedPac and other analysts, the costs for Medicare Advantage plans – particularly the HMO plans – do not vary nearly as much by area as fee-for-service costs do. As a result, Medicare Advantage plans can produce cost savings in areas where fee-for-service Medicare is very expensive; but it is much more difficult for Medicare Advantage plans to produce cost-savings in areas where fee-for-service costs are low.

Medicare Advantage bids correlate highly with the cost of fee-for-service Medicare. In counties where fee-for-service costs were between \$545 and \$699, the median bid submitted by a Medicare Advantage plan was equal 105 percent of the fee-for-service costs. On the other hand, in the counties where fee-for-service costs were between \$900 and \$1,300, the median bid for Medicare Advantage was only 73 percent of the Medicare fee-for-service costs.

Thus in the lowest cost areas, the median bid by Medicare Advantage plans was approximately \$550 dollars. Meanwhile, the median bid of Medicare Advantage plans in the high cost areas was approximately \$825. Bids offered by Medicare Advantage in low- and high-cost areas differ but the range of the bids is much narrower than the range of fee-for-service costs.

Limited variation in the Medicare Advantage bids suggests that Medicare Advantage payment rates are higher than Medicare Advantage costs in many instances. This finding is born out in a direct analysis of Medicare Advantage costs. MedPac and

Mathematica⁵ have separately calculated the risk-adjusted bid submitted by MA plans.⁵

An analysis of the Medicare Advantage risk-adjusted bids suggests that there is a wide gap between Medicare Advantage payment rates and the plans' costs. In the lowest fee-for-service cost quartiles (by county) the average payment to Medicare Advantage plans is 118.2 percent of the average fee-for-service costs. But in the highest fee-for-service cost quartiles, the average Medicare Advantage payments are only 95 percent of the fee-for-service costs. There is also a substantial variation in plan costs according to the type of the Medicare Advantage plan. HMOs are cheaper than other plan types. On average, HMOs cost only 96.6 percent of fee-for-service costs while local PPOs cost 118.7 percent of fee-for-service costs. The difference is even large in higher cost areas. In the highest cost quartile of fee-for-service costs, private HMOs costs are only 91.4 percent of fee-for-service costs; whereas local PPOs cost 112.9 percent of fee-for-service costs in the same area. In the lowest cost quartile, however, no plans' average costs are lower than fee-for-service costs.

The bids submitted by Medicare Advantage firms demonstrate that there is a substantial difference between the costs of providing insurance coverage through Medicare Advantage plans and the payments made to the Medicare Advantage plans. This difference suggests that using a competitive bidding mechanism to set the

benchmark for Medicare Advantage plans could reduce costs.

V. Competitive Bidding in Medicare Advantage

Competitive bidding in Medicare Advantage has been suggested many times as one solution to the high cost of Medicare.⁶ In 1996, a demonstration project for competitive bidding in Medicare Advantage was introduced for the city of Baltimore, but political pressure prevented its implementation. In 1997, another demonstration project was attempted in Denver but legal objections stopped it. Further attempts to launch a demonstration project took place in 1999 and 2010.

Despite these setbacks, health policy scholars across the political spectrum have been attracted to the potential benefits of competitive bidding in Medicare. The American Enterprise Institute has published several policy briefs advocating competitive bidding. The Obama Administration advocated competitive bidding in the 2010 budget proposal. The Center for American Progress issued a somewhat similar proposal. In what follows, we first explore the possible advantages and uncertainties associated with plans for limiting the bidding to Medicare Advantage plans, leaving traditional Medicare as it is. Then we consider including traditional Medicare in the bidding process—a form of premium support.

Plan One: Bidding within Medicare Advantage

Instead of competing on the richness of their benefits, CMS could require plans to name the price at which they would agree to supply the Medicare package of benefits in the area. The concept would be the same

⁵ The bids submitted by the health plans are adjusted by the average risk-scores for the entire Medicare Advantage population; for example, if the average risk-score of all beneficiaries in the risk pool was 1.5. The payment rate for that Medicare Advantage plan is equal to 1.5 times the plan's bid.

as health plans offering to supply, say, the ACA silver plan in the area at a particular price. Plans would submit sealed bids. Bidders would have to meet quality standards and show that they had sufficient capacity to meet demand. These bids would determine the benchmark, which would be the federal payment for MA in the area. The benchmark payment could be calculated in different ways. For example, setting the benchmark equal to the enrollment-weighted average of all bids; or setting the benchmark equal to the second-lowest bid. The benchmark on the ACA exchanges is the second lowest silver plan, but an enrollment weighted average of the bids might yield a more stable, sustainable benchmark.

Under the current bidding system the actual payments to the Medicare Advantage plans may be higher than the plans' bids – and sometimes significantly higher – because the benchmarks are determined by the fee-for-service costs in the relevant area. Under Plan One the cost of traditional Medicare in the area would not be part of the bidding process. The benchmark would be determined by the MA plan bids alone. It would be the competitively determined price of capitated plans providing Medicare benefits in the area.

Medicare beneficiaries who wanted to enroll in Medicare Advantage would then be able to choose among plans on an electronic exchange, possibly an expansion of the ACA exchange. Plans would provide accurate information on the providers in their network, including health outcomes and other quality information that would be refined as the system improved. Plans would compete to offer the best service at the lowest price. A beneficiary who chose a plan that cost more than the benchmark—either because it was less efficient or

offered supplementary benefits—would have to pay extra. A beneficiary who chose a cheaper plan, would receive a cash rebate. The plan would receive the benchmark payment or their bid, whichever was less. The payment would be adjusted for the health risk of the beneficiary, and possibly for up-coding and quality, as at present. Traditional Medicare would continue to be an option.

Such a bidding system would likely bring down MA costs and improve quality in higher cost urban areas where a substantial fraction of the Medicare population lives. However, without subsidies many MA plans would not maintain a presence in low-cost areas, especially sparsely population rural ones. One policy option would be simply to use competitive bidding to improve competition and lower costs in places where it is most likely to be able to do so (i.e., high cost urban areas), but not to force MA into areas where it is unlikely to thrive.

A variety of studies have examined the implications of these alternative benchmarks by looking at bids submitted by the Medicare Advantage plans and comparing the bids to the current cost of Medicare Advantage. For example, Zuri Song, David Cutler, and Michael Chernew⁷ estimated the cost of Medicare Advantage under a competitive bidding system by looking at the bids submitted between 2006 and 2009. Their analysis indicated that a competitive bidding system could lower the Medicare Advantage payment rates to about 90 percent of traditional fee-for-service costs.

According to the historical pattern of bids and payments analyzed by Song and his coauthors if the payment rates were set equal to the second-lowest bid then the

cost of Medicare Advantage would be *about 91 percent of fee-for-service costs*. The President's budget would set the Medicare Advantage payment rate equal to the average of all Medicare bids so the cost of the Medicare Advantage program would be considerably lower if the payment rates were also lowered substantially.

These calculations suggest that competitive bidding in Medicare Advantage could produce substantial cost-savings under either method of defining the benchmark. However, our analysis and other studies assume that Medicare Advantage plans will submit bids to the Centers for Medicare and Medicaid Services according to their historical tendencies. Unfortunately, it is hard to know what the MA bids would be under a new system not anchored to the cost of FFS Medicare. One reason for the uncertainty is that MA markets are highly concentrated and MA plans often have considerable market power. Another is that withdrawal of the subsidy for MA plans in low cost areas would likely trigger substantial withdrawal health plans from the bidding process.

Concentration and Market Power

Brian Biles, Jonah Pozen, and Stuart Guterman,⁸ examined the level of concentration in Medicare Advantage markets by calculating Herfindahl Index (HHI) for each county. The HHI represents the extent to which Medicare Advantage enrollment is concentrated among a small number of firms. The majority of the Medicare Advantage markets – 71.5 percent of them – have high levels of concentration. These counties also contained nearly 75 percent of the total Medicare Advantage population. Only 2.1 percent of the Medicare Advantage markets have low level of concentration and only 1.6 percent of

Medicare Advantage beneficiaries live in these counties.

Several studies have shown that when the Medicare Advantage benchmarks increase the bids submitted also increase—an indication that the plans have market power. Ziuri Song, Mary Landrum, and Michael Chernow⁹ show that when the payments to Medicare Advantage HMO increased by \$1 the HMOs increased their bids by \$0.49 and only \$0.34 was passed along to beneficiaries in the form of rebates. The correlation between the benchmarks and other types of Medicare Advantage plans was smaller but still significant. Other studies have shown smaller but still significant relationships.

Taking a similar approach, Mark Duggan, Amanda Starc, and Boris Vabson¹⁰ show that when the payment rates to Medicare Advantage plans increase Medicare Advantage plans keep almost half of the increase in payments and pass about one-third of the increase onto the beneficiaries. Numerically, this finding aligns closely with the finding by Song and his coauthors. The authors of this study also show that when the government's payments to Medicare Advantage plans a significant amount of that payment is devoted to advertising. Naturally therefore, the government's payments tend to correlate with an increase in the number of beneficiaries in Medicare Advantage—not surprising in a concentrated market.

High concentration in Medicare Advantage markets makes it difficult to have confidence in estimates of the outcomes of competitive bidding – a problem that also affects the ACA exchanges. It is possible that experience with the ACA market places—combined with rising numbers of Medicare

beneficiaries—will bring additional plans into the Medicare Advantage market and increase competition. On the other hand, there is reason to worry that plans will engage in predatory pricing in order to drive other firms out of the market before increasing their bids. If this happens, invoking the anti-trust laws would be appropriate, although such actions tend to be lengthy and cumbersome.

Exit from Low Cost Areas

Another concern with a competitive bidding system is that Medicare Advantage firms are likely to exit the market as subsidies are withdrawn. Before the subsidies were increased in 2003, a large number of private HMO plans left the Medicare market many because they found it difficult to operate in rural areas. Providing access to at least one Medicare Advantage plan in market has been a political objective for some time.

The policy of “over-paying” Medicare Advantage plans to enter in low-cost areas been successful. Almost 99 percent of Medicare Advantage beneficiaries have a choice of two or more Medicare Advantage plans. Unsurprisingly, studies of Medicare Advantage entry and exit decisions have concluded that high payment rates heavily induce private plans to enter the market. Conversely, if the Medicare Advantage rates decline, plans are expected to exit.

Austin Frakt, Steven Pizer, and Roger Feldman¹¹ studied twelve large insurance firms as they decided whether or not to enter different Medicare Advantage markets. They conducted a simulation study to determine how entry and exit decisions will change under the new Affordable Care Act benchmarks. Under the new benchmarks, the probability that a private insurer enters the market declines by 40 percent. Another

simulation by Shiko Maruyama¹² estimated the change in the number of Medicare Advantage HMOs rather than the individual probability that a firm enters the market. Maruyama simulated the effect of equating the Medicare Advantage benchmarks with the average fee-for-service costs; this is different from the scenario considered by Frakt and his coauthors but the simulation suggests that HMOs will exit from markets where the initial number of HMO plans is small. But in markets with more than 5 HMOs, plans actually enter the market.

The ultimate effect is that uncompetitive Medicare Advantage markets become more uncompetitive and competitive markets become more competitive. If a competitive bidding system causes the payment rate for Medicare Advantage plans to decline significantly then there is likely to be substantial exit by Medicare Advantage plans. The implication of a substantial exit by Medicare Advantage plans is likely to be one of two outcomes: in some markets, firms may exit the market leaving no viable Medicare Advantage plan for beneficiaries; in other markets, firms may exit the market leaving only one or two Medicare Advantage firms with considerable market power.

Plan Two: Both FFS Medicare and MA plans in competitive bidding

A more drastic proposal would bring traditional FFS Medicare into the same bidding system with private MA plans and give Medicare beneficiaries the full range of choice on an exchange. In such a system, the government would submit a bid on behalf of fee-for-service Medicare. The bid would equal the average fee-for-service cost in each geographic reference area. Traditional Medicare would then function

just like another Medicare Advantage plan in the competitive bidding mechanism. The competitively determined benchmark would define the government's contribution. The benchmark could be set as the second lowest bid or the enrollment-weighted average of the bids (including FFS) or some other way. In some places the FFS plan would cost more than the benchmark and beneficiaries who chose it would have to pay a premium in order to obtain their choice. In other areas, FFS might be below the benchmark and those who chose it would get a rebate. If no private MA plans entered the market, FFS would be the only option.

Such a system would preserve the entitlement of Medicare beneficiaries to the Medicare package of benefits. They could obtain those benefits without paying more than the Part B premium. However, unlike Plan One, Plan Two would not guarantee that the Medicare benefits would be available in a FFS setting without extra charges. In areas where FFS was more costly than MA, a beneficiary might want to stay with a particular provider and that provider might not be in a plan available at or below the benchmark price, such a beneficiary would have to pay extra for that option.

In areas where FFS Medicare was more costly than efficient MA plans, Plan Two would clearly generate more cost savings than Plan One. The Congressional Budget Office analyzed one option that allowed traditional fee-for-service Medicare to compete with Medicare Advantage plans. The analysis found that the total cost of Medicare would be reduced by about 11 percent relative to baseline spending.

Plan Two is form of Medicare premium support—a program in which the

government makes a specified contribution to Medicare and allows the beneficiary to choose among competing plans, including FFS Medicare. In this case, government contribution would be the local cost, determined by competitive bidding, of delivering the Medicare benefit package.

The Congressional Budget Office has also analyzed a similar proposal and estimated the cost-savings from the introducing competitive bidding in Medicare Advantage. They expect that Medicare Advantage plans will submit bids roughly equivalent to the bids that they have submitted in the past, similar to Song, Cutler, and Chernew. Under this assumption, the Congressional Budget Office estimated that competitive bidding would reduce the cost of Medicare Advantage by \$158 billion when the benchmark was set equal to the average of all bids submitted.⁶ President Obama's 2009 budget estimated total savings of \$176 billion. OMB's estimate assumed that Medicare Advantage plans would reduce their bids in the face of greater competitive pressures. The Congressional Budget Office projected savings of \$161 billion if the benchmark was set at the lowest bid.⁷

⁶ See Option 65 of the Congressional Budget Office's report on *Budget Options, Volume 1: Health Care*. The projected savings apply to the 2010-2019 budget window and would likely be different given the changes in CBO's projections for Medicare costs since the publication of the report in 2009.

⁷ See Option 64 in the Congressional Budget Office's report on *Budget Options, Volume 1: Health Care*. The budget window covers 2010-2019 and so the same caveats apply regarding the changes in the Congressional Budget Office's projections for Medicare spending.

The controversy over premium support

The term “premium support” goes back to a proposal by Henry Aaron and Robert Reischauer in 1995.¹³ The Aaron-Reischauer plan called for Medicare to pay a defined sum for a defined benefit. Individuals would then have the option to enroll in private health insurance plans. Their plan would have equated the growth rate in the premium contribution with the growth rate of health care for the non-elderly. The basic idea was featured in the National in the Bipartisan Commission on the Future of Medicare (Breux-Thomas Commission)¹⁴ in 1999, but failed to gain the support of the Democrats on the Commission.

Premium support resurfaced in the political debate in 2008 when Congressman Paul Ryan put forward the first of a series of controversial proposals to convert Medicare to a premium support plan. Under the Ryan plan, the government would make a defined contribution (initially equal to the average cost of Medicare) and allow Medicare beneficiaries to choose among private plans. Various versions of the Ryan proposal were incorporated into House-passed Budget Resolutions after Ryan became Chairman of the House Budget Committee.

Early versions of the Ryan plan would have phased out traditional Medicare by putting all new beneficiaries in the premium support plan, while existing ones were allowed to stay in traditional Medicare if they wanted to. Substantial savings were achieved by allowing the government contribution to grow only with the increase in prices. Since health care spending was then projected to rise much faster than prices, indeed considerably faster than the growth in GDP, this strict growth cap

implied substantial cuts in future Medicare benefits.¹⁵

The Ryan plan provoked an explosion of opposition among Democrats, including an effective political ad in which a tall, lanky Ryan-like figure was shown pushing a sweet-faced old lady off a cliff in her wheel chair. Democrats characterized Republican plan as a “voucher,” an end to “Medicare as we know it,” and a medical/financial disaster for the elderly and disabled.

While this political battle raged, more moderate versions of premium support emerged. The Bipartisan Policy Center’s Debt Reduction Task Force, co-chaired by Pete Domenici and Alice Rivlin, proposed a premium support plan involving competitive bidding among private plans on a Medicare exchange, but preserved traditional Medicare as an option. The proposal was similar to Plan One except that it included a cap on the growth in of the government contribution to Medicare spending, albeit a more generous cap than Ryan’s. The cap was included because of uncertainty about the success of competitive bidding in holding down costs and the need for savings that the Congressional Budget office would score.

Another similar premium support proposal was a compromise between Republican Congressman Paul Ryan and Democratic Senator Ron Wyden that also capped the increase in the per capita government contribution at the growth of per capita GDP + 1 percent. This compromise produced smaller savings than Congressman Ryan’s premium support proposal in his 2011 “Path to Prosperity” Budget that linked the government’s contribution to a price index (the CPI-U). Much of the public discussion of these plans

focused on their spending caps rather than the details of the competitive bidding.

For a time, the Democrats' total rejection of the original Ryan proposal (which phased out traditional Medicare and reduced out year benefits) appeared to rule out any bipartisan consideration of premium support—even a version that kept traditional Medicare as an option and preserved beneficiaries' entitlement to the Medicare benefit package at no extra cost. The whole concept seemed politically toxic. But the success of the ACA exchanges—as well as the growth of private exchanges and the older population's experience with choosing among private plans in Part D of Medicare—has familiarized Americans with the idea choosing among health plans and with electronic exchanges. Payment reforms in traditional Medicare may also make more people familiar with provider-led groups, such as Accountable Care Organizations (ACOs) that are evolving in the direction of capitated plans. In this atmosphere, introducing competitive bidding into Medicare Advantage could be seen as an effort to improve the efficiency of an existing—and well-accepted part of Medicare, rather than a scary new departure that might cut back expected benefits.

Unlike the Domenici-Rivlin proposal, our Plans One and Two do not involve an arbitrary cap on growth in the government contribution. They are more in the spirit of the Aaron-Reischauer proposal, in that changes in the government contribution would reflect actual costs. While a global cap provides an additional policy level for the government to control the cost of Medicare, we have concluded that it is either unnecessary or unsustainable, depending on what happens to Medicare

spending over time. If increased competition in Medicare Advantage combined with other reforms in traditional Medicare were successful in keeping Medicare cost growth to a moderate rate (say, no faster than the growth of GDP), the cap would be unnecessary. If on the other hand, Medicare spending began growing rapidly again, the cap would require cuts in the Medicare benefit package. The cap would quickly become politically unsustainable and legislative action would be required. Hence, adding the cap seems undesirable. Besides, Congressional Budget Office estimated that there would savings from competitive bidding even without caps on total spending.

The risk adjustment challenge of integrating FFS into a competitive bidding system

Besides the political challenges of reforming Medicare, there are technical challenges that need to be resolved before Medicare Advantage and fee-for-service can compete on a level playing field. Currently, Medicare Advantage beneficiaries are healthier than traditional fee-for-service beneficiaries. Sicker beneficiaries tend to enroll in fee-for-service, rather than Medicare Advantage. As a result, the fee-for-service and Medicare Advantage plans cover different populations, sometimes significantly different.

An analysis by MedPac showed that the average risk score of those enrolling in Medicare Advantage was an average of only 84 to 87 percent of those individuals enrolling in fee-for-service Medicare. Thus the Medicare Advantage population is substantially healthier than the fee-for-service Medicare. Additionally, data from the Centers for Medicare and Medicaid and MedPac show that about 10 percent of the

Medicare Advantage population switches plans each year. Only about two percent of the Medicare Advantage population switch into Medicare fee-for-service but these individuals tend to be disproportionately less healthy than the remaining Medicare Advantage population.¹⁶

For example, Lauren Nicholas¹⁷ showed that individuals with serious comorbidities were likely to choose Medicare fee-for-service coverage. In fact, minorities, the previously disabled, and dually eligible beneficiaries are likely to disenroll from Medicare Advantage. On the other hand, individuals with easily treatable hypertension and diabetes will remain in Medicare Advantage. Additionally, Gerald Riley showed that beneficiaries who disenroll from Medicare Advantage incur \$1,201 per month compared to \$798 per month for “similar” individuals who stayed in Medicare Advantage.

As a result, Medicare Advantage starts substantially healthier than fee-for-service Medicare and becomes increasingly more so as individuals switch out of Medicare Advantage and into fee-for-service. It is not terribly surprising that Medicare Advantage plans enroll healthier beneficiaries than fee-for-service Medicare. After all, sicker beneficiaries want access to broader networks and higher cost facilities, such as teaching hospitals. If FFS were one of the plans included in the bidding system and it attracted the sickest patients, risk adjustment might not be adequate to prevent a death spiral in which FFS cost escalated out of control and low-income beneficiaries were unable to pay for care.

Recent reductions in MA benefits

Recent information shows that MA plans have become less generous, presumably as

a result of declining subsidies. Medicare Advantage plans⁸ have slowly increased the amount of out-of-pocket costs their beneficiaries paid. A report by the Kaiser Family Foundation⁹ showed that in 2011, 51 percent of health plans capped beneficiaries’ out-of-pocket spending at less than \$3,400. However, by 2015 only 9 percent of Medicare Advantage plans limited plans’ out-of-pocket spending by that much. The result has been a substantial increase—\$752 on average—in the amount of out-of-pocket costs paid by Medicare Advantage beneficiaries.

Similarly, Medicare Advantage plans have slowly increased the amount of the premiums charged to beneficiaries. In fact, between 2014 and 2015 the average premiums in HMOs increased from \$3 to \$38; premiums for other plan types have increased as well. Because plans’ premiums keep increasing, Medicare Advantage beneficiaries are losing access to plans that do not charge a premium to beneficiaries. Prior to 2011, the vast majority of beneficiaries, about 90 percent, had access to a Medicare Advantage plan that covered prescription drugs. However, by 2015 a smaller majority over beneficiaries, only 78 percent of plans, had access to a zero premium plan.

Medicare Advantage plans have also reduced the breadth of their provider networks in order to reduce their costs. Anecdotal reports suggest that plans have

⁸ The Kaiser Family Foundation estimated out-of-pocket spending specifically for those MA plans that offered prescription drug coverage in addition to the Part A and B benefits.

⁹ Jacobson, Gretchen, Anthony Damico, Tricia Neuman, and Marsha Gold. 2014. “Medicare Advantage 2015 Data Spotlight: Overview of Plan Changes.” *Kaiser Family Foundation*, Issue Brief.

significantly reduced the breadth of their networks as a cost-saving measure in response to the payment reductions included in the Affordable Care Act. The research on Medicare Advantage provider networks is sparse and there are no systematic studies on Medicare Advantage provider networks.¹⁰

The timing of these changes in the Medicare Advantage system coincides with the beginnings of the Affordable Care Act's effect on Medicare Advantage payment rates. The competitive bidding systems that we have described above are designed to reduce the costs of Medicare Advantage. Therefore, it is possible that a competitive bidding system would accelerate the trends towards higher out-of-pocket costs, higher premiums, and narrower provider networks.

VI. Conclusions

In response to the question: "Could improving choice and competition in Medicare Advantage be the future of Medicare?" Our conclusion is a very qualified, "yes."

Choice and competition can play a major role in improving Medicare, starting with Medicare Advantage, but mechanisms for implementing choice and competition have to be very carefully designed to realize their promise and avoid adverse outcomes.

An attractive scenario for the future of Medicare could involve two parallel tracks that eventually converge. One track would start with Medicare Advantage and build on its strengths. It would use competitive

bidding, improved quality measures and consumer choice on user-friendly exchanges to reduce costs and improve health outcomes in areas where MA plans can compete effectively without subsidies. The second track would use payment reforms to lower costs and improve health outcomes in traditional Medicare. It would involve giving beneficiaries incentives to enroll in Accountable Care Organizations that accepted risk and received capitated payments. If both tracks were successful in improving health outcomes and the efficiency of delivery, they might eventually converge. Medicare beneficiaries—perhaps consumers of health care at all ages—would make well-informed choices among integrated health care organizations. Some of these would be run by insurers and others by provider groups that accepted insurance-like risk, but all would endeavor to keep their enrollees as healthy as possible in exchange for a periodic per capita payment.

Making Medicare Advantage more competitive would be a good first step toward this future. The current pricing system often results in the MA plans more than it costs them to deliver the Medicare benefit package and meet quality standards. A system in which payments to MA plans are set by competitive bidding among plans would save taxpayers money (Plan One). With reliable measures of care quality, health outcomes and patient satisfaction available on a user-friendly exchange, informed MA consumers, as well as tax payers could enjoy higher value than they do under the current system, while traditional Medicare remained as an option for those who preferred it.

Even this first step, however, would require resolving difficult policy issues. First,

¹⁰ See a discussion of many of these trends in Senger, Alyene, and Robert Moffit. 2015. "Medicare Advantage Under the ACA: Replace Payment Cuts with Market-Based Reforms." *The Heritage Foundation*, Background No. 3020.

experience has shown that MA plans compete very well in higher cost, mostly urban areas, but not in low-cost, mostly sparsely populated areas. One option would be simply to accept this fact, expect the benefits of competition to be largely confined to higher cost, more populous areas and rely on traditional Medicare to serve the others. Alternatively, taxpayers could continue to subsidize MA plans in the low cost areas in order give those residents a wider choice of plans. We know such subsidies are effective, but are they worth paying?

Another issue would be whether the predicted benefits of competition would actually be realized, since most health insurance markets are highly concentrated and firms have considerable market power. This is a problem that goes beyond Medicare Advantage—it threatens all health insurance customers including those enrolled in employer plans and the ACA. Not taking concentration in health insurance markets seriously and failing to design a strategy to mitigate it could prove detrimental to both taxpayers and customers.

The more ambitious step of bringing traditional Medicare into structured competition with MA plans could yield additional cost savings (Plan Two). It would allow beneficiaries to choose among health plans on an exchange and could bring costs down substantially in areas where FFS Medicare is most expensive. Two other issues, in addition to the two just mentioned, would have to be resolved before these benefits could be realized. One is the difficult problem of risk adjustment. MA plans have historically attracted healthier beneficiaries and those

who switch from MA to traditional Medicare tend to be in poorer health than those who stay. Risk adjustment techniques are improving and may advance faster with as more timely and accurate individual health information becomes available. Without rapid improvement in risk adjustment, however, competitive bidding that included both MA and traditional Medicare could result in traditional Medicare attracting the sickest and most expensive patients and becoming inaccessible to those with modest incomes.

The final policy issue goes to the basic question of what the guarantee of entitlement to Medicare means. Both Plans One and Two would guarantee seniors the package of Medicare benefits without additional premiums. But Plan Two would not guarantee that the Medicare benefit package would be available in a FFS setting without paying extra. The benchmark plan in the area might well be an MA plan. Moreover, experience shows that competition to reduce cost and attract beneficiaries often results in narrower networks. To stick with a particular provider or have access to a broader network would likely cost the beneficiary more. However, if payment reforms in traditional Medicare also lead to narrower networks and capitated payments, beneficiaries may come to regard them as the new normal.

None of these policy issues are easy ones, but, if they can be resolved satisfactorily, well- designed competitive bidding could be part of a viable, well-funded Medicare that delivers quality care to the seniors of 2030. Achieving such a result is worth a lot of effort, since maintaining the status quo—“Medicare as we know it”—is not a viable option.

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