

# Potential Consequences of Reforming Medicare Into a Competitive Bidding System

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**T**HE IDEA OF A PREMIUM SUPPORT (OR VOUCHER) SYSTEM for Medicare has generated substantial debate. Under premium support, Medicare beneficiaries would choose from health plans that compete in a market-based bidding system. In some models, traditional Medicare is abandoned entirely in favor of private health plans. In other models such as the Ryan-Wyden plan, traditional Medicare becomes one option among many.

Proponents of premium support cite 2 potential strengths. First, competition may lower health care spending. Second, by pegging the Medicare contribution to one of the lower-cost plans and limiting the increase in the government's contribution over time, public spending on Medicare will slow.<sup>1</sup> Critics state that bidding essentially shifts costs to beneficiaries by increasing their required premiums.<sup>2</sup>

Competitive bidding is not new to Medicare. The Medicare Advantage (MA) program has used bidding to determine plan payments since 2006. In MA, plans submit a price (bid) they are willing to accept to insure a beneficiary. Payment is determined by comparing the bid with a benchmark payment rate set by Medicare (published annually online), based on the counties the plan serves. If the bid exceeds the benchmark, Medicare pays the plan the benchmark rate and the plan must collect the difference by charging a premium to enrollees. If the bid undercuts the benchmark, the plan is paid its bid plus 75% of the difference (a rebate), which it must return to enrollees via extra benefits or lower premiums. Currently, more than 90% of MA plans offer some kind of rebate to attract enrollees.

Based on the Ryan-Wyden plan, the bidding system proposed in the recent House Republican budget replaces the administratively set benchmark with a market-determined benchmark.<sup>3</sup> In every county, either the plan with the second-lowest bid or traditional Medicare (whichever is lower) becomes the benchmark. Thus, every beneficiary would have at most 1 lower-cost option. Any beneficiary choosing a plan (including traditional Medicare) that bids above the benchmark must pay the difference between that plan's bid and the benchmark out of pocket.

An estimate of what such a bidding system may mean for Medicare beneficiaries, using 2006-2009 data on MA plan bids and traditional Medicare costs, is shown in the TABLE. Nationally, in 2009, the benchmark plan under the Ryan-Wyden framework (ie, the second-lowest plan) bid an average of 9% below traditional Medicare costs (traditional Medicare was equivalent to approximately the tenth-lowest bid). Since traditional

Medicare is simply another plan option under the Ryan-Wyden plan, a beneficiary in 2009 would have paid an average of \$64 per month (9% of \$717) in additional premiums to stay in traditional Medicare. Across the United States, 68% of traditional Medicare beneficiaries in 2009 (approximately 24 million beneficiaries) lived in counties in which traditional Medicare spending was greater than the second-least expensive plan and would have paid more to keep their choice of coverage (a share that would have been 81% in 2008, 75% in 2007, and 67% in 2006). Furthermore, more than 90% of MA beneficiaries (approximately 6.6 million seniors, excluding those dually eligible or in employer plans) would have also paid more for the plan they chose.

Private plans can cost less than traditional Medicare because: (1) they may use medical resources more efficiently; (2) they may enroll healthier patients relative to the risk-adjusted payment; or (3) their negotiated prices may not fully reflect the costs of indirect medical education or payments for disadvantaged hospitals, which traditional Medicare explicitly pays. The magnitudes of efficiency, selection, and avoided add-on payments are unclear; debate over whether add-on payments should be included in the traditional Medicare amount for bidding purposes is ongoing. To the extent that the 9% cost advantage reflects efficiency, it suggests there are better ways to provide the traditional Medicare benefit. Indeed, if plans are bidding above their cost of insuring beneficiaries, the 9% gap may underestimate the full efficiency gain.

Affordable Care Act (ACA) reforms to traditional Medicare may change these estimates by moving traditional Medicare toward improved incentives for cost and quality through accountable care organizations, bundled payments, and strengthening primary care.<sup>5</sup> The ACA also aims to slow the growth of traditional Medicare costs by reducing fee increases for some health care institutions. If traditional Medicare costs slow but do not close the 9% gap entirely, as currently projected, millions of beneficiaries will still have to pay more, although less than \$64 per month, to maintain their choice of coverage—assuming the benchmark stays the same. However, if the ACA reduces traditional Medicare costs enough so that traditional Medicare becomes the benchmark, beneficiaries would no longer pay more to keep traditional Medicare; instead, MA plans would be costlier than traditional Medicare and require a premium.

These estimates may have potential implications for policymakers. Specifically, if competition or the ACA does not lower

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**Table.** Lowest Plan Bids vs Traditional Medicare Costs, 2006-2009<sup>a</sup>

Year	Average Traditional Medicare Costs, \$/mo	Average Plan Bid, % of Traditional Medicare Costs				
		Lowest	Second-Lowest <sup>b</sup>	Third-Lowest	Fourth-Lowest	Fifth-Lowest
2009	717	87	91	94	95	96
2008	721	82	87	89	91	91
2007	705	84	89	92	94	95
2006	699	82	88	90	93	94

<sup>a</sup>Based on Medicare Advantage plan payment data and actual fee-for-service Medicare spending data.<sup>4</sup> All costs are adjusted to 2009 US dollars.

<sup>b</sup>Under the Ryan-Wyden plan, the second-lowest bidding private health plan in a county (or the county's traditional Medicare costs, whichever is lower) serves as the benchmark. All plans bidding above the benchmark must charge beneficiaries a premium equal to the difference between the plan's bid and the benchmark. The lowest-bidding private plan, in counties in which traditional Medicare is not the lowest bidder, would offer a rebate to plan beneficiaries.

the benchmark, a bidding system such as the Ryan-Wyden plan faces the prospect of millions of Medicare beneficiaries being asked to pay more for the coverage in which they are currently enrolled. The estimates in the Table are broadly consistent with a prior analysis,<sup>6</sup> although approximately 2.5 million more beneficiaries in this estimate would have paid more to stay in traditional Medicare compared with the prior report, which used aggregated estimates of the 25th percentile of bids as the benchmark, rather than actual plan bids used in this analysis. The estimate of the \$64 per month (9% of \$717) in additional premiums that traditional Medicare beneficiaries would pay may also be higher than in the prior report, although a direct comparison is not possible. For high-income seniors, paying more may not be problematic. For low- and moderate-income seniors however, \$64 per month could be very significant. Additional premium support for low-income seniors would help, but likely would not make up the difference.

Moreover, incentivizing beneficiaries to join private Medicare plans, even if less expensive, may have undesirable effects. In particular, reliance on beneficiary shopping to discipline the market has been problematic. Beneficiaries are often slow to switch plans due to cognitive impairment, choice overload, consumer inertia, or other influences. For example, Medicare Part D plans, which also operate in a bidding system, have found it profitable to price low initially, attract many enrollees, then increase prices over time.<sup>7</sup> Moreover, beneficiaries do not enroll in Part D plans that offer them the best coverage for their premiums and medical conditions.<sup>8</sup> These market failures would likely be even greater in a market-based Medicare system in which choosing plans would likely be even more difficult than in Part D. The market requires beneficiaries to trade restrictions on care or limited physician networks for premiums, which is counter to how many seniors view Medicare.

Premium support, based on competitive bidding, may offer a fiscal solution if ACA reforms fail, but at the cost of making Medicare beneficiaries responsible for solving Medicare's fiscal crisis. Success of the ACA can make premium support less risky by lowering traditional Medicare costs and helping to monitor and improve quality in private plans. Without ACA improvements, beneficiaries must pay more for traditional Medicare or join a private plan. Given the current fiscal pressures, this may be acceptable, but it is a major shift from traditional Medicare that may have deleterious consequences.

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