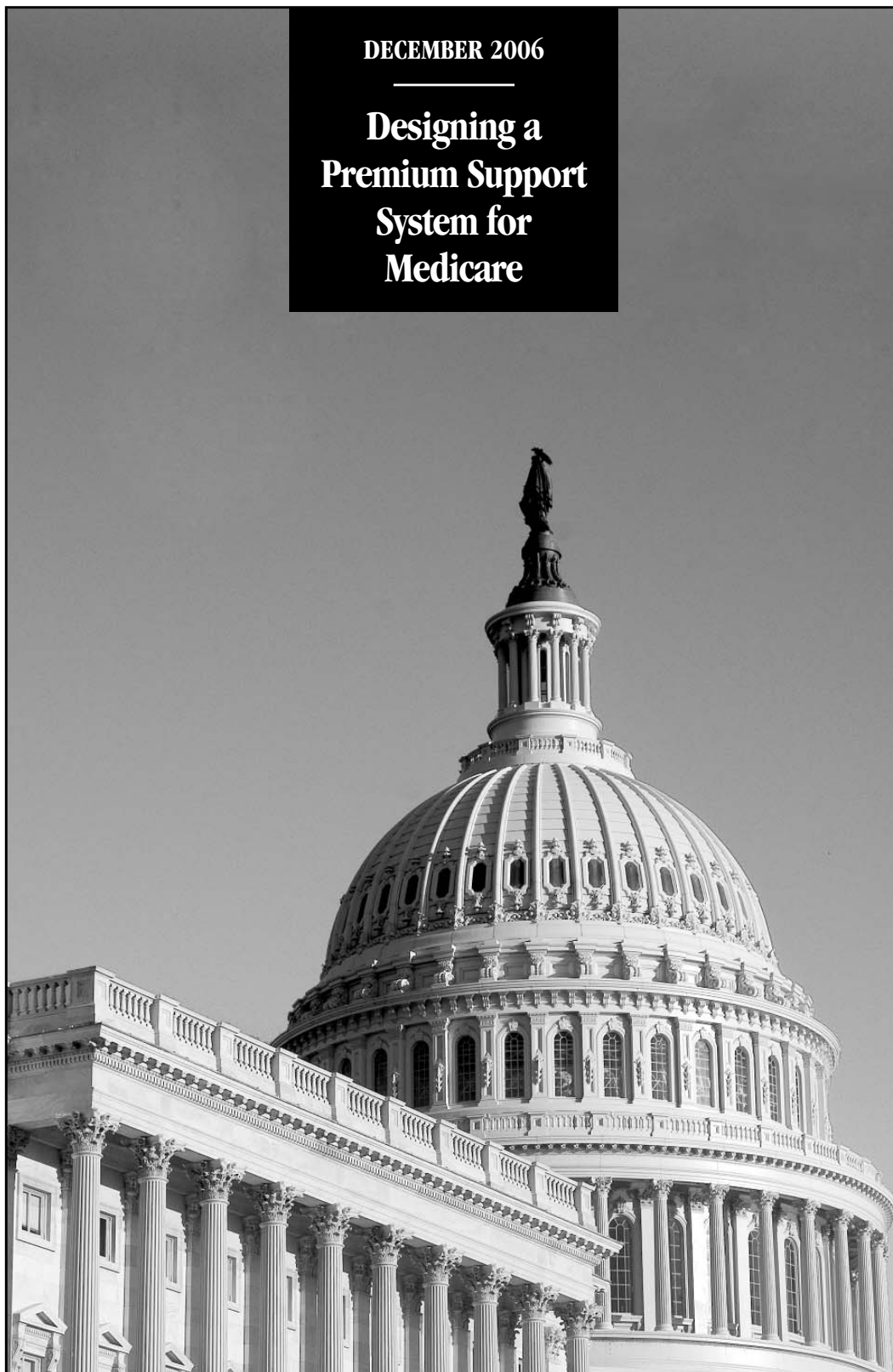


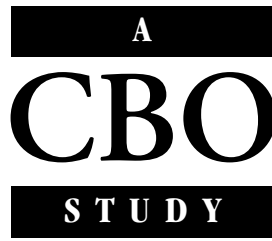
CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

A
CBO
STUDY

DECEMBER 2006

**Designing a
Premium Support
System for
Medicare**





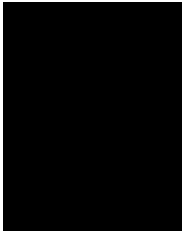
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Notes

All years referred to in this study are calendar years.

All dollar amounts are expressed in current dollars.



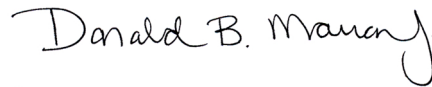
Preface

Driven by rising health care costs and an aging population, federal spending on the Medicare program will exert substantial pressures on the federal budget over the coming decades. Policymakers have considered a number of strategies for restraining Medicare spending. One approach would restructure the competition between private health plans and the traditional Medicare program by converting Medicare to a “premium support” system. Under such a system, the federal government would contribute an amount that beneficiaries could use to purchase Medicare coverage by enrolling in the traditional program or in a private plan.

This Congressional Budget Office (CBO) study—prepared at the request of William M. Thomas, chairman of the House Ways and Means Committee—examines the key decisions to be confronted in designing a premium support system for Medicare and the implications of alternative design choices for federal spending and beneficiaries’ premiums. In accordance with CBO’s mandate to provide objective, impartial analysis, the study makes no recommendations.

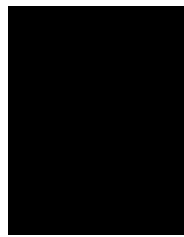
Lyle Nelson prepared the study, with contributions from David Auerbach, under the supervision of Bruce Vavrichek and James Baumgardner. Carol Frost provided assistance with data and tabulations. Tom Bradley, Philip Ellis, Timothy Gronniger, Arlene Holen, and Allison Percy, also of CBO, provided comments on drafts, as did Bryan Dowd of the University of Minnesota and Robert Reischauer of the Urban Institute. (The assistance of external reviewers implies no responsibility for the final product, which rests solely with CBO.)

Christine Bogusz edited the study, and Kate Kelly proofread it. Maureen Costantino prepared the study for publication and designed the cover. Lenny Skutnik printed the initial copies, and Simone Thomas produced the electronic version for CBO’s Web site (www.cbo.gov).



Donald B. Marron
Acting Director

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Summary and Introduction

Under current policies, federal spending on Medicare will increase substantially in the coming decades, exerting significant strains on the federal budget.¹ The growth in Medicare spending will come from two sources: an increase in the number of elderly and disabled people and growth in costs per beneficiary. If past trends continue, the growth in costs per beneficiary will be a more important driver of future growth in Medicare spending, causing that spending to increase much more rapidly than enrollment.

Policymakers and analysts have offered various proposals aimed at limiting the growth of Medicare spending and making the program more efficient. One approach that has received attention in the Congress and the policy community would convert Medicare into a “premium support” system. Under such a system, the federal government would contribute an amount that beneficiaries could use to purchase Medicare coverage either by enrolling in the traditional fee-for-service (FFS) part of the program or in a private plan. The government’s contribution would be based on the bids of competing plans or set at a predetermined amount. Beneficiaries who enrolled in plans whose premiums exceeded the government’s contribution would be responsible for paying the difference between the two, while those who enrolled in lower-cost plans would receive additional benefits or a rebate. An important feature of this system is that Medicare’s fee-for-service part of the program would compete for enrollees on the same terms—its bid, as well as the quality of services it provides—as private plans. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 mandated that the government conduct a six-year demonstration of premium support in up to six metropolitan areas beginning in 2010.

Proponents of premium support proposals point to several advantages. Depending on how the government’s contribution was determined, such a system could restrain federal spending on Medicare (that is, spending after subtracting the premiums that beneficiaries pay to the government). Moreover, proponents assert, premium support could reduce total systemwide spending on Medicare benefits (including beneficiaries’ premiums and cost sharing) by stimulating greater price competition among plans and making beneficiaries more cost-conscious in their choice of plans. In that way, proponents maintain, premium support could lead to a more efficient Medicare program, one in which the government and beneficiaries received more for the money that is spent on Medicare, whatever that level of spending might be, than they do today.

Opponents of premium support proposals have voiced several concerns, however. One is that some beneficiaries who stayed in the traditional FFS program could see their premiums increase sharply, even if they do not have a private plan available in their area or do not consider it a desirable option for receiving their medical care. Another concern is that the traditional program might attract the sickest enrollees, which could raise the average beneficiary’s premium for that program because methods of adjusting the government’s contribution to account for differences in beneficiaries’ health status are inadequate. Opponents also maintain that much of the federal savings from premium support would come from increases in the premiums paid by beneficiaries, not from increases in the efficiency of health care delivery.

This Congressional Budget Office study examines the key decisions that policymakers would confront in designing a premium support system for Medicare and the implications of alternative design choices for government spending and beneficiaries’ premiums. In the following chapters, this study describes the current Medicare program

1. Congressional Budget Office, *The Long-Term Budget Outlook* (December 2005).

and the payment system now used to pay private plans; explains how premium support would differ from payment structures under current law; reviews the available evidence on the experiences of other payers, such as university systems, that have adopted comparable payment systems for health care services; and concludes with a simulation analysis that examines the potential effects of selected design options on Medicare spending and beneficiaries' premiums. The rest of this chapter summarizes some of that information.

Background on Medicare

Medicare provides federal health insurance for 42 million elderly and disabled people. The funding for the program comes primarily from a payroll tax, general revenues, and premiums paid by beneficiaries.

Most Medicare beneficiaries receive their care through the fee-for-service program, which pays providers for each service (or bundle of services) they provide. About 17 percent of beneficiaries are enrolled in private health plans (termed Medicare Advantage plans) that assume financial risk and responsibility for providing Medicare benefits.

Private plans that want to participate in Medicare submit bids indicating the per capita payment for which they are willing to provide the package of benefits that Medicare covers.² The government's maximum payment for an enrollee in a private plan—which is called the “benchmark” and varies geographically—is established by statutory rules and made public each year before the plans submit their bids. Plans whose bids exceed the government's maximum (benchmark) payment receive a payment from the government equal to the benchmark and must charge enrollees the additional cost (as an add-on to their regular monthly Medicare premium). Plans whose bids are less than the benchmark are paid the amount of their bid, plus 75 percent of the difference between that bid and the benchmark, for each person they enroll (see Table 1-1). Those plans are required to return the extra 75 percent to beneficiaries in the form of additional benefits or as a rebate on their Medicare premium. (The government retains the other 25 percent.)

2. This discussion focuses on the bids that plans submit for providing all Medicare services except the new prescription drug benefit. (Plans submit separate bids for the drug benefit.)

The additional benefits and premium rebates offered by most private plans provide a major incentive to beneficiaries to enroll in those plans: for each \$1 per month that a plan's bid is less than the federal benchmark in its area, enrollees in the plan receive 75 cents in additional benefits or lower premiums (or some combination of the two). That structure gives private plans an incentive to provide Medicare benefits efficiently, because the lower their bid is relative to the benchmark in their area, the greater the additional benefits and premium rebates they can offer to their enrollees.

The maximum government payment per enrollee in a private plan is set at the county level each year by statutory rules that are based in part on a payment mechanism that was established in 1997 and subsequently modified. Under those rules, the benchmark in each county must be at least as high as average per capita FFS spending there. In many counties, the benchmark is higher than per capita FFS spending, in some cases substantially so. For 2006, the benchmark is about 11 percent higher, on average, than is per capita FFS spending nationwide.

Although the current payment system for Medicare Advantage plans has some elements of a premium support system, it diverges from such a system by treating private plans differently from the FFS program. Currently, beneficiaries who receive their care in the FFS program pay a monthly premium for that coverage equal to a percentage of national per capita Medicare spending that is specified in law. Beneficiaries who enroll in private plans receive a rebate or pay a surcharge, depending on whether their plan's bid is below or above a benchmark that is constrained to be at least as high as local per capita FFS spending. Under a premium support system, in contrast, the FFS program would be treated on the same basis as private plans. The government's contribution would either be determined from plans' bids—with the “bid” of the FFS program treated in the same manner as the bids of private plans—or set at a predetermined level. Consequently, enrollees in the FFS program could be required to pay higher or lower premiums than they would face under current law, depending on the bid of the FFS program. By incorporating those differences, and allowing a potentially more flexible benefit package (as discussed below), premium support proponents have attempted to construct a system to expand the role of competition in the operation of the entire Medicare program.

Table 1-1.
The Bidding Mechanism in the Medicare Advantage Program

Plan's Bid Relative to the Benchmark	Medicare Program's Payment		Additional Premium Paid by Enrollees
	Retained by the Plan	Returned to Enrollees as Additional Benefits or Premium Rebates	
Bid Equals Benchmark	Bid	Zero	Zero
Bid Is Less Than Benchmark	Bid	75 Percent of the Difference Between Bid and Benchmark	Zero
Bid Is Greater Than Benchmark	Benchmark	Zero	Difference Between Bid and Benchmark

Source: Congressional Budget Office.

Note: The benchmark is the government's maximum payment for an enrollee in a private plan. The benchmark for each plan is a weighted average of the benchmarks for the counties in its service area, with each county weighted by the proportion of the plan's enrollees who live there. Benchmarks are determined by statutory rules that guarantee that they will be at least as high as per capita fee-for-service spending in every county. In some counties, benchmarks are substantially higher than fee-for-service spending.

Issues in Designing a Premium Support System for Medicare

Instituting a premium support system for Medicare would affect the amount of money the federal government spent on the program and the level of premiums charged to beneficiaries. Key design choices include the mechanism for setting the government's contribution and the requirements the government would impose for the benefit package.

The Government's Contribution

The government's contribution toward beneficiaries' purchase of Medicare coverage under a premium support system could follow two general approaches: it could be determined from the bids of competing health plans or set at a predetermined amount.

The competitive-bidding approach could be adopted by modifying the current Medicare Advantage program in two ways. First, the benchmarks could be determined from the bids of participating plans instead of from the current statutory rules. Second, to apply the influences of competition more broadly in the program, the fee-for-service part of the program could be designated as one of the bidding plans, with projected per capita FFS spending in each county used as that plan's bid. The premium for beneficiaries who enrolled in a plan whose bid was

equal to the benchmark could remain the same as the current Medicare premium, or it could be set at a specified percentage of the benchmark.

As in the current Medicare Advantage program, beneficiaries who enrolled in a plan whose bid was above the benchmark would pay the regular Medicare premium plus an additional premium equal to the difference between the bid and the benchmark, whereas those who enrolled in a plan whose bid was below the benchmark could receive some or all of the difference as a premium rebate or in additional benefits. A key difference between the competitive-bidding approach and the current program is that beneficiaries who enrolled in the FFS program would have to pay the regular Medicare premium plus a premium surcharge if they lived in an area where the bid of that program (the average projected FFS spending per beneficiary) was above the benchmark, and they would pay a lower premium if the bid of the FFS program was below the benchmark.

The effects of a competitive-bidding approach to premium support would depend to a great extent on how the benchmarks were determined from the bids. Many options are possible, such as setting benchmarks equal to the minimum bid in each market area, the average or median bid in each market area, or the national average bid. (Setting the benchmark equal to the minimum bid

in each market area is analogous to the managed competition purchasing strategy that some employers have adopted.)³

In the second general approach to premium support, the federal government would decide in advance how much to spend on the Medicare program each year and set its contribution at a level that would meet that target. The main advantage of this approach is that it would give the federal government direct control over the amount that it spent on Medicare. However, because the federal contribution would be determined on the basis of budgetary criteria rather than the bids of competing health plans, it may not grow at the same rate as plans' costs of providing Medicare benefits under the same standards of medical care that are typical in the privately insured population.

If the government's contribution was determined from the national average bid of competing plans or set at a predetermined amount, a key design choice would be the extent to which it would be adjusted to account for geographic variation in per capita Medicare spending, which is substantial. In 2005, 10 percent of beneficiaries lived in counties in which average spending in the FFS program was over \$700 per month, while another 10 percent lived in counties in which average FFS spending was less than \$500 per month. The main source of that variation in spending is geographic variation in the level and intensity of service utilization.⁴ Other contributing factors are geographic variation in the health status and other characteristics of beneficiaries and variation in Medicare's payment rates. The government adjusts Medicare's FFS payment rates to account for geographic differences in the prices of inputs that are used to provide Medicare services (such as wages and office rents) and also adjusts payments for certain types of providers (such as teaching hospitals and those that serve a high proportion of low-income people).

The government's contribution could be adjusted to account for some or all of the sources of geographic variation in Medicare spending. For example, adjustments could account only for differences in beneficiaries' health status and input prices across areas or, alternatively, could also account for geographic differences in beneficiaries'

utilization of services. One rationale for excluding geographic differences in service utilization from the adjustment is that the higher rates of utilization in high-spending areas do not appear to improve the quality of care that beneficiaries receive or their health outcomes.⁵

The Benefit Package

Another key design choice under premium support would be whether the government would define a standard Medicare benefit package that all participating plans would be required to offer or whether plans would be allowed to vary their benefit packages and, if so, by how much. A standard benefit package offers three advantages: first, in a system in which benchmarks were determined from plans' bids, it would help assure the fairness of the bidding process because all plans would bid on the same product; second, it would make it easier for beneficiaries to compare their premiums across plans and for the government to educate them about their options; and third, it would prevent plans from designing their benefit packages to discourage enrollment by beneficiaries with medical conditions that are costly to treat. (Another way to reduce plans' incentive to design their benefit packages to limit the enrollment of beneficiaries who have costly medical conditions would be for the government to adjust its contribution for the health status of a plan's enrollees.)

Standardization of benefits would have two important disadvantages, however. It would prevent plans from developing innovative benefit designs that might lead to more efficient delivery of care, and it would prevent plans from offering benefit packages that some beneficiaries might prefer to a standard package specified by the government. Indeed, allowing plans to offer varying benefit designs is one of the sources of increased efficiency that some proponents envision under a system of premium support.

Several alternatives to benefit standardization are possible. For example, under the competitive-bidding approach, plans could be allowed to vary their benefit package as long as it was actuarially equivalent to a specified package. That alternative would help ensure the fairness of the bidding process while avoiding some of the disadvantages of benefit standardization. Under a system in which the government's contribution was set at a pre-

3. Alain C. Enthoven, "The History and Principles of Managed Competition," *Health Affairs*, supplement (1993), pp. 24–48.

4. John E. Wennberg, Elliott S. Fisher, and Jonathan S. Skinner, "Geography and the Debate Over Medicare Reform," *Health Affairs*, Web exclusive (February 13, 2002).

5. Ibid.

determined amount, plans could be given even greater flexibility in the design of their benefit package, because the absence of a formal bidding mechanism would lessen the need for actuarial equivalence. An important design choice in that case would be what minimum coverage requirements the federal government would specify.

Potential Effects of Premium Support

The effects of premium support on Medicare spending and beneficiaries' premiums are highly uncertain, primarily because of uncertainty about how health plans and beneficiaries would respond to the new incentives. Although information is available on the bids that private plans submit under the Medicare Advantage program, the incentives created by premium support might induce some plans to submit lower bids than they do currently. There is little basis for predicting the magnitude of any such effect, however. Moreover, the limited evidence that is available on the responsiveness of Medicare beneficiaries to changes in premiums pertains primarily to relatively small changes, which may not provide a reliable guide for predicting beneficiaries' responses to the larger changes that might occur under some approaches to premium support.

Despite the uncertainty about the effects of premium support, several general conclusions can be drawn.⁶ Among the approaches to premium support that are based on competitive bidding, setting benchmarks equal to the minimum bid in each market area would generate the greatest federal savings and the highest increase in premiums in certain areas for beneficiaries who wanted to remain in the FFS program. The main source of federal savings would be lower federal contributions on behalf of enrollees in the FFS program. Most beneficiaries are currently enrolled in that program, and many live in areas where the benchmarks set under the minimum-bid approach would be lower than per capita FFS spending. In addition, the federal contributions on behalf of enrollees in private plans would fall because benchmarks under the minimum-bid approach would be lower than the benchmarks currently established for the Medicare

Advantage program. The effects of such a system on total spending for Medicare benefits (including the premiums paid by beneficiaries) would depend on the extent to which beneficiaries switched to less expensive plans, but the extent of that response is highly uncertain.

Under the minimum-bid approach to setting benchmarks, the greatest reduction in federal spending would occur in areas where per capita FFS spending is high, and beneficiaries who live in those areas would probably face substantially higher premiums if they remained in the FFS program. Private plans are more likely to submit bids that are lower than per capita FFS spending in areas where such spending is high because those areas tend to have high rates of service utilization in the FFS program, and reductions in service utilization are a key mechanism through which private plans seek to achieve savings. In contrast, the FFS program is likely to be the lowest-bidding plan in areas where FFS spending is low, so beneficiaries in those areas would not be required to pay higher premiums if they wanted to remain in the traditional program. In all areas, the additional benefits and premium rebates that are available to enrollees in private plans would be eliminated because, by definition, no plan's bid would be lower than the benchmark.

Setting benchmarks equal to the average bid in each market area (with each plan's bid weighted by its enrollment in the previous year) would yield much smaller federal savings than would the minimum-bid approach. The sources of federal savings would be the same—namely, lower federal contributions for enrollees in the FFS program and for enrollees in private plans—but the benchmarks would be much higher than under the minimum-bid approach. Consequently, setting benchmarks equal to the average bid in each area would result in much smaller increases in premiums for beneficiaries who wanted to remain in the FFS program and smaller reductions in the additional benefits and premium rebates that would be available to enrollees in private plans.

The effect of setting benchmarks equal to the national average bid would depend on the extent to which benchmarks were adjusted to account for geographic variation in per capita Medicare spending. Some policymakers and analysts have recommended that the benchmarks in such a system be adjusted to account for geographic variation in input prices and beneficiaries' health status but not for

6. Those conclusions are based on the results of a simulation analysis presented in Chapter 5 of this study, which examines the potential effects of premium support under a range of assumptions about the responses of plans and beneficiaries.

geographic variation in service utilization.⁷ That approach would result in benchmarks that are considerably lower than per capita FFS spending in areas where such spending is high and considerably higher than per capita FFS spending in areas where such spending is low.

7. That approach to geographic adjustment was contained in the premium support proposal that was included in the Medicare Preservation and Improvement Act of 2001 (S. 357).

Consequently, the premiums for beneficiaries who remained in the FFS program would increase substantially in the highest-spending areas and decline significantly in the lowest-spending areas. Benchmarks under such a system would be lower than the benchmarks established under the Medicare Advantage program, so the additional benefits and premium rebates available to enrollees in private plans would decline.

Traditional Medicare and Private Health Plans

Medicare provides federal health insurance for 42 million people who are aged or disabled or who have end-stage renal disease. Part A of Medicare (Hospital Insurance) covers inpatient services provided by hospitals as well as skilled nursing and hospice care. Part B of Medicare (Supplementary Medical Insurance) covers services provided by physicians and other practitioners, hospitals' outpatient departments, and suppliers of medical equipment. Home health care may be covered by either Part A or Part B. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a voluntary prescription drug benefit beginning in 2006 under Part D.

Part A benefits are financed primarily from a payroll tax. Premiums paid by beneficiaries currently cover about 25 percent of the costs of the Part B program, and the rest comes from general revenues.¹ Those Part B premiums are currently about 11 percent of the total combined cost of the Part A and Part B programs. Enrollees' premiums under Part D are set at a level to cover about one-quarter of the cost of the basic prescription drug benefit, but receipts from premiums will cover less than one-quarter of the total cost of the Part D program because some of the costs of that program (such as subsidies for low-income beneficiaries and for employers that maintain drug coverage for their retirees) are not included in the calculation of premiums.

The majority of Medicare beneficiaries receive services through the traditional fee-for-service part of the program. The rest (about one-sixth) are enrolled in private health plans. This chapter briefly discusses traditional

Medicare and examines private plans in more detail, describing the payment system for private plans, the costs of those plans relative to the costs of traditional Medicare, and the sources of geographic variation in plans' costs.

The Fee-for-Service Program

Most Medicare beneficiaries receive their care in the fee-for-service program, which pays providers for each covered service (or bundle of services) they provide. The FFS program is popular with beneficiaries because, unlike many private insurance plans, it does not restrict their choice of providers and does not require prior authorization for any covered service.

The FFS program has several inefficiencies, however. To begin with, it is likely that beneficiaries who are enrolled in the program receive services whose costs exceed their benefits, for two reasons: the program gives providers incentives to increase the volume of services they deliver, and the out-of-pocket costs beneficiaries face are typically much lower than the total costs of providing the services. In addition, the FFS program does not give providers incentives to coordinate the care of beneficiaries who obtain services from multiple providers. Consequently, many beneficiaries—especially those with multiple chronic conditions—may receive care that is fragmented and inefficient.

The government has implemented changes to improve the efficiency of care delivery in the FFS program. For example, in 1983, Medicare replaced its cost-based reimbursement mechanism for inpatient hospital care with a prospective payment system in which the payment for each hospital stay is based on a patient's diagnosis (and, in some cases, on whether certain procedures are performed). That system is designed to encourage hospitals to provide care during each inpatient stay as efficiently as possible. Medicare subsequently implemented

1. Premiums will cover a somewhat higher proportion of Part B costs in the future because premiums for high-income beneficiaries will be increased beginning in 2007. Higher premiums will be required of single beneficiaries with annual income over \$80,000 and couples with annual income over \$160,000 in 2007. Those income thresholds will be indexed to inflation in future years.

prospective payment systems for hospital outpatient departments, home health agencies, and skilled nursing facilities. Although those systems encourage providers to use resources efficiently for each bundle of services for which payment is made (such as a hospital stay), they do not limit providers' incentives to increase the number of "service bundles" they provide. Moreover, they do not address inefficiencies associated with the lack of coordination of care across providers.

Beneficiaries must pay a portion of the costs of their care through deductibles and coinsurance. Cost-sharing liabilities can be substantial for some beneficiaries, in part because Medicare does not include an annual cap on beneficiaries' cost sharing, as many private plans do. Nearly 90 percent of beneficiaries who receive care in the FFS program have supplemental insurance that covers many or all of Medicare's cost-sharing requirements. The most common sources of supplemental coverage are retiree plans offered by former employers (held by 38 percent of beneficiaries in the FFS program), individually purchased Medigap policies (34 percent), and Medicaid (16 percent).² Supplemental insurance substantially reduces beneficiaries' exposure to financial risk. By largely insulating beneficiaries from the financial consequences of their treatment decisions, however, such coverage leads to greater utilization of services and higher Medicare spending.

Private Health Plans

In nearly all areas of the country, Medicare beneficiaries have the option of enrolling in Medicare Advantage—the program through which private plans participate in Medicare—rather than receiving their care through the fee-for-service program.³ As of October 2006, about 17 percent of beneficiaries were enrolled in private health plans, which accept responsibility and financial risk for providing Medicare benefits.⁴ Although the payment system for private plans has been modified several times dur-

ing the more than 20 years that they have participated in Medicare, a key feature of the system has remained intact: plans that can provide Medicare benefits at a cost below their payment from the government are required to give enrollees additional benefits or, in an option that became available recently, rebates on their Part B or Part D premiums.⁵ The additional benefits and rebates are a major incentive for beneficiaries to enroll in Medicare Advantage plans.

About 75 percent of the Medicare beneficiaries enrolled in private plans are in health maintenance organizations (HMOs). The other main types of available plans are local preferred provider organizations (PPOs), regional PPOs, and private fee-for-service (PFFS) plans. Both HMOs and PPOs have comprehensive networks of providers. Some HMOs offer coverage for services received outside their network (and thus resemble PPOs, which allow beneficiaries to obtain care outside the network if they pay a higher amount), while others require that their enrollees receive all of their nonemergency care within the network. Regional PPOs, an option that became available in 2006, are required to serve broad regions of the country rather than define their service areas on a county-by-county basis, as local PPOs do. PFFS plans allow their enrollees to obtain care from any provider who will furnish it.

As of 2006, 80 percent of beneficiaries live in a county served by an HMO or a local PPO, up from 67 percent in 2005.⁶ Nearly all beneficiaries who do not have access to an HMO or local PPO have access to a PFFS plan or a regional PPO.

The number of private plans that participate in Medicare varies across geographic areas. In 2005, HMOs participated in Medicare in about one-quarter of U.S. counties, although those counties account for about two-thirds of the national Medicare population. About 14 percent of counties had one HMO that participated in Medicare in 2005, 10 percent had two or three HMOs, 3 percent had four or five HMOs, and less than 1 percent had more than five HMOs.

2. Medicare Payment Advisory Commission, *A Data Book: Healthcare Spending and the Medicare Program* (June 2006).

3. The program through which private plans participate in Medicare is also called Part C. Previously, the program had been called Medicare+Choice.

4. Another 1 percent of beneficiaries were enrolled in private plans that are paid on a cost-reimbursement basis. Those plans are not included in this study.

5. Plans have had the option of giving their enrollees a rebate on their Part B premium since 2003. Beginning in 2006, plans can also offer a rebate on the Part D premium.

6. Medicare Payment Advisory Commission, *Report to the Congress: Increasing the Value of Medicare* (June 2006), p. 206.

The Payment System for Private Health Plans

The latest changes to the payment system for private health plans were mandated by the Medicare Modernization Act. The modified payment system is largely similar to the previous system, as are the incentives facing plans and beneficiaries.

Beginning in 2006, private plans that want to participate in Medicare must submit bids indicating the per capita payment for which they are willing to provide Medicare's Part A and Part B benefits.⁷ The government compares those bids with county-level benchmarks that are determined in advance through statutory rules. The benchmarks are the maximum payment that the government will make for enrollees in private plans. (The benchmark for a plan that serves more than one county is an enrollment-weighted average of the county-level benchmarks in its service area.) Plans are paid their bids (up to the benchmark) plus 75 percent of the amount by which the benchmark exceeds their bid. Plans must return that 75 percent to beneficiaries as additional benefits or as a rebate on their Part B or Part D premium. Plans whose bids are above the benchmark are required to charge enrollees the full difference between the bid and benchmark as an additional premium for the Medicare benefit package.⁸

Under current law, benchmarks are required to be at least as great as per capita FFS expenditures in every county and are higher than FFS expenditures in many counties. For 2006, benchmarks are 11 percent higher, on average, than projected per capita FFS expenditures nationwide. Benchmarks are updated each year by either the amount of growth in national per capita Medicare spending or 2 percent, whichever is greater.⁹

The benchmarks for 2006 were derived from the payment rates for private plans that were established by the

Balanced Budget Act of 1997 (BBA) and modified through subsequent legislation. Under the BBA, the payment rate in each county was the greatest of three amounts: a minimum or "floor" rate, a blend of a local rate and the national average rate, and a minimum increase from the previous year's rate (which was equal to 2 percent in most years).¹⁰ The BBA rules resulted in rates in some counties that were higher—in some cases, by a substantial amount—than local per capita spending in the FFS program. In other counties, however, the update mechanism resulted in payment rates that were lower than local per capita FFS spending. (In counties where payment rates were below FFS spending, the benchmarks were raised to meet the MMA's requirement that the benchmark in each county be at least as great as local per capita FFS spending.)

Despite some differences in terminology, the bidding mechanism established by the MMA is analogous to the payment system that was already in place. Under the previous system, private plans that participated in Medicare were required to submit a projection of their per capita revenue requirement for delivering Medicare's covered benefits, which was called the adjusted community rate (ACR). If a plan's ACR was less than its projected per capita payment from Medicare, it was required to return the difference to enrollees in the form of additional benefits or as a rebate on their Part B premium. If the difference was returned in the form of additional benefits, the cost of those benefits to the plan had to be equal to the entire difference between the plan's ACR and its payments from Medicare. If the difference was returned in the form of a rebate on the Part B premium, the Medicare program retained 20 cents for every dollar the plan used to provide the rebate, and enrollees received the other 80 cents. In contrast, under the payment mechanism that went into effect in 2006, beneficiaries receive 75 cents for

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7. Plans must also submit bids for the voluntary prescription drug benefit and their premiums for any supplemental benefits they intend to offer.
 8. The description of the MMA payment mechanism in this section pertains to plans that participate in Medicare on a county-by-county basis (or "local" plans). The payment mechanism for regional PPOs is analogous to the mechanism described here for local plans but uses a modified approach to compute benchmarks. See Medicare Payment Advisory Commission, *Report to the Congress: Issues in a Modernized Medicare Program* (June 2005), pp. 59-81.

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9. The MMA also requires that the government "rebase," or re-estimate, per capita FFS expenditures in each county at least once every three years using the most current data available. In those years in which rebasing occurs, the benchmark for each county will be the greater of the rebased per capita FFS expenditure or the update from the previous year's rate.
 10. Prior to enactment of the BBA, county-level payment rates for private plans had been set equal to 95 percent of projected average per capita spending in the FFS program. For a description of that payment mechanism and the modifications that were mandated by the BBA, see Sandra Christensen, "Medicare+Choice Provisions in the Balanced Budget Act of 1997," *Health Affairs*, vol. 17, no. 4 (July/August 1998), pp. 224-231.

every dollar of difference between the plan's bid and the benchmark, regardless of whether it is given in the form of additional benefits or premium rebates, and the government retains the other 25 cents.

The Costs of Private Health Plans and Traditional Medicare

The Congressional Budget Office (CBO) analyzed how private health plans' costs of delivering Medicare benefits under the incentives created by the Medicare Advantage program compare with the costs of the traditional FFS program. CBO compared plans' projected per capita costs of providing Medicare benefits as reported in their 2005 ACR submissions (including administrative costs and normal profits) with average per capita FFS expenditures in their service areas.¹¹ Because differences between private plans and the FFS program in the costs of delivering Medicare benefits may partially reflect differences in their enrollees' health status, CBO adjusted plans' costs—by using risk scores from the Hierarchical Condition Codes (HCC) model—to try to remove those differences.

Adjusting Costs for Differences in Health Status. The HCC model uses diagnoses and demographic characteristics in a given year to assign each beneficiary a risk score that measures his or her predicted expenditure in the following year relative to the national average. The higher the risk score, the higher the beneficiary's predicted expenditure in the following year. (A beneficiary whose predicted spending is equal to the national average has a risk score of 1.0.) CBO used those estimated risk scores for enrollees in private plans to adjust plans' reported costs to reflect the costs that they would have incurred for a "standard beneficiary"—that is, a beneficiary whose predicted expenditures are equal to the national average. The county-level estimates of per capita spending in the FFS program obtained from the Centers for Medicare and Medicaid Services (CMS) also reflect the projected spending for a standard beneficiary.

Although HCC risk scores were the best method available for this study to measure beneficiaries' relative health status, there is uncertainty about how well they do so. The

Medicare program began phasing in the HCC model for adjusting payments to private plans in 2004, so experience with the new system has been limited.¹² Moreover, in the two most recent years for which data are available (2003 and 2004), the average risk score for enrollees in private plans increased significantly relative to the average risk score for beneficiaries in the FFS program, even though there was little change during that period in the composition of the private plans that participate in Medicare or in their enrollment. Risk scores for private-plan enrollees estimated from 2003 data were about 12 percent lower than risk scores for enrollees in the FFS program, on average. That difference narrowed to about 6 percent when risk scores were computed using 2004 data.¹³

It is not known why risk scores for enrollees in private plans increased during that two-year period. Private plans may have become better at collecting and reporting diagnostic information on their enrollees, which they have a strong incentive to do because they receive higher payments for enrollees with greater expected costs. (In the FFS program, by contrast, physicians have a limited incentive to ensure that all diagnoses are fully reported on their claims because the extent to which diagnoses are reported does not influence their payment.) If private plans and FFS providers differ systematically in how completely they report their diagnostic information, risk scores computed from that information could give a biased measure of the relative health status of enrollees in

11. CBO received data on the bids that plans submitted for 2006 after it had completed the analysis. The ratios of the 2006 bids to local spending in the FFS program are very similar to the corresponding ratios estimated from plans' costs reported in the 2005 ACR submissions, so using the bid data would not have affected the basic conclusions of the analysis.

12. In 2004, payments computed using the HCC risk adjuster accounted for 30 percent of plans' total payments, with the remaining 70 percent determined by a risk-adjustment formula that relies on enrollees' demographic characteristics. The share of plans' total payments that is determined by the HCC risk adjuster increased to 50 percent in 2005 and 75 percent in 2006, and it is scheduled to reach 100 percent in 2007 and later years. However, through 2006, CMS applied a "budget-neutrality" adjustment to HCC-based payments to ensure that, in the aggregate, plans received the same payments that they would have received if CMS had paid them using the adjuster that considers only demographic characteristics. Thus, aggregate payments to plans were not affected by the phased implementation of the HCC risk adjuster, although payments to individual plans were affected. The Deficit Reduction Act of 2005 requires that the budget-neutrality adjustment be phased out beginning in 2007.

13. CBO obtained risk scores based on 2003 data from plans' ACR submissions for 2005 (which were submitted in mid-2004). Average county-level risk scores based on 2004 data for private-plan enrollees were provided by CMS.

Table 2-1.

Private Plans' Per Capita Costs of Providing Medicare Benefits Relative to Those of the FFS Program, 2005

Average Per Capita FFS Expenditure Per Month in County (Dollars)	Percentage of Private-Plan Enrollees	Average Ratio of Plans' Costs to Per Capita FFS Expenditures	
		Using 2004 Risk-Adjustment Data	Using 2003 Risk-Adjustment Data
Less Than 550	14.2	1.21	1.29
550 to 599	20.1	1.08	1.16
600 to 649	23.4	1.00	1.08
650 to 699	15.3	1.01	1.09
700 and Higher	27.0	0.92	1.02
National Average	n.a.	1.03	1.11

Source: Congressional Budget Office based on data submitted by private plans to the Medicare program for 2005.

Notes: FFS = fee for service; n.a. = not applicable.

The estimates measure plans' projected costs of providing Medicare benefits, including administrative costs and profits. Plans' costs and FFS expenditures were standardized using risk scores from the Hierarchical Condition Codes model, which measures differences in beneficiaries' health status and characteristics. Estimates are presented under two different assumptions about the risk scores of private-plan enrollees, based on estimates generated from 2003 data and 2004 data. For each U.S. county, the average plan cost is the enrollment-weighted average of the county-level cost of the plans that serve the county. Only counties that had plans in 2005 were included in the analysis. Each county was weighted by the number of private-plan enrollees who live there.

private plans and those in the FFS program. The Deficit Reduction Act of 2005 requires that CMS compare the diagnostic coding patterns of private plans and FFS providers and, if important differences are found, appropriately adjust the payments to private plans.

Because of uncertainty about how well the available estimates of risk scores measure the relative health status of enrollees in private plans and those in the FFS program, CBO conducted the analysis of plans' costs under two different assumptions, corresponding to the 2004 risk-adjustment data and the 2003 data. The analysis focused on HMOs, which have lower costs relative to spending in the FFS program than the other types of Medicare Advantage plans.

Private Plans' Adjusted Costs per Enrollee. Using 2004 risk-adjustment data, CBO estimates that private plans' adjusted costs per enrollee of delivering Medicare benefits in 2005 were an average of 3 percent higher than those of the FFS program (see Table 2-1). The costs of private plans relative to those of the FFS program varied greatly across geographic areas, though. For example, private plans' costs were lower relative to FFS expenditures in areas where FFS spending is high. On a per capita basis,

private plans' adjusted costs averaged 8 percent lower than FFS expenditures in the highest-spending counties (those with per capita FFS spending of at least \$700 per month) but 21 percent higher than FFS expenditures in the lowest-spending counties (those with per capita FFS spending of less than \$550 per month).¹⁴

Using 2003 risk-adjustment data, CBO estimates that private plans' adjusted costs per enrollee of delivering Medicare benefits in 2005 were an average of 11 percent higher than those of the FFS program (see Table 2-1).¹⁵ Private plans' adjusted costs per enrollee averaged 2 percent higher than per capita FFS expenditures in the highest-spending counties and 29 percent higher than per capita FFS expenditures in the lowest-spending counties.

14. ACR filings contain data at the plan level and are not broken out by county. CBO's approach to estimating plans' costs at the county level is described in Appendix A.

15. Plans' adjusted costs per enrollee are higher when 2003 risk-adjustment data are used because estimates from the 2003 data, relative to estimates from the 2004 data, imply that enrollees in private plans are healthier. Consequently, removing the influence of differences in health status from the comparison between plans' costs and costs of the FFS program has a bigger effect when the 2003 risk-adjustment data are used.

Private plans are able to participate in Medicare even if their costs are greater than those of the FFS program because their payment rates are higher than per capita FFS expenditures. Among the areas that were served by private plans in 2005, those payment rates were 26 percent higher than per capita FFS expenditures in the lowest-spending counties, on average, and 4 percent higher than per capita FFS expenditures in the highest-spending counties.¹⁶ Roughly 14 percent of Medicare Advantage enrollees live in the lowest-spending counties, while 27 percent live in the highest-spending counties.

Sources of Geographic Variation in Costs

Private plans' costs relative to FFS expenditures vary greatly across geographic areas. That variation generally depends on the net effect of three factors:

- The administrative costs of private plans relative to those of FFS Medicare;
- The level and intensity of beneficiaries' use of services in private plans relative to their use of services in the FFS sector; and
- The payment rates that providers receive from private plans relative to the rates they receive from FFS Medicare.

Administrative Costs. Private health plans that participate in Medicare have higher administrative costs per enrollee than the traditional Medicare program because of their smaller scale of operations and their costs associated with marketing, utilization management, network development and retention, and reinsurance. Administrative costs and return on investment account for about 11 percent of private plans' costs of delivering Medicare benefits, whereas the administrative costs of the fee-for-service Medicare program (as reported by CMS) account for less than 2 percent of its expenditures.¹⁷ There is some disagreement among analysts about the size of that differ-

ence in costs, however. Some analysts contend that the latter estimate understates the administrative costs of the Medicare program because it excludes some costs that should be allocated to Medicare, such as portions of the salaries of legislators, legislative staff, and CMS administrators; depreciation on certain federal office buildings; and the costs of collecting Medicare premiums and payroll taxes.¹⁸ Following that reasoning, however, a portion of those additional costs should also be allocated to the Medicare Advantage program.

The higher administrative costs of private plans do not imply that those plans are less efficient than the traditional FFS program. Some of the plans' administrative expenses are for functions, such as utilization management and quality improvement, that are designed to increase the efficiency of care delivery. The main point for this analysis is that, because of their higher administrative costs, private plans can provide Medicare services at a lower cost than the FFS program only if they can achieve savings through lower service utilization or reductions in provider payment rates that more than offset their higher administrative costs. The ability of plans to achieve such savings varies greatly across geographic areas.

Service Utilization. Prior research on the effects of private plans on service utilization has focused primarily on comparing HMOs with other types of plans (mainly indemnity plans and PPOs). That research suggests that, in general, HMOs keep their medical costs down by reducing the level and intensity of service utilization, particularly by limiting their enrollees' use of services such as visits to specialists, inpatient hospital care, costly tests and procedures, and services in intensive care units.¹⁹ HMOs use various approaches to reduce the costs of health care in general, such as contracting with low-cost providers, giving primary care physicians responsibility for coordinating care, requiring prior authorization for certain services, giving providers financial incentives that discourage excessive use of services, and educating providers on prac-

16. In addition, the budget-neutrality adjustment described previously results in higher payments to plans than would have been the case if those payments had been adjusted to account for differences in beneficiaries' health status.

17. CBO computed the average administrative cost of Medicare Advantage plans from 2005 ACR data. Information on Medicare's administrative costs is available from the *2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (May 1, 2006), p. 5.

18. See Merrill Matthews, *Medicare's Hidden Administrative Costs: A Comparison of Medicare and the Private Sector* (Alexandria, Va.: Council for Affordable Health Insurance, January 10, 2006), available at www.cahi.org.

19. Robert H. Miller and Harold S. Luft, "HMO Plan Performance Update: An Analysis of the Literature, 1997-2001," *Health Affairs*, vol. 21, no. 4 (July/August 2002), pp. 63-86.

tice guidelines and offering feedback on their practice patterns.²⁰

On balance, the evidence suggests that the quality of care in HMOs is similar to that in other types of plans.²¹ The best information available, although limited, suggests that HMOs provide care to Medicare enrollees that is similar in quality to that provided to nonelderly enrollees who have employment-based coverage.²² Moreover, Medicare beneficiaries who are enrolled in HMOs report similar levels of satisfaction with their care as do beneficiaries who are enrolled in the FFS program. More research is needed, however, to draw more-definitive conclusions about how the quality of care received by Medicare beneficiaries in HMOs compares with that received by beneficiaries in the FFS program.

Private plans that participate in Medicare have much greater potential to achieve savings relative to the FFS program in geographic areas where FFS practice involves relatively high utilization of costly services—which also tend to be areas with high per capita FFS expenditures. Private plans have much less opportunity to achieve such savings in areas where utilization rates for expensive services in the FFS sector are already relatively low. Those areas tend to have low per capita FFS expenditures, which explains the findings presented in Table 2-1 showing that plans' costs are higher relative to FFS spending in areas where FFS spending levels are relatively low.

Providers' Payment Rates. Private health plans seek to reduce medical spending by contracting with providers who are willing to accept discounted payment rates in exchange for a greater number of patients. Even those discounted rates generally exceed the rates that FFS Medicare pays to providers, however. An analysis of claims data conducted for the Medicare Payment Advisory Commis-

sion found that, on average, private plans paid physicians about 20 percent higher rates than FFS Medicare paid in 2001.²³ In general, the fees that private plans pay physicians are slightly higher than Medicare's fees for office visits and other medical services but are substantially higher for major procedures, tests, and diagnostic imaging.

Differences between the rates paid to physicians by private plans and those paid by FFS Medicare also vary geographically. In the FFS program, payment rates for physicians vary to account for differences in providers' costs of inputs. Relative to FFS rates, the rates paid by private plans are higher in rural and small metropolitan areas than in large metropolitan areas. According to one study, the rates paid to physicians by private plans are an average of 30 percent higher than Medicare's FFS rates in small metropolitan areas and rural areas, 10 percent higher in medium-sized metropolitan areas, and 1 percent higher in large metropolitan areas.²⁴

Less information is available on how the hospital payment rates of private plans compare with those of FFS Medicare. In recent years, the rates that private plans pay hospitals have grown substantially, as hospitals have achieved much stronger bargaining positions relative to health plans.²⁵ The stronger negotiating positions of hospitals are the result of various factors, including hospital consolidations, strong consumer preferences that hospitals not be excluded from plans' networks, and high demand for hospital services relative to the available supply in some markets, which reduces hospitals' incentive to accept discounts.

20. In the late 1990s, some HMOs eliminated or scaled back their utilization management procedures in response to widespread dissatisfaction among consumers and providers. More recently, however, many of those plans have reintroduced such procedures and begun experimenting with new cost-containment strategies. See Glen P. Mays, Gary Claxton, and Justin White, "Managed Care Rebound? Recent Changes in Health Plans' Cost Containment Strategies," *Health Affairs*, Web exclusive (August 11, 2004).

21. Miller and Luft, "HMO Plan Performance Update."

22. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (March 2004), pp. 31-50.

23. Direct Research, LLC, *Medicare Physician Payment Rates Compared to Rates Paid by the Average Private Insurer, 1991-2001* (report prepared for the Medicare Payment Advisory Commission, August 2003).

24. Dyckman & Associates, *Survey of Health Plans Concerning Physician Fees and Payment Methodology* (report prepared for the Medicare Payment Advisory Commission, August 2003). In the analysis cited, small metropolitan areas are those with a population of less than 1 million, medium-sized metropolitan areas are those with a population of between 1 million and 3 million, and large metropolitan areas are those with a population of more than 3 million.

25. Justin S. White, Robert E. Hurley, and Bradley C. Strunk, *Getting Along or Going Along? Health Plan-Provider Contract Showdowns Subside*, Issue Brief No. 74 (Washington, D.C.: Center for Studying Health System Change, January 2004).

The payments that rural hospitals receive from private health plans exceed their associated costs by a much greater percentage than is true for urban hospitals.²⁶ In contrast, the payments that rural hospitals receive from FFS Medicare are lower relative to the hospitals' costs of providing the services than is true for urban hospitals.

26. Medicare Payment Advisory Commission, *Medicare in Rural America* (report to the Congress, June 2001).

Those findings are supported by industry sources who have reported that private plans typically must pay rates to hospitals and physicians in rural areas that far exceed Medicare's FFS rates because of the lack of competition among providers in such areas. That factor contributes to the higher relative costs reported for plans in counties where FFS expenditures are low, since those areas are more likely to be rural.

Issues in Designing a Premium Support System for Medicare

Concern about the projected growth of Medicare expenditures and the fiscal strains those expenditures will create under current policies has prompted some policy-makers and analysts to propose that Medicare be converted to a premium support system. Under such a system, the federal government would contribute an amount that beneficiaries could use toward the purchase of Medicare coverage, which they could obtain by enrolling in the fee-for-service program or a private health plan. The FFS program would compete on the same terms as private plans, and the projected average per capita cost of that program would be regarded as its premium. Beneficiaries who enrolled in plans whose premiums were higher than the government's contribution would be responsible for paying the difference between the two, whereas beneficiaries who enrolled in plans whose premiums were lower than the government's contribution could receive premium rebates or additional benefits.

Proponents maintain that, depending on how the government's contribution was determined, premium support could reduce net federal spending on Medicare.¹ Moreover, proponents say, such a system could reduce total spending on Medicare benefits (including beneficiaries' premiums and cost sharing) by stimulating greater price competition among plans and making beneficiaries more cost-conscious in their choice of plans.

This chapter examines the key issues that would have to be addressed in designing a premium support system for Medicare, including the mechanism for setting the government's contribution and the requirements for the benefit package. Decisions about those issues would have important implications for the effects of premium support on federal spending and beneficiaries' premiums.

The Government's Contribution

Under premium support, the government's contribution toward the cost of Medicare coverage could be determined from the bids of competing health plans or could be set equal to a predetermined amount. Those two approaches could have very different implications for federal spending on Medicare.

Determining the Government's Contribution from Plans' Bids

In a premium support system based on competitive bidding, plans would submit bids indicating the per capita payment for which they were willing to provide Medicare benefits. The government would compute benchmarks based on those bids and would pay plans their bids, up to the benchmark. Beneficiaries who enrolled in plans whose bids were equal to the benchmark would be required to pay a premium for their Medicare coverage (as they do now), which could be determined in various ways (see below). Beneficiaries who enrolled in plans whose bids were above the benchmark would be required to pay that premium plus an additional premium equal to the difference between their plan's bid and the benchmark. Beneficiaries who enrolled in plans whose bids were below the benchmark could receive some or all of the difference between their plan's bid and the benchmark as a premium rebate or additional benefits. Such a system would be similar to the current payment mechanism for the Medicare Advantage program, although it would differ in two important ways: the benchmarks would be determined from plans' bids (rather than set by statutory rules), and the FFS program would be one of the bidding plans.²

1. Net federal spending on Medicare is the amount that the federal government spends on the program after subtracting the premiums it collects from beneficiaries.

2. The projected per capita spending in the FFS program would be regarded as that program's bid.

One key choice in designing a premium support system based on competitive bidding is the mechanism for setting the benchmarks. The benchmarks could be set in many ways. For example, they could be set equal to the minimum bid in each market area, the average or median bid in each market area, or the national average bid.³ Setting benchmarks equal to the minimum bid in each area would ensure that beneficiaries had access to a plan that met certain basic standards, without requiring the government to subsidize the choice of a more expensive plan. Setting benchmarks equal to the average bid in each area (with plans' bids weighted by their enrollments in the previous year) would allow the choices of enrollees to influence the government's subsidy. Determining benchmarks from the national average bid would have the added effect of altering the cross-subsidies that now exist within Medicare, whereby beneficiaries who live in areas with lower spending levels pay a larger share of such spending (through their Part B premiums) than beneficiaries who live in areas with higher spending levels. The effects on those cross-subsidies, like the other effects from setting benchmarks equal to the national average bid, would depend on the extent to which benchmarks were adjusted to account for geographic variation in per capita Medicare spending.

Another key choice in designing a premium support system based on competitive bidding is the premium that would be required of beneficiaries who enrolled in plans whose bids were equal to the benchmark. That premium could be determined in various ways. One approach would be to require such beneficiaries to pay the national Part B premium, just as they do in the Medicare Advantage program. (That approach will be used in the premium support demonstration that was mandated by the Medicare Modernization Act; see Box 3-1.) Another approach would be to set the premium equal to a fixed percentage of the benchmark. Under that approach, net federal spending and beneficiaries' premiums would depend greatly on the level at which the percentage was set.

Setting Benchmarks Equal to the Minimum Bid in Each Market Area. Setting benchmarks equal to the minimum bid in each market area is analogous to the managed competition purchasing strategy that some employers

have adopted.⁴ Two advantages of this approach are that it would lead to lower federal spending than would setting benchmarks equal to the average or median bid in each market area, and it would give beneficiaries stronger incentives to be cost-conscious in their choice of plans.

According to projections presented in Chapter 5 of this study, benchmarks under this approach could be substantially lower than average FFS expenditures in market areas where those expenditures are high, so the premium paid by beneficiaries for the FFS program in those areas could be substantially greater than it would be under current law. In many other market areas, however, benchmarks would probably be equal to average FFS expenditures.

There are three potential problems with the minimum-bid approach to setting benchmarks. First, the substantial increases in beneficiaries' premiums for the FFS program in some market areas could generate protests by beneficiaries and lead to confusion. To the extent that beneficiaries did not understand the new rules in the first year, they could experience a large unexpected increase in their premium, which could cause financial hardships. Those problems could be partially addressed by gradually phasing in the new system. For example, the increases in premiums for the FFS program could be constrained not to exceed certain amounts that would slowly rise over a suitable phase-in period, giving beneficiaries time to learn about and adjust to the new rules.⁵ Another option is to implement a premium support system that would initially produce smaller changes in beneficiaries' premiums (such as by setting benchmarks equal to the average bid in each market area) and then switch to the minimum-bid system on a phased-in basis.

A second potential problem with setting benchmarks equal to the minimum bid in each market area is that the lowest-bidding plans in some areas might achieve their savings by providing either low-quality care or poor customer service, or both. The government's contribution in

3. Market areas could be defined as counties or as larger geographic units, such as metropolitan areas.

4. The minimum-bid approach to setting benchmarks was proposed by Bryan E. Dowd, Roger Feldman, and Jon Christianson in *Competitive Pricing for Medicare* (Washington, D.C.: AEI Press, 1996). The managed competition purchasing strategy is discussed in Chapter 4 of this study.

5. A government campaign to educate beneficiaries about their choices would be an important element of a premium support system.

those market areas would be lower than it would have been if the government had recognized the problems with the lowest-bidding plans and excluded them from the program. Because plans that provide low-quality care or poor customer service would probably have trouble attracting large numbers of enrollees, however, they would have less of an incentive to engage in such behavior. The government already has numerous mechanisms in place in the Medicare Advantage program to ensure that plans meet certain standards regarding quality of care, and those mechanisms could be continued under a premium support system.⁶ Even so, monitoring the quality of care provided by health plans is difficult, and it is possible for problems to go undetected.

A third potential problem with the minimum-bid approach to setting benchmarks is that the lowest-bidding plan might not have the capacity to accept all of the beneficiaries who might want to enroll. In principle, that problem could be addressed by requiring plans to state their enrollment capacity when they submit their bids. The government could then rank the bids in each area from lowest to highest and set the benchmark at the level at which the combined enrollment capacity of the plans whose bids are at or below that amount meets a specified threshold. Plans might overstate their enrollment capacity, however, and it would be difficult for the government to detect such behavior during the bid evaluation process.⁷ One way in which the government could deter plans from overstating their enrollment capacity would be by imposing strong sanctions on plans that were later found to have done so.

Several alternatives related to the minimum-bid approach would at least partly address some of those potential problems, although they would most likely result in smaller federal savings. For example, benchmarks could

be set equal to the second-lowest bid in each market area or to a specified percentage above the lowest bid. Alternatively, benchmarks could be set equal to the average of the lowest three bids in each market area (or the average of the lowest two bids in areas with fewer than three bidders). With each of those approaches, plans' incentives to submit low bids would be strongest if plans whose bids were below the benchmark were allowed to offer rebates.

Setting Benchmarks Equal to the Average Bid or the Median Bid in Each Market Area. A second option would be to set benchmarks equal to the average bid or the median bid in each market area.⁸ In either case, bids could be weighted according to plans' enrollments in the previous year, which would take into account the preferences and perceptions of beneficiaries in the local market area regarding the relative quality of care and other attributes of the available plans. Under that approach, however, the geographic variation in benchmarks might partly reflect differences in beneficiaries' demand for higher-cost plans, resulting in a higher federal subsidy in market areas where beneficiaries have greater preferences for higher-cost plans or a greater ability to pay for them. In the premium support demonstration that was mandated by the MMA, benchmarks will be set equal to the average bid in each county (see Box 3-1).

Setting benchmarks equal to the average or median bid in each market area would at least partially address some of the problems with the minimum-bid approach. For example, plans that achieved savings by providing low-quality care or poor customer service would have less potential for influencing the government's contribution than if benchmarks were set equal to the minimum bid. Moreover, benchmarks set equal to the average or median bid would be higher than those set equal to the minimum bid, so beneficiaries who live in areas where per capita FFS spending is high and who wanted to remain in the FFS program would face smaller increases in their premiums.

A recommendation that benchmarks be set equal to the enrollment-weighted average bid or the median bid came from a panel of experts that was convened to advise the

6. For example, plans must meet certain standards regarding the size and geographic coverage of their provider networks, they must have an ongoing quality improvement program, and they must collect and report data on health outcomes and measures of quality to the federal government. The data on health outcomes and quality are made available to beneficiaries to assist them in selecting a plan.

7. For example, information on the number and geographic distribution of providers in a plan's network does not, by itself, indicate a plan's enrollment capacity, because some of those providers may have limited capacity (or willingness) to accept new Medicare patients.

8. The average bid is defined as the sum of the bids divided by the number of plans. The median bid is defined as the middle of the distribution of bids: half the bids are above the median and half are below it.

Box 3-1.**Legislative Context for a Premium Support System**

Numerous policy analysts have proposed changing the Medicare program by adopting the principles of premium support.¹ The proposals vary in specificity and design, but all envision a system in which private plans would compete on the same terms as the fee-for-service (FFS) program and beneficiaries would face incentives to choose plans on the basis of their relative premiums and the quality of care they provide. A demonstration that is scheduled to begin in 2010 and a bill that was introduced in the Congress in 2001 illustrate alternative design options for premium support that have been debated by lawmakers in recent years.

Demonstration Program

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108-173, requires that the federal government conduct a six-year demonstration of premium support in

up to six metropolitan areas beginning in 2010. (The legislation uses the term “comparative cost adjustment program” rather than premium support.) The demonstration is a compromise that was achieved as part of the conference agreement. The original bill that passed the House (H.R. 1) called for the nationwide implementation of premium support beginning in 2010 in all areas that are served by at least two private plans, whereas the Senate bill (S. 1) did not include a provision for premium support.

Under the demonstration, the benchmark—the government’s maximum payment for an enrollee in a private plan—in each county will be a weighted average of the bids of private plans and local per capita FFS expenditures.² The rules for local Medicare Advantage plans will remain in place in the demonstration sites, but they will be subject to the demonstration benchmarks. The fee-for-service program in the

1. For example, see Henry J. Aaron and Robert D. Reischauer, “The Medicare Reform Debate: What Is the Next Step?” *Health Affairs*, vol. 14, no. 4 (Winter 1995), pp. 8–30; Bryan E. Dowd, Roger Feldman, and Jon Christianson, *Competitive Pricing for Medicare* (Washington, D.C.: AEI Press, 1996); and Stuart M. Butler and Robert E. Moffit, “The FEHBP as a Model for a New Medicare Program,” *Health Affairs*, vol. 14, no. 4 (Winter 1995), pp. 47–61.

2. The bid of the FFS program will be weighted by either the percentage of beneficiaries in the county who are in the FFS program or the percentage of beneficiaries nationally who are in the FFS program, whichever is greater. The average bid of private plans in the county will be computed by weighting each plan’s bid by its share of local private-plan enrollees, and that average bid of private plans will be weighted by 1 minus the weight of the FFS bid.

federal government on a demonstration of competitive bidding for private health plans under Medicare.⁹ That demonstration, which was mandated by the Balanced Budget Act of 1997 but was never implemented, would have had some of the elements of a premium support system. However, the FFS program would not have been included as a bidding plan, and the Part B premiums of enrollees in that program would not have been affected by the demonstration. The advisory panel considered rec-

ommending that benchmarks be set equal to the minimum bid in the demonstration sites, but it rejected that approach because of a desire to limit the increases in premiums that enrollees in some plans would have faced in those sites.

Setting Benchmarks Equal to the National Average Bid.

As an alternative to setting the benchmark in each market area on the basis of the bids in that area, benchmarks could be determined from the national average bid. A key design choice for such a system is the extent to which benchmarks would be adjusted to account for geographic variation in per capita Medicare expenditures, which is

9. Bryan Dowd, Robert Coulam, and Roger Feldman, “A Tale of Four Cities: Medicare Reform and Competitive Pricing,” *Health Affairs*, vol. 19, no. 5 (September/October 2000), pp. 9–29.

Box 3-1.**Continued**

demonstration sites will be subject to rules that are analogous to those in place for private plans. However, the increase or decrease in the Part B premium for beneficiaries in the FFS program in any year will be constrained to not exceed 5 percent of the national Part B premium. In addition, low-income beneficiaries in the FFS program will not be subject to any change in their Part B premium.

Breaux-Thomas and Breaux-Frist I

In 1999, the National Bipartisan Commission on the Future of Medicare, chaired by Senator John Breaux and Representative Bill Thomas, developed a Medicare proposal based on premium support. Although the majority of the commission's members voted in favor of the proposal (named Breaux-Thomas after the chairmen of the commission), it did not receive enough votes to be presented as a formal recommendation to the President and the Congress. Subsequently, some members of the commission introduced a bill, the Medicare Preservation and Improvement Act of 2001 (S. 357), based on the commission's proposal. That bill became known in the policy community as Breaux-Frist I.

Under Breaux-Frist I, benchmarks would have been set equal to the national average bid, weighted by plans' enrollments in the previous year. Benchmarks would have been adjusted to account for geographic differences in the prices of inputs that are used to provide Medicare services but not for geographic differences in the level and intensity of beneficiaries' use of services. (Payments to plans would have also been adjusted to account for differences in beneficiaries' health status.) Beneficiaries who enrolled in plans whose bids were equal to the benchmark would have been required to pay a Medicare premium that would have been analogous to the Part B premium required under current law.³ Those who enrolled in plans whose bids were below the benchmark would have received 80 percent of the difference between the bid and benchmark as a reduction in their premium, whereas those who enrolled in plans with bids above the benchmark would have been required to pay an additional premium equal to the amount by which their plan's bid exceeded the benchmark.

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3. Breaux-Frist I also would have combined Medicare Parts A and B, established a unified Medicare trust fund, and replaced the Part B premium with a Medicare premium.

substantial.¹⁰ That variation in expenditures results primarily from geographic differences in the level and intensity of service utilization.¹¹ Other contributing factors are geographic differences in the health status and other characteristics of beneficiaries and geographic differences in

Medicare's payment rates. Currently, the payment rates in the FFS program are adjusted to account for geographic differences in the prices of inputs that are used to provide medical care and differences in the characteristics of providers (for example, payments are higher for teaching hospitals and hospitals that serve a large proportion of low-income people).

There are many possible approaches to adjusting the national average bid to account for geographic variation in spending. One general approach is to adjust for all sources of geographic variation. If that approach was implemented by using plans' bids to measure geographic differences in spending, the outcome would be the same

10. In 2005, 10 percent of Medicare beneficiaries lived in counties where average spending in the FFS program was at least \$730 per month, while another 10 percent of beneficiaries lived in counties where average FFS spending was no more than \$500 per month.

11. John E. Wennberg, Elliott S. Fisher, and Jonathan S. Skinner, "Geography and the Debate Over Medicare Reform," *Health Affairs*, Web exclusive (February 13, 2002); and Marsha Gold, "Geographic Variation in Medicare Per Capita Spending: Should Policymakers Be Concerned?" Research Synthesis Report No. 6 (Princeton, N.J.: Robert Wood Johnson Foundation, July 2004).

as if benchmarks were set equal to the average bid in each county.

Another general approach is to adjust the national average bid to account for part of the geographic variation in spending. That approach was contained in the premium support proposal included in the Medicare Preservation and Improvement Act of 2001 (S. 357), which would have adjusted the national average bid to account for geographic variation in the prices of inputs that are used to produce Medicare services (see Box 3-1).¹² (That bill also would have adjusted payments to plans to account for differences in the health status and other characteristics of beneficiaries, as is currently done for Medicare Advantage plans.) No geographic adjustment would have been made to account for differences in the level and intensity of service utilization. The rationale for that approach is that the higher rates of service utilization in high-spending areas do not appear to improve the quality of care that beneficiaries receive or their health outcomes.¹³ Not adjusting benchmarks on the basis of service utilization means that the benchmarks in high-spending areas would be lower than they would have been if they had been adjusted to account for the higher service utilization in those areas. Conversely, the benchmarks in low-spending areas would be higher than they would have been if they had been adjusted to account for the lower service utilization in those areas.

Adjusting benchmarks to account for geographic variation in the prices of inputs that are used to deliver Medicare services would require an index measuring that variation. The Medicare program has several indexes that measure geographic variation in the prices of inputs faced by providers in the FFS program, which it uses to adjust payment rates in that program. However, those indexes may not accurately reflect the geographic variation in input prices faced by private plans, which must negotiate rates with providers. The rates that private plans pay to providers in local markets depend greatly on the amount of competition those providers face. As noted previously,

private plans must typically pay providers in non-metropolitan areas rates that far exceed Medicare's FFS rates because of the lack of competition among providers in those areas.

Setting the Government's Contribution Equal to a Predetermined Amount

A second general approach to premium support is to set the federal government's contribution at an amount that is designed to meet a specified trajectory of spending. For example, that trajectory could be specified to ensure that federal spending on Medicare did not exceed a targeted percentage of the nation's economy. The contribution could be based initially on current spending levels (net of premium collections) and then updated by a certain amount to ensure that Medicare spending followed the specified trajectory.

The effects of such an approach would depend in large part on the level at which the government's contribution was set. If the contribution was set at a level that was below the average spending that the federal government would have otherwise incurred, then beneficiaries and health plans would have stronger incentives to seek lower-cost modes of care. Depending on the responses of beneficiaries, plans, and providers, such an approach could increase the amount of costs borne by beneficiaries. In addition, if the government's contribution grew at a rate that was substantially lower than the rate of growth of total health care spending in the nation, beneficiaries could be faced with higher costs, lower-quality care, or reduced access to care. Alternatively, some beneficiaries could enroll in health plans that are more efficient and better at coordinating care than the plans that they would have otherwise been enrolled in.

How the government's contribution would be adjusted to account for geographic differences in per capita Medicare spending would also be an important design choice in this type of premium support system. The government's contribution could be adjusted to account for some or all of the geographic differences in per capita spending using the approaches described above for adjusting the national average bid.

Finally, in a premium support system in which the government's contribution was set at an amount to achieve a budgetary target, special consideration could be given to geographic areas that lack private plans and where the premium of the FFS program substantially exceeds the

12. The Medicare Preservation and Improvement Act of 2001 was based on a premium support proposal that was developed in 1999 by the National Bipartisan Commission on the Future of Medicare. Although a majority of the commission's members voted for the proposal, it did not receive enough votes to be presented as a formal recommendation to the President and the Congress.

13. Wennberg, Fisher, and Skinner, "Geography and the Debate Over Medicare Reform."

government's contribution. For example, rules could be specified to limit the increase in premiums for beneficiaries in those areas.

The Benefit Package

A system of premium support would have to include rules concerning the design of the Medicare benefit package and any supplemental coverage that was offered.

The Medicare Benefit Package

A premium support system could be designed so that all plans would be required to offer a standard package of Medicare benefits. Alternatively, plans could be allowed to vary their benefit packages. Standardizing the benefit package would offer three advantages.¹⁴ First, if the government's contribution is determined through competitive bidding, benefit standardization would help assure plans and beneficiaries of the fairness of the bidding process, because all plans would bid on the same product and the government could evaluate bids in a straightforward manner. Second, regardless of how the government's contribution is determined, a standard benefit package would facilitate beneficiaries' comparisons of premiums and simplify the task of informing beneficiaries about their options. For example, beneficiaries would be assured that lower-priced plans did not achieve their savings through benefit exclusions that might be difficult for them to detect prior to enrollment. Third, standardization would prevent plans from structuring their benefit packages to achieve favorable risk selection. Although a premium support system should adjust payments to plans to account for differences in their enrollees' health status, such adjustments are imperfect. Plans could therefore have an incentive to design their benefit packages to attract beneficiaries who are in good health and discourage enrollment by those with chronic conditions that are costly to treat.

A standard benefit package would specify detailed requirements regarding the scope and limits of covered benefits and cost-sharing requirements. Health benefits have many dimensions, however, and even under stan-

dardization, some variation would probably persist regarding what benefits were covered under what circumstances. For example, plans' utilization management protocols determine the circumstances under which visits to specialists and other services are covered.

A standard benefit package would not have to be identical to the current Medicare benefit package. That package has several important limitations, including the absence of an annual cap on beneficiaries' out-of-pocket costs and a complex set of cost-sharing requirements that does not give beneficiaries accurate signals regarding the costs of different types of care. A thorough evaluation and possible modification of the current Medicare benefit package would be an important element in the design of a premium support system.

Standardization of benefits would have two major disadvantages. First, requiring all plans to offer the same benefit package would prevent them from implementing innovative benefit designs that might lead to more efficient delivery of care. For example, plans would be prevented from implementing alternative cost-sharing arrangements or more flexible benefits for managing patients' care. Second, standardization would keep plans from offering benefit packages that some beneficiaries might prefer to a standard package specified by the federal government.

An alternative to benefit standardization is to give plans flexibility in their benefit design but require that their benefit packages be actuarially equivalent to a specified package.¹⁵ In a premium support system in which the government's contribution is determined through competitive bidding, this alternative would help preserve the fairness of the bidding process. The requirement for actuarial equivalence could be specified in either of two general ways. The first approach would require that all private plans offer the same benefits as the FFS program, but plans could vary their cost-sharing requirements as long as they were actuarially equivalent to those of the FFS program. (The Medicare program has traditionally given private plans the flexibility to vary their cost-sharing requirements in this manner.) The second approach is to let plans vary their cost-sharing requirements and the scope and limits of covered benefits, as long as the actuar-

14. See *Report to Congress by the Competitive Pricing Advisory Committee of the U.S. Department of Health and Human Services* (January 19, 2001). The advisory committee recommended a standard benefit package for the Medicare competitive-pricing demonstration for private health plans that was mandated by the BBA but never implemented.

15. The federal government could be given the discretion to reject benefit designs that appeared likely to result in favorable risk selection.

ial value of their benefit package equaled that of the FFS program. The federal government could specify a set of services that plans were required to cover—and could perhaps specify minimum coverage requirements for those services—but the details would be left to the plans. Thus, plans could be given greater opportunity for innovation than if they were allowed to vary only their cost-sharing requirements.

Under the two approaches to determining actuarial equivalence, plans would be required to certify, and the federal government verify, that their benefit packages satisfied the necessary requirements. Actuarial projections pose a number of analytical challenges, however, and they are subject to error. In the proposed rule for the Medicare Advantage program, for instance, the Centers for Medicare and Medicaid Services presented three different methods for determining cost-sharing levels in private plans that are actuarially equivalent to those in the FFS program and acknowledged important limitations in the method that the agency had used previously.¹⁶ Furthermore, the potential for plans to manipulate their actuarial projections could raise questions about the fairness of the bidding process, because some plans might try to reduce their bids by offering benefit packages whose true actuarial values were less than the required level.

In a premium support system in which the government's contribution is set at a predetermined amount, plans could be given even greater flexibility in their benefit designs. (Because the government's contribution would not be determined through a formal bidding mechanism, one of the reasons for requiring actuarial equivalence would be eliminated.) The federal government would specify minimum coverage requirements, which would enable policymakers to ensure that all benefit packages met certain minimum standards. In principle, those standards could specify certain services that all plans were required to cover or could specify more-detailed coverage requirements by type of service (such as requirements concerning the number of inpatient hospital days that would be covered, along with any limitations on beneficiaries' cost sharing). Decisions about minimum coverage requirements would depend in part on decisions about the federal government's contribution amount, because

beneficiaries' access to coverage would depend on plans' ability to offer benefit packages whose premiums did not greatly exceed the federal contribution.

Supplemental Benefits

An important set of choices in designing a premium support system concerns the supplemental benefits that plans would offer to beneficiaries. The great majority of Medicare beneficiaries currently have supplemental coverage, which typically reduces their cost sharing on Medicare services and, in some cases, pays for some services that are not covered by Medicare.

This section first examines how supplemental benefits might be offered under premium support and then looks at whether those benefits should be standardized, how outcomes under premium support could depend on the decisions of employers that offer supplemental coverage to their retirees, and how supplemental coverage could affect plans' incentives to compete aggressively on their bids to provide Medicare benefits.

Supplemental Benefits Under Premium Support. Currently, the vast majority of enrollees in the fee-for-service program have supplemental insurance that covers much or all of Medicare's cost-sharing requirements. Continuing supplemental coverage in its current form could put the FFS program at a competitive disadvantage relative to private plans, however, under a system of premium support. Generous or complete coverage of Medicare's cost sharing increases spending in the FFS program because it largely negates one purpose of cost sharing, which is to give beneficiaries financial incentives to be judicious in their use of care. Thus, the FFS program's bids under premium support would be higher than if beneficiaries faced greater cost sharing. The FFS program would be more competitive, and federal spending would be reduced, if restrictions were placed on the amount of Medicare's cost sharing that could be covered by Medigap insurers and retiree plans.¹⁷

Private plans could be permitted to offer supplemental benefits under premium support in much the same manner as they do under current law. If a plan's bid on the Medicare benefit package was below the benchmark, it

16. Department of Health and Human Services, "Medicare Program; Establishment of the Medicare Advantage Program; Proposed Rule," *Federal Register*, vol. 69, no. 148 (August 3, 2004), pp. 46865–46914.

17. For an estimate of the federal savings that could be achieved by restricting Medigap coverage of Medicare's cost sharing, see Congressional Budget Office, *Budget Options* (February 2005), pp. 210–211.

could use some or all of the difference (depending on the program's design) to reduce its enrollees' premiums for Part B, Part D, or supplemental coverage. Under current law, private plans can prohibit their enrollees from obtaining supplemental coverage from another source. The advantage of maintaining that restriction under premium support is that plans could continue to use cost sharing as a means of reducing enrollees' use of services that have low value relative to their cost. Allowing enrollees in private plans to obtain supplemental coverage from a third party would increase the plans' costs of providing the basic Medicare benefit package. Unless plans were able to recover those costs from their enrollees through higher premiums on the basic Medicare package, the increased costs would result in higher bids and lower federal savings.

Standardization of Supplemental Benefits. Standardization of supplemental benefits would be appropriate under a premium support system only if the Medicare benefit package was standardized. A standard package of supplemental benefits could include a schedule of cost-sharing requirements that are lower than those in the standard Medicare package and a cap on cost sharing (if such a cap was not included in the Medicare package).

The advantages and disadvantages of standardizing supplemental benefits are analogous to those discussed above for the Medicare benefit package. Standardizing supplemental benefits would reinforce some of the advantages of standardizing the Medicare benefit package. Conversely, not standardizing supplemental benefits would lessen some of the advantages of standardizing the Medicare benefit package. For example, allowing plans to vary their supplemental packages could result in widely varying cost-sharing requirements for Medicare benefits even though those requirements were standardized in the underlying Medicare benefit package.

Coverage for Retirees. The effects of premium support would depend in part on the response of employers that provide health care coverage to their retirees. Most employers that provide such coverage offer their retirees a limited choice of plans. According to one recent study, 46 percent of large private employers that provide coverage to their Medicare-eligible retirees offer only one plan, and 23 percent offer a choice of only two plans.¹⁸ The most commonly offered types of plans are those that supplement benefits in the FFS program, although an estimated 43 percent of large employers offer one or more Medicare Advantage plans. If employers offered a limited

set of plan options under premium support, their employees would be constrained in their ability to respond to incentives created by the new program.

Implications for Plans' Bidding Incentives. In a premium support system based on competitive bidding, plans should be given an incentive to submit bids that reflect their costs of efficiently providing Medicare benefits. That incentive could be reduced, however, if plans competed on the basis of their total premium for a combined package of Medicare benefits and supplemental benefits. Under some program designs, plans could have an incentive to inflate their Medicare bids and reduce their premiums for supplemental benefits by an equivalent amount, thereby shifting some of the costs for supplemental benefits from beneficiaries to the government.¹⁹ For example, plans would have such an incentive in a program in which enrollees in plans whose bids are below the benchmark receive a rebate that is only a portion of the difference between the bid and the benchmark. Under that type of program, a plan that raised its bid for Medicare benefits by \$1 would reduce its enrollees' rebate by less than \$1, while the full amount of the \$1 reduction in its premium for supplemental benefits would be passed on to enrollees as savings (see Box 3-2).

That concern about plans' inflating their Medicare bids could be addressed in several ways. One approach would be to set the rebate equal to the entire difference between the benchmark and the bid, or to a relatively high percentage of that difference, which would reduce the incentive for plans to inflate their Medicare bids. A second approach would be for the federal government to review plans' bids and their supplemental premiums for actuarial soundness, as it does under the Medicare Advantage program. Although it is likely that such reviews would identify plans that inflated their Medicare bids by large amounts, plans that inflated their bids by smaller amounts could go undetected because of the uncertainty surrounding actuarial projections.

18. Kaiser Family Foundation, *Current Trends and Future Outlook for Retiree Health Benefits: Findings from the Kaiser/Hewitt 2004 Survey on Retiree Health Benefits* (December 2004).

19. Plans would have this incentive only if the vast majority of beneficiaries continued to want supplemental coverage under premium support, which would be likely unless the basic Medicare benefit package was expanded to reduce beneficiaries' cost sharing (for example, by including a cap on beneficiaries' annual out-of-pocket costs).

Box 3-2.**Illustration of Plans' Incentives to Inflate Their Medicare Bids**

In a premium support system based on competitive bidding, plans could have incentives to inflate their Medicare bids. As an example, consider a hypothetical county in which one private plan would compete with the fee-for-service (FFS) program. Assume that the plan would submit a bid of \$700 per month to provide the Medicare benefit package if it was competing for enrollees strictly on the basis of the cost of that package and that the average FFS expenditure in the county would be \$800. Also assume that the benchmark would be set equal to the median of the two bids (\$750). Beneficiaries in the FFS program would pay an additional premium for their Medicare coverage equal to the difference between the FFS bid and the benchmark, or \$50 per month, which would increase their monthly Medicare premium from \$88.50 (the national Part B premium in 2006) to \$138.50. Assume that the rebate for enrollees in the private plan would be 75 percent of the difference between the plan's bid and the benchmark, or \$37.50, which would reduce their Medicare premium to \$51, or \$87.50 less than the premium paid by enrollees in the FFS program (see the first column of the table at right).

Next, assume that the private plan would offer supplemental benefits for which it would charge a monthly premium of \$100. It would offer Medicare benefits and supplemental benefits as a unified package for which the net cost to beneficiaries would be \$151 per month.¹ Beneficiaries in the FFS program who bought supplemental insurance for a monthly premium of \$100 would face a total cost of \$238.50 per month.² Thus, the total premium for Medicare benefits and supplemental benefits would be \$87.50 less in the private plan than in the FFS program.

If the private plan inflated its Medicare bid by \$20 and reduced its premium for supplemental benefits by \$20 (without changing its benefit package), its monthly premium for Medicare and supplemental benefits would be \$90 less than the cost of such coverage in the FFS program—rather than the \$87.50 difference that would prevail otherwise (see the first column of the table at right). Thus, the plan's total premium for Medicare and supplemental benefits relative to that of the FFS program would be reduced by \$2.50.³ That outcome stems from the fact that only part of the \$20 increase in the plan's Medicare bid would be translated into an increase in its Medicare premium relative to that of the FFS program, because the forgone rebate would be 75 percent (rather than 100 percent) of the reduction in the difference between the plan's bid and the benchmark. Conversely, the entire \$20 reduction in the premium for supplemental benefits would be passed on to beneficiaries. The plan could realize an even greater reduction in its total premium relative to that of the FFS program by inflating its Medicare bid and reducing its premium for supplemental benefits by higher amounts.

In general, the greater the percentage of the difference between the bid and the benchmark that is given to beneficiaries as a rebate, the lower the incentive for plans to inflate their Medicare bids. In the previous example, if the rebate was set equal to the entire difference between the benchmark and the bid, the private plan's total premium for Medicare benefits and supplemental benefits would be \$100 less than the total premium for such coverage in the FFS program, regardless of whether the plan inflated its Medicare bid (see the second column of the table at right).

1. The total premium of \$151 is equal to the \$88.50 national Part B premium plus the \$100 premium for the supplemental benefits minus the \$37.50 rebate.
2. The assumption that enrollees in private plans and those in the FFS program both demand \$100 of supplemental benefits was made to simplify the comparisons. It does not affect the basic conclusions of this example.

3. Moreover, the total premium for Medicare and supplemental benefits in the plan relative to the premium that a beneficiary would face in the FFS program without supplemental benefits would also be reduced by \$2.50. Thus, the plan would become more attractive to beneficiaries who otherwise would have remained in the FFS program without supplemental insurance.

Box 3-2.**Continued****An Example of the Incentive for Plans to Inflate Their Bids**

	Private Plan, Under Alternative Assumptions About Size of Rebate		
(Dollars)	75 Percent Rebate	100 Percent Rebate	FFS Program
Bids Based on Plan's Best Estimate of Costs			
Medicare Benefits			
Bid	700.00	700.00	800.00
Benchmark	750.00	750.00	750.00
National Part B premium	88.50	88.50	88.50
Premium adjustment (rebate or surcharge)	-37.50	-50.00	50.00
Premium for Supplemental Benefits	100.00	100.00	100.00
Premium for Medicare and Supplemental Benefits	151.00	138.50	238.50
Premium for Private Plan Relative to FFS Program	-87.50	-100.00	n.a.
Private Plan's Bid, Inflated			
Medicare Benefits			
Bid	720.00	720.00	800.00
Benchmark	760.00	760.00	760.00
National Part B premium	88.50	88.50	88.50
Premium adjustment (rebate or surcharge)	-30.00	-40.00	40.00
Premium for Supplemental Benefits	80.00	80.00	100.00
Premium for Medicare and Supplemental Benefits	138.50	128.50	228.50
Premium for Private Plan Relative to FFS Program	-90.00	-100.00	n.a.

Source: Congressional Budget Office.

Notes: FFS = fee for service; n.a. = not applicable.

This hypothetical example focuses on a county in which one private plan is assumed to participate in Medicare. The benchmark is computed as the median of the bids of the private plan and the FFS program.

The estimates in the column labeled "75 Percent Rebate" were calculated under the assumption that the rebate for enrollees in the private plan is 75 percent of the difference between the plan's bid and the benchmark. The estimates in the column labeled "100 Percent Rebate" were calculated under the assumption that the rebate for enrollees in the private plan is equal to the entire difference between the plan's bid and the benchmark.

From that perspective, plans would be indifferent to inflating their Medicare bid or submitting a true bid. However, by inflating their Medicare bid, plans could reduce the total dollar cost of Medicare benefits and supplemental benefits for their enrollees (from \$138.50 to \$128.50 in the example), although the total dollar cost of such benefits in the FFS program

would be reduced by the same amount (from \$238.50 to \$228.50). Plans might pursue a strategy of inflating their bid if they considered it advantageous to market their combined package of Medicare and supplemental benefits as being available for less than a certain dollar amount.

Another possible approach would be to penalize plans with high bids on the Medicare benefit package. For example, in market areas with a large number of plans, the government could select only the lowest bidders for participation in the program and exclude the others. Such a policy would not only focus the competition on plans' Medicare bids but would also add another layer of competition that could cause plans to lower their bids. Two drawbacks to this approach are that it would only be feasible in market areas with multiple bidders and that it would limit beneficiaries' choice of plans.

A fourth possible approach would be to prohibit plans from offering supplemental benefits, which would focus the competition strictly on the Medicare benefit package. The elimination of supplemental benefits would increase the financial risk facing Medicare beneficiaries, however. That risk could be substantially reduced by restructuring Medicare's cost-sharing requirements to include a cap on beneficiaries' annual out-of-pocket expenses.

Other Design Issues

Other issues that would have to be addressed in designing a premium support system for Medicare include the structure of the incentives that beneficiaries would face, the adjustment of payments to plans to account for differences in their enrollees' health status, the dissemination of information to beneficiaries, the geographic definition of bidding areas, and possible subsidies for low-income beneficiaries.

Beneficiaries' Incentives

In a premium support system based on competitive bidding, beneficiaries who enroll in plans whose bids are above the benchmark would be required to pay the entire difference between the bid and benchmark as an additional premium for their Medicare coverage. Beneficiaries who enroll in plans whose bids are below the benchmark could be given a rebate equal to a certain percentage of the difference between the bid and the benchmark. That enrollee rebate percentage could range from zero to 100 percent. In the premium support demonstration that was mandated by the MMA, the rebate will be 75 percent of the amount by which the benchmark exceeds the plan's bid.

It is unclear what enrollee rebate percentage would minimize federal spending. On the one hand, increasing the percentage of the rebate kept by enrollees would

strengthen the incentive for beneficiaries to enroll in low-bidding plans and thus strengthen the incentive for plans to submit low bids. Those factors could reduce the benchmarks and thus reduce federal spending. On the other hand, decreasing the percentage of the rebate kept by enrollees would allow the federal government to capture more of the savings when beneficiaries switched to lower-cost plans. The effect of different rebate percentages on federal spending would depend on the responses of health plans and beneficiaries to the change in incentives, and there is little experience from which to predict those responses.

Risk Adjustment

A mechanism for adjusting payments to plans to account for differences in the health status of their enrollees would be an important element of a premium support system. If payments to plans were not adequately adjusted to account for differences in the expected costs of their enrollees, plans would have a strong incentive to discourage enrollment by beneficiaries with costly chronic conditions. Plans could design their benefit packages to discourage such beneficiaries from enrolling (if benefits were not standardized) or could exclude from their networks providers who are highly regarded for treating certain high-cost conditions. Plans could also impose stringent utilization controls to limit access to certain specialists, which would in all likelihood encourage their costliest enrollees to switch to other plans at the next open enrollment period.

Inadequate risk adjustment could also distort the competition between private plans and the traditional fee-for-service Medicare program. Medicare spending is highly concentrated in a relatively small proportion of the beneficiary population.²⁰ If the FFS program attracted enrollees who were sicker and had higher health care costs than average—and such differences were not adequately accounted for in determining payments to plans—then beneficiaries' premiums for the FFS program would be higher as a result. Those higher premiums could discourage beneficiaries from enrolling in the FFS program, even if that program was able to provide Medicare benefits at the same cost as private plans for the same set of enrollees.

20. In 2001, the costliest 5 percent of beneficiaries enrolled in the FFS program accounted for 43 percent of total spending, and the costliest 25 percent accounted for 85 percent of total spending. See Congressional Budget Office, *High-Cost Medicare Beneficiaries* (May 2005).

One way to determine payments to plans under premium support would be to use the risk-adjustment mechanism that the federal government has developed for the Medicare Advantage program, which is based on the Hierarchical Condition Codes model. As in the Medicare Advantage program, plans could be asked to submit bids for a standard beneficiary. The government would compare those bids with the standardized benchmark to determine whether the plan would be allowed to offer a rebate or whether it would be required to charge beneficiaries an additional premium for their Medicare coverage. In determining the government's payment to each plan, each plan's standardized bid would be multiplied by its risk score to compensate for differences across plans in the health status and other characteristics of their enrollees. As noted in Chapter 2, it would be important for the government to determine whether risk scores are biased because of differences between private plans and FFS providers in their diagnostic coding practices and to make appropriate adjustments if such biases are found.

Even after adjusting for differences in coding practices, however, existing risk-adjustment mechanisms are imperfect, and the implications for a premium support system would need to be considered carefully. Current risk-adjustment systems tend to overpredict the costs of beneficiaries who end up with low health care spending and to underpredict the costs of those who end up with high spending.²¹ If those differences are systematic, they could cause premiums for enrollees in plans that attract higher-cost beneficiaries to rise substantially over time.²²

Dissemination of Information

Educating beneficiaries about their choices under a premium support system would be challenging, in part because the Medicare population has a higher prevalence of frailty and cognitive limitations than the general population. The government faces a similar challenge in educating beneficiaries and their caregivers about their

options under the current Medicare Advantage program and the new prescription drug benefit.

The federal government could educate beneficiaries about their choices under premium support using the methods it has traditionally used for the Medicare Advantage program as well as the additional methods it developed for the prescription drug benefit. In the past, the government has informed beneficiaries about their options under the Medicare Advantage program using a federally funded toll-free telephone information service; marketing information disseminated by plans (which must be approved in advance by the government); the State Health Insurance Assistance Program, which provides in-person counseling and other assistance to Medicare beneficiaries and their caregivers through funds provided by federal, state, and local governments; and a government Web site that compares the premiums and benefits of competing plans. Moreover, the government collects and disseminates information on the quality of care provided by participating plans to assist beneficiaries in selecting a plan.

To inform beneficiaries of their options under the prescription drug benefit that went into effect in 2006, the government supplemented the approaches it has traditionally used for the Medicare Advantage program with more personalized approaches. Those approaches were designed to reach a wider audience and to target certain populations, such as low-income beneficiaries, the homebound, those who live in rural areas, and those with limited English language skills.²³ For example, the Medicare program developed partnerships with senior citizens' organizations, community centers, churches, civic and social organizations, and state and local governments to develop a network of trained volunteers to educate beneficiaries about the new drug benefit and help them enroll. The Medicare program also held numerous outreach events throughout the country to inform beneficiaries about the new benefit.

The government could build on the approaches it developed for the Medicare Advantage program and the prescription drug benefit to inform beneficiaries about their options under a premium support program. Even so, many beneficiaries and their caregivers may have limited

21. See Medicare Payment Advisory Commission, *Report to the Congress: Issues in a Modernized Medicare Program* (June 2005), pp. 52–53.

22. For an illustration of how inadequate risk adjustment could lead to higher premiums for beneficiaries in the FFS program under premium support, see Thomas Rice and Katherine A. Desmond, "The Distributional Consequences of a Medicare Premium Support Proposal," *Journal of Health Politics, Policy, and Law*, vol. 29, no. 6 (December 2004), pp. 1187–1226.

23. Statement of Mark B. McClellan, Administrator, Centers for Medicare and Medicaid Services, before the House Committee on Ways and Means (June 14, 2006).

understanding of the consequences of their enrollment decisions under such a program, particularly in the initial years of the program. Confusion and lack of knowledge could lead some beneficiaries to enroll in plans whose premiums are much higher than they anticipated. That risk could be lessened through a phased implementation of premium support, which would give beneficiaries and their caregivers time to adjust to the new system. For example, in a premium support system based on competitive bidding, benchmarks in the first year could be constrained not to fall below average FFS expenditures by more than a specified percentage, and benchmarks in subsequent years could be similarly constrained (with the constraints gradually phased out). Plans whose bids were below the constrained benchmark could be permitted to offer premium rebates or additional benefits, which would preserve their incentive to submit low bids.

Defining Market Areas Under Premium Support

Another design choice for a premium support system is whether benchmarks would be set at the county level, as they are in the Medicare Advantage program, or whether they would be set for broader geographic areas. The Medicare Payment Advisory Commission (MedPAC) has recommended that the government establish payment areas for the Medicare Advantage program that are larger than counties.²⁴ In particular, MedPAC recommended that payment areas for the Medicare Advantage program be collections of counties that are in the same state and the same metropolitan statistical area. For counties that are outside metropolitan areas, MedPAC recommended that payment areas be collections of counties in the same state that are accurate reflections of health care market areas.

In making those recommendations, MedPAC pointed to two limitations of counties as payment areas for the Medicare Advantage program. First, in counties with small Medicare populations, the government's projection of per capita spending in the FFS program (which is used in constructing benchmarks) can vary dramatically from year to year.²⁵ Second, projected per capita FFS spending often differs greatly among adjacent counties within a metropolitan area, leading plans to avoid serving some of those counties or offering lower benefits in them.

24. Medicare Payment Advisory Commission, *Report to the Congress: Issues in a Modernized Medicare Program*, pp. 41–52.

In principle, the bidding areas in a premium support system (which would also be the areas for which benchmarks would be established) could be defined as counties or as collections of counties, such as those recommended by MedPAC for the Medicare Advantage program. If bidding areas were defined as collections of counties, they should closely match the service areas of private plans. Even so, policymakers would have to decide whether to allow plans to participate in Medicare if they were capable of serving only a portion of a defined bidding area. Not allowing such plans to participate could limit beneficiaries' choice of plans and limit the competitiveness of the market. But allowing plans to participate in only some counties within a bidding area would raise questions about how to adjust for the fact that average Medicare spending in those counties may differ substantially from average spending in the entire bidding area. Such differences should be taken into account when using plans' bids to compute benchmarks. Adjustments would also be needed when comparing such a plan's bid to the benchmark to determine the amount of any premium rebate or surcharge for its enrollees.

Subsidies for Low-Income Beneficiaries

In a premium support system in which beneficiaries' premiums could increase substantially in certain geographic areas, the government may need to provide subsidies to low-income beneficiaries. Currently, certain Medicare beneficiaries who are very poor or who spend a substantial portion of their income on medical care qualify for full Medicaid coverage, which not only pays their Medicare premiums and cost-sharing amounts but also covers certain services that are not covered by Medicare, such as long-term care. Other poor Medicare beneficiaries with somewhat higher income have more limited Medicaid benefits, consisting of payments to cover Medicare's premiums and cost sharing or the premiums only.

Subsidies for low-income beneficiaries in a premium support system could be specified in various ways that would depend in part on how the government's contribution was determined. For example, in a system in which the

25. Large year-to-year variation in those projections can occur in counties with relatively few beneficiaries, even though the projections are based on a five-year moving average of per capita spending at the county level. In counties with small Medicare populations, modest changes in the number of beneficiaries who have very high expenses can result in substantial changes in the estimated average spending in the county.

benchmark in each market area was determined from the average or median bid in the area, one approach would be for Medicaid to pay the Medicare premiums of beneficiaries who would have qualified for such assistance under current law, as long as they enrolled in a plan whose bid was equal to or below the benchmark. Depending on the program's design, such beneficiaries could receive a rebate if they enrolled in a plan whose bid was below the benchmark, but they would have to pay a premium surcharge (just like all other beneficiaries) if they enrolled in a plan whose bid was above the benchmark. That approach could also be applied in a program in which benchmarks were set equal to the minimum bid in each market area. In areas where spending in the FFS program is high, such a program would provide strong incentives for low-income beneficiaries to enroll in the lowest-cost private plan. As discussed previously, close federal monitoring of such plans would be needed to ensure that they provided care of acceptable quality.

In a premium support system in which benchmarks are determined from the national average bid, or in a system in which the government's contribution is set at a predetermined amount, the only plans available in some market areas might require higher premiums from benefi-

ciaries than would have been required for the traditional program under current law. Careful consideration would have to be given to the design of low-income subsidies in such market areas. For example, one approach would be for Medicaid to pay an estimate of the Part B premium that would have prevailed under current law for beneficiaries who would have qualified for such assistance. The federal government could provide additional assistance to ensure that low-income beneficiaries had at least one plan available at no out-of-pocket premium. The federal costs of providing such assistance would depend on how the program was structured.

Under any type of premium support system, coordination of low-income subsidies for Parts A and B of Medicare with low-income subsidies under the prescription drug benefit (Part D) would require attention. Because plans would submit separate bids for the basic Medicare benefit package and for the prescription drug benefit, rules would have to be developed for determining the subsidies that would be available to low-income beneficiaries in plans whose bids were low enough for their enrollees to qualify for low-income subsidies for the basic benefit package or the drug benefit, but not both.

Health Care Systems That Are Similar to Premium Support

Premium support would establish the government's contribution toward the cost of Medicare coverage using methods that are similar to those used by the health benefits programs of some large employers. Although Medicare differs from employment-based insurance in some important ways, the experiences of those employers provide lessons for designing a premium support system for Medicare and for assessing the potential effects of such a system. This chapter examines evidence from the research literature on two types of employment-based systems that are similar to premium support: the "managed competition" purchasing strategy and the Federal Employees Health Benefits program.

Managed Competition

Managed competition is a purchasing strategy that creates incentives for consumers to be cost-conscious in their choice of health plans and for plans to compete on the basis of premiums and quality of care. Alain Enthoven and others have developed a managed competition purchasing model that includes a detailed set of recommendations.¹ Two key recommendations are that employers should offer a choice of health plans and that they should make a fixed-dollar contribution toward all employees' premiums that is no greater than the premium of the lowest-priced plan offered. Employees, therefore, would bear the full cost of any difference in premiums across plans.

Employers that use this general approach vary in the extent to which they have adopted the other features of

the model. Those other features call for employers to measure the quality of care provided by plans and disseminate that information to employees, define a standard benefit package that all plans must offer, and adjust premium payments to plans to account for differences in the health status of their enrollees. Standardization of the benefit package is intended to facilitate premium comparisons by employees and to prevent plans from structuring their benefits to achieve favorable risk selection.

Most employers do not currently use the principles of managed competition to purchase health insurance benefits for their employees. According to one recent study, only about one-quarter of Fortune 500 companies make fixed-dollar contributions to their employees' insurance premiums.² Instead, most companies seek to contain health care costs primarily through competition at the stage at which plans vie to be selected by the employer rather than the stage at which employees select plans.

Mechanisms to Potentially Reduce Health Care Spending

The effect of managed competition on health care spending depends in large part on the alternative system with which it is compared. Many employers contribute a larger dollar amount when their employees choose a plan with a higher premium—for example, by paying the entire premium or paying a fixed percentage of the premium. Replacing that type of system with managed competition could reduce total spending on health care through two mechanisms: encouraging employees to switch from higher-cost plans to lower-cost plans and inducing plans

1. See Alain C. Enthoven, "The History and Principles of Managed Competition," *Health Affairs*, supplement (1993), pp. 24–48. To simplify the discussion, this study refers to the entity that sponsors managed competition as an employer. Other entities, such as purchasing alliances, can also act as sponsors.

2. See James Maxwell and Peter Temin, "Managed Competition Versus Industrial Purchasing of Health Care Among the Fortune 500," *Journal of Health Politics, Policy, and Law*, vol. 27, no. 1 (2002), pp. 5–30.

to reduce their premiums through greater price competition.³

A simple example is useful for illustrating the incentives that managed competition creates for employees and plans. Assume that prior to implementing managed competition, an employer paid 80 percent of the total premium for each employee (the so-called 80 percent contribution rule), regardless of the plan chosen. An employee who chose a plan with a total premium of \$4,000 would pay \$800 (or 20 percent of \$4,000), while an employee who chose a plan with a total premium of \$5,000 would pay \$1,000. Although the total premium of the more expensive plan is \$1,000 more than that of the less expensive plan, the price difference facing the employee is only \$200. In contrast, under managed competition, an employee would face the full \$1,000 price difference between the two plans and would therefore have a much stronger incentive to choose the lower-cost plan. Making employees face the full difference in premiums could also give plans a greater incentive to contain costs. Under the 80 percent contribution rule, if a plan implemented cost-saving mechanisms that enabled it to lower its premium by \$100, the price to employees for the plan would fall by only \$20. Under managed competition, however, the price to employees would fall by the full \$100, which could give the plan a greater expected increase in enrollment in return for its cost-saving initiative.

The effect of managed competition on an employer's health care costs depends in part on the level at which it sets the fixed-dollar contribution and how that compares with its previous contribution formula. An employer can reduce its health care costs by setting its premium contribution sufficiently low. If total health care costs are not reduced, however, such a policy would simply shift costs from the employer to its employees.

Evidence on the Effects of Managed Competition

Evidence on the effects of managed competition on health care costs is limited. A few studies have conducted in-depth analyses of particular employers that implemented managed competition. Other studies have compared employers that make fixed-dollar contributions to their employees' insurance premiums with employers that

use other contribution formulas. Both types of studies have estimated the effect of managed competition on total health care spending, not merely its effect on employers' spending.

Several conclusions can be drawn from the available research on managed competition. First, managed competition reduces total spending on health care, when compared with systems in which employers subsidize the purchase of more expensive plans. Second, the introduction of managed competition often leads large numbers of employees to switch to lower-cost plans, which is an important source of the cost reductions. Little information is available on whether managed competition leads plans to reduce their premiums. Third, there is insufficient evidence to conclude that managed competition can reduce the growth of health care costs. Fourth, for the most expensive plans, managed competition can trigger "adverse selection spirals" in which successive waves of relatively healthy employees "disenroll," leaving only the sickest employees enrolled. In some cases, employers have dropped such plans because their premiums skyrocketed and their enrollments plummeted. (Those employers did not adjust premium payments to plans to account for differences in enrollees' health status; still, it is not known whether the more expensive plans would have survived even if the premium payments had been adjusted for risk.)

Distinguishing between the effects on *levels* of health care costs and the effects on the long-term *growth* of those costs is important when evaluating managed competition or other policies designed to contain costs.⁴ Managed competition could reduce the level of costs through the mechanisms noted above. Reducing the long-term growth of costs is more difficult. Studies have concluded that the major factor contributing to the growth of health care costs is the development and use of new medical technology, which has been fueled in part by the prevalence of health insurance that gives patients and providers

3. Total spending on health insurance premiums includes both the employer's portion and the employee's portion.

4. Some policies may reduce the level of costs but may not affect the long-term growth of costs (even though it may appear so in the first few years of implementation, as spending adjusts to the new, lower level). Such policies would yield a permanent reduction in the level of costs, but after adjusting to the lower level, costs would continue growing at the same rate as before. Policies that reduce both the level of costs and their rate of growth offer the greatest potential to contain costs over the long term.

little incentive to contain costs.⁵ That evidence suggests that if managed competition was to reduce the long-term growth of health care costs to an appreciable extent, it would have to alter the incentives facing individuals, health plans, and providers in such a way as to reduce the growth in the development and use of new medical technology. The evidence presented below, although limited, suggests that the adoption of managed competition by a minority of employers has not had that effect. Some analysts maintain that managed competition could reduce the long-term growth of health care costs if it was adopted by a sufficiently large number of employers, but there is currently no evidence to support that contention.⁶

Studies of Particular Employers. Some of the best evidence on managed competition comes from in-depth studies of particular employers. Although those studies are informative, they do not provide sufficient evidence to quantify the effects of implementing managed competition on a broader scale. In studies that focus on a single employer, the results depend heavily on circumstances that are unique to that employer, such as the nature of the contribution formula that was used before managed competition was implemented, the level at which the fixed-dollar contribution is set, the number and types of health plans that are offered, the characteristics of the local health care market, and the characteristics of the employees (in particular, their responsiveness to differences in premiums when choosing among health plans). To date, employer-specific studies of managed competition have focused on a limited range of employers (universities and state governments) that are not representative of all employers nationally. Moreover, studies that focus on a single employer face a difficult challenge in estimating the total health care spending that would have prevailed at that employer in the absence of the change in policy. Some studies have used spending per employee at other local employers or national average spending for that purpose, but there is a risk that the observed differences in spending may at least partly reflect underlying differences between employers and their workforces.

The State of Wisconsin. One study examined the experiences of the state of Wisconsin when it implemented a managed competition system for its employees in 1984.⁷ In the first year under the new policy, the change in relative premiums facing employees prompted a dramatic shift in enrollment from indemnity plans to health maintenance organizations, increasing the share of employees who were enrolled in HMOs from 21 percent to 85 percent. The study compared premium trends for state employees with national premium trends for employment-based insurance during the two years before the policy change and the next nine years, using statistical methods to adjust for differences in demographic characteristics and benefits. The study concluded that, largely because of the shift in enrollment to lower-cost plans, total health care spending per employee fell in the first two years under the new system. After falling to a lower level, health care spending for state employees continued growing at a rate similar to national trends.

The state of Wisconsin set its premium contribution equal to 105 percent of the premium of the lowest-priced plan. Thus, plans whose premiums did not exceed the premium of the lowest-priced plan by more than 5 percent were available at no cost to employees. In general, that approach is expected to yield a smaller reduction in health care spending than would be achieved if the employer's contribution was set at or below the premium of the lowest-priced plan, because it gives weaker incentives for employees to select the lowest-priced plan and for plans to compete to be the lowest-priced plan. In the other employer-specific studies discussed next, the employers set their contributions at or below the premium of the lowest-priced plan.

Various Universities. Several studies have examined the experiences of universities that implemented managed competition systems for their employees. In each case, a substantial number of employees switched to lower-cost plans under managed competition. At the University of California, about half of the employees who had been enrolled in indemnity plans switched to a lower-cost plan in the first year under the new system (1994), when the employee premiums for the indemnity plans increased

5. Michael E. Chernew and others, "Managed Care, Medical Technology, and Health Care Cost Growth: A Review of the Evidence," *Medical Care Research and Review*, vol. 55, no. 3 (September 1998), pp. 259–288.

6. For example, see Alain C. Enthoven and Brian Talbott, "Stanford University's Experience with Managed Competition," *Health Affairs*, vol. 23, no. 6 (November/December 2004), pp. 136–140.

7. See Steven C. Hill and Barbara L. Wolfe, "Testing the HMO Competitive Strategy: An Analysis of its Impact on Medical Care Resources," *Journal of Health Economics*, vol. 16, no. 3 (June 1997), pp. 261–286.

substantially.⁸ Many employees also switched from higher-cost HMOs to lower-cost HMOs. After factoring out the effects of general inflation, the study found that such switching caused total health care spending per employee to fall by about 6 percent in the first year under the new policy and by an additional 1 percent in the second year.⁹ The study was not able to determine whether managed competition led to additional savings by inducing plans to reduce their premiums. The university implemented managed competition at a time of intense competition among health plans in California, which led to declining premiums statewide.

A study of Harvard University's implementation of managed competition in 1995 concluded that increased price competition led plans to reduce their premiums. The study estimated that those premium reductions lowered health care spending per employee by about 5 percent to 8 percent in the first year, and spending remained at that lower level in the following two years.¹⁰ That estimate does not include spending reductions that were generated as a result of employees' switching to lower-cost plans and therefore does not measure the total reduction in health care spending at Harvard.¹¹ The study estimated the effects of increased competition by comparing the growth of premiums per employee at Harvard with the growth of premiums at other local employers during the four years prior to the policy change and the following three years (and excluding changes in spending that resulted from plan switching). Because premiums were analyzed for a relatively short period following the policy changes at Harvard and the University of California, the long-term effects of those changes are not known.

8. Thomas C. Buchmueller and Paul J. Feldstein, "The Effect of Price on Switching Among Health Plans," *Journal of Health Economics*, vol. 16, no. 2 (April 1997), pp. 231–247.

9. Thomas C. Buchmueller, "Does a Fixed-Dollar Premium Contribution Lower Spending?" *Health Affairs*, vol. 17, no. 6 (November/December 1998), pp. 228–235.

10. David M. Cutler and Sarah J. Reber, "Paying for Health Insurance: The Trade-Off Between Competition and Adverse Selection," *Quarterly Journal of Economics*, vol. 113, no. 2 (May 1998), pp. 433–466.

11. The authors of the study removed the estimated spending reduction that resulted from employees' switching plans (which they did not report separately) to estimate the effect of the policy change on the premiums that health plans charged.

Stanford University implemented a managed competition system for its employees in 1992. A recent study found that from 1999 to 2004, the premiums of the plans offered by Stanford grew at approximately the same rate as the premiums charged to other employers in the region.¹² That evidence suggests that managed competition has not reduced the long-term growth of health care spending at Stanford.

At both the University of California and Harvard University, the adoption of managed competition triggered an adverse selection spiral for the most expensive plans offered (an indemnity plan at California and a preferred provider organization at Harvard). In each case, the university dropped the plan from its menu. Like many employers that use managed competition, the two universities did not adjust their payments to plans to account for differences in the health status or other characteristics of enrollees. In principle, a well-designed risk adjuster could minimize or even eliminate adverse selection spirals.¹³ Risk adjustment to account for differences in enrollees' health status is imprecise, however. The Medicare program has been in the forefront of the development of risk-adjustment methods and, as noted previously, has developed a risk adjuster for the Medicare Advantage program that uses beneficiaries' diagnoses and demographic characteristics to adjust payments to private plans.

Other Studies. A few other studies have estimated the effects of managed competition by comparing health care spending at employers that make a fixed-dollar contribution toward their employees' insurance premiums with employers that subsidize their employees' purchase of more-expensive plans. Those studies use statistical methods to control for differences in the characteristics of employers that use different contribution methods, in an effort to remove the influence of those factors from the comparison of health care spending. Such studies have concluded that a fixed-dollar contribution reduces total health care spending per employee. For example, one

12. Enthoven and Talbott, "Stanford University's Experience with Managed Competition."

13. There is no guarantee that even accurate risk adjustment would have prevented the loss of the higher-cost plans from the Harvard and University of California systems, however. To the extent that the higher-cost plans encouraged excessive utilization of services, the risk-adjusted premiums may have been so high that few, if any, employees would have enrolled.

study estimated that city and county governments that make a fixed-dollar contribution toward their employees' health insurance premiums reduce their total health care spending by about 6 percent to 7 percent.¹⁴ That study did not determine how much of the savings were from employees' switching to lower-cost plans and how much were from plans' reducing their premiums as a result of increased competition. An inherent limitation of such studies is the possibility that the estimates may partly reflect differences in the characteristics of employers, their employees, and their local health care markets—and thus may not isolate the effect of managed competition on total health care spending.

The Federal Employees Health Benefits Program

Some analysts regard the Federal Employees Health Benefits (FEHB) program as a model for changing Medicare.¹⁵ The FEHB program offers federal employees, retirees, and their dependents a wide choice of health plans. In 2006, there are 13 national plan options available in the program, and most participants have access to numerous local plans (which are mostly HMOs).¹⁶ Plans are allowed to vary their benefits and cost-sharing requirements.

National plans determine their premiums on the basis of their prior claims experience with the FEHB program. They are not permitted to vary their premiums geographically. The premiums of local plans are not allowed to exceed the average premiums they charge their two largest commercial accounts in the local market area (although plans are allowed to adjust for differences between the FEHB program and the commercial clients with respect to benefit design and demographic characteristics). National insurers that offer local FEHB program plans in

different market areas may vary their premiums across those areas.

The government contributes 75 percent toward the premium of the insurance plan selected by the employee, up to a maximum dollar amount that is equal to 72 percent of the weighted average premium of all participating plans. The government's maximum contribution is determined separately for single and family coverage, but it does not vary geographically. In 2006, the government's maximum contribution for single coverage is \$3,619, so the government pays 75 percent toward the cost of any single-coverage plan whose total annual premium does not exceed \$4,825.¹⁷ Employees who enroll in a more-expensive plan have to pay the full amount by which the plan's premium exceeds \$4,825. Thus, among plans whose premiums are greater than that amount, employees and plans face incentives that are similar to those under managed competition. Among lower-cost plans, however, employees have a much weaker incentive to be cost-conscious in their choice of plans because they pay only 25 cents for each \$1 increase in the total premium. Consequently, those health plans face weaker incentives to compete on price than they would under managed competition.

Some analysts have suggested that the Medicare program could be made more efficient by incorporating key features from the FEHB program, and a few studies have compared the growth of costs for the two programs. Drawing inferences from such comparisons is difficult, however, because differences between the programs in benefit design and population characteristics could influence the growth of their costs. For example, outpatient prescription drugs have historically been covered by plans in the FEHB program and most other private health insurance plans but not by Medicare (until 2006). That is an important difference because spending on prescription drugs has grown faster than spending on most other types of medical care. Partly because of that difference, the average annual growth in Medicare expenditures per beneficiary from 1969 to 2002 (9.3 percent) is lower than the growth of average premiums per enrollee in the FEHB program over that period (10.6 percent) or the

14. Bryan Dowd and Roger D. Feldman, "Employer Premium Contributions and Health Insurance Costs," in Michael A. Morrisey, ed., *Managed Care and Changing Health Care Markets* (Washington, D.C.: AEI Press, 1998).

15. For example, see Stuart M. Butler and Robert E. Moffit, "The FEHBP as a Model for a New Medicare Program," *Health Affairs*, vol. 14, no. 4 (Winter 1995), pp. 47–61.

16. That figure does not include four additional national plan options that are available only to employees or retirees of certain small federal agencies. Some insurers offer multiple plan options under the FEHB program, which are counted separately here.

17. A premium of \$4,825 is the amount for which the government's maximum contribution for single coverage is reached, since \$3,619 is 75 percent of \$4,825.

growth of average premiums per enrollee for private health insurance generally (11.1 percent).¹⁸

Those differences are narrowed, but not eliminated, when the influence of prescription drugs on spending growth is removed. One study found that, for benefits that are commonly covered by Medicare as well as by plans in the FEHB program, Medicare expenditures per beneficiary grew at an average annual rate of 9.1 percent from 1969 to 2002, compared with average annual rates of growth of 9.6 percent for premiums in the FEHB program and 10.1 percent for private health insurance spending generally.¹⁹ That study did not control for other differences between the two programs that could influence the growth of their costs—such as the characteristics of the covered populations or changes in benefit design—and therefore does not provide definitive evidence on whether the FEHB program can control costs better than the Medicare program.

Implications for Medicare

Studies of managed competition have found that health care spending in employment-based settings can be reduced by giving consumers incentives to be more conscious of costs when choosing a health plan. Although those findings suggest that premium support could reduce Medicare's costs, the effects on those costs would depend to a large extent on how the program was designed. Some of the design options for premium support differ from managed competition because they would set benchmarks at a level other than the minimum bid. However, even a premium support system in which benchmarks are set equal to the minimum bid could have

a different effect on Medicare's costs from the effects that have been reported for employers.

The Medicare program—which is national in scope—differs from the employment-based settings in which managed competition has been implemented in some important ways that could influence the effects of premium support. To begin with, studies of managed competition have focused primarily on urban areas, where such changes are likely to have greater effects (because of the greater competition among health plans and providers) than they would in rural areas. Moreover, the vast majority of Medicare beneficiaries are currently enrolled in the traditional fee-for-service program, and the unique features of that program could heavily influence the outcomes under premium support. For example, as discussed in Chapter 2, Medicare is able to set payment rates for providers that are substantially below the rates that private health plans pay. In addition, there is evidence that Medicare beneficiaries are less responsive to differences in premiums when choosing a health plan than the privately insured population is, so plans may have less incentive to compete on the basis of premiums in the Medicare market than in the privately insured market.²⁰ Because of those factors, premium support could yield less savings for Medicare than a comparable policy change by an employer.

Because of other factors, however, premium support could produce greater savings for Medicare. Because Medicare is such a large program (often constituting a major share of a given provider's revenue), changes to the program could introduce greater incentives for health plans and providers to modify their behavior than comparable changes enacted by individual employers, who may constitute only a tiny fraction of a provider's revenue base.

18. Katherine Levit and others, "Health Spending Rebound Continues in 2002," *Health Affairs*, vol. 23, no. 1 (January/February 2004), pp. 147–159.

19. Ibid.

20. Thomas C. Buchmueller, "The Health Plan Choice of Retirees Under Managed Competition," *Health Services Research*, vol. 35, no. 5 (December 2000), pp. 949–976.

Potential Effects of Selected Approaches to Premium Support

The effects of premium support on federal spending and beneficiaries' premiums would depend on how the program was designed and on how health plans and beneficiaries responded to the change in incentives. To illustrate the potential range of effects, this chapter presents estimates of different approaches to premium support under a set of plausible assumptions about how market participants would respond. Although those assumed responses are based on the best evidence available, that evidence is limited in many ways. Consequently, the effects of premium support are uncertain and could differ markedly from the estimates presented here.

The analysis in this chapter focuses on premium support systems in which the government's contribution is determined from plans' bids. It examines the effects of alternative methods for setting benchmarks (other features of the premium support system are left unchanged). The premium support prototypes that the Congressional Budget Office analyzed do not directly correspond to any specific legislative proposals.

Although the estimates in this chapter are subject to considerable uncertainty, several general conclusions can be drawn from the findings. First, different approaches to determining benchmarks are likely to have substantially different effects on federal spending. Among the options analyzed here, setting benchmarks equal to the minimum bid in each county would generate the greatest federal savings and lead to the highest increase in premiums in certain geographic areas for beneficiaries who wanted to remain in the fee-for-service program. Second, under each approach that CBO examined, benchmarks would be lower than per capita FFS expenditures in geographic areas where those expenditures are high, which would increase beneficiaries' premiums for the FFS program in those areas. Third, benchmarks would be lower than the

statutory benchmarks for the Medicare Advantage program, which would reduce the Medicare program's per capita payments for enrollees in private plans. Consequently, the premium rebates and additional benefits that are currently offered by private plans would probably be reduced and, in some cases, replaced by premium surcharges. In any given area, the change in beneficiaries' incentives regarding plan choice would depend on the amount of any changes in the premium for the FFS program and any changes in the premium rebates and additional benefits offered by private plans.

CBO's Key Assumptions

CBO projected benchmarks at the county level by projecting the bids of private plans and using county-level data on per capita spending in the fee-for-service program (available from the Centers for Medicare and Medicaid Services). The estimates in this chapter are intended to measure the potential effects of different approaches to setting benchmarks after the system fully adjusts to the change in policy.

Projections of Plans' Bids

CBO projected the bids of private plans under premium support from cost data in the Adjusted Community Rate submissions of plans that participated in the Medicare Advantage program in 2005.¹ The Medicare Advantage payment system gives plans an incentive to provide Medicare benefits efficiently because the lower a plan's costs of providing those benefits relative to the benchmark, the

1. After completing the analysis, CBO received data on the bids that plans submitted for 2006. The ratios of those bids to per capita FFS spending are very similar to the ratios predicted from the 2005 ACR data, so using the 2006 data would not change the basic conclusions of this study.

greater the additional benefits or premium rebates it can offer to its enrollees.

Projections of plans' bids under premium support are subject to considerable uncertainty from several sources. One source of uncertainty is whether premium support would give plans a greater incentive to limit their costs of providing Medicare benefits than they face under the Medicare Advantage program. If so, plans' bids under premium support could be lower than their costs under Medicare Advantage. Currently, many beneficiaries who live in the service areas of private plans do not seriously consider enrolling in those plans and have little or no information on the additional benefits or premium rebates that are available.² That situation would probably change under premium support, however, particularly in market areas where the premium for enrollees in the FFS program increased substantially. Raising beneficiaries' awareness of the differences in premiums across plans could stimulate greater price competition among those plans because it would increase the number of beneficiaries who might switch to a plan in response to a given decrease in its bid.

There is little experience from which to predict whether and to what extent plans' bids under premium support would be lower than their costs under the Medicare Advantage program (or how such differences might vary with the mechanism for setting benchmarks or vary geographically). Because of that uncertainty, this study presents estimates under two alternative assumptions about plans' bids—first, that plans' bids under premium support would be the same as their projected costs in the Medicare Advantage program; and, second, that premium support would induce all plans to reduce their bids below their costs in the Medicare Advantage program by 5 percent.³ A comparison of the two sets of estimates provides information on the sensitivity of the projected outcomes to those different assumptions about plans' bids.

A second source of uncertainty in projections of plans' bids is how much of the difference between the costs of Medicare Advantage plans and the costs of the FFS program stems from differences in beneficiaries' health status. CBO used risk scores from the Hierarchical Condi-

tion Codes model to remove the influence of those differences in health status to project plans' bids for a standard beneficiary. As noted in Chapter 2, however, average risk scores computed from the two most recent years of available data differ significantly, and it is not known which of those two sets of risk scores more accurately measures differences in health status. As a result, CBO projected standardized bids using risk scores derived from the 2004 data as well as scores derived from the 2003 data.⁴

A third source of uncertainty in projections of plans' bids is whether, under any of the approaches to setting benchmarks analyzed in this study, premium support would reduce the long-term rate of growth of Medicare expenditures. At this time, CBO has insufficient evidence to conclude that premium support would have such an effect. As noted previously, the limited evidence that is available suggests that employers that have adopted managed competition have not seen a decline in the rate of growth of their health care costs. Moreover, the available evidence, although limited, is that both health care costs and the use of new technologies grow at about the same rate in health maintenance organizations as in other types of health plans.⁵ Consequently, the estimates in this chapter measure the effects of alternative approaches to setting benchmarks on the levels of federal spending and beneficiaries' premiums. CBO made no assumption about

2. Marsha Gold and Natalie Justh, "How Salient Is Choice to Medicare Beneficiaries?" (report prepared for the Robert Wood Johnson Foundation by Mathematica Policy Research under the Monitoring Medicare+Choice Project, January 2001).

3. The assumption of a 5 percent reduction in plans' bids is within the range of estimated premium reductions among health plans that contracted with Harvard University during the period of the university's implementation of managed competition in 1995. See David M. Cutler and Sarah J. Reber, "Paying for Health Insurance: The Trade-Off Between Competition and Adverse Selection," *Quarterly Journal of Economics* (May 1998), pp. 433–466. As noted in Chapter 4, however, the experiences of a single employer cannot be generalized to the Medicare program because those experiences are likely to depend on circumstances that are unique to that employer.

4. On average, risk scores estimated from the 2004 data for enrollees in private plans were about 6 percent lower than risk scores for the FFS population; using the 2003 data, the difference in the two sets of risk scores was about 12 percent.

5. For example, see Joseph P. Newhouse and others, "Are Fee-for-Service Costs Increasing Faster Than HMO Costs?" *Medical Care*, vol. 23, no. 8 (August 1985), pp. 960–966; and Michael Chernew, A. Mark Fendrick, and Richard A. Hirth, "Managed Care and Medical Technology: Implications for Cost Growth," *Health Affairs*, vol. 16, no. 2 (March/April 1997), pp. 196–206.

effects on the long-term rate of growth of those outcomes.⁶

In projecting plans' bids under premium support, CBO used data on the costs of plans that Medicare classifies as "coordinated care plans," most of which are HMOs. CBO did not include private fee-for-service plans, plans that operate under demonstrations, or those that are paid by Medicare on a cost basis. CBO excluded PFFS plans because they are not likely to be competitive with the FFS program under premium support.⁷

In its analysis, CBO assumed that private plans could designate their service areas on a county-by-county basis and would not enter any counties that they did not serve in early 2005.⁸ The Medicare Advantage payment rates in counties that were not served by private plans in early 2005 were 13 percent higher than per capita FFS expenditures, on average. The absence of private plans in those areas suggests that they would not have been able to provide Medicare benefits at a lower cost than the FFS program.

Additional information on CBO's approach to the analysis is provided in Appendix A.

Assumptions About Key Features of the Premium Support System

Under each approach to setting benchmarks, CBO assumed that other features of the premium support system would remain the same as they are under current law. In particular, CBO assumed that plans would bid on the current Medicare benefit package but could vary their cost-sharing requirements as long as they were actuarially equivalent to those of the current package. Moreover, CBO assumed that beneficiaries who enrolled in plans

whose bids were above the benchmark would pay the regular Medicare premium plus an additional premium equal to the entire difference between the bid and the benchmark, while those who enrolled in plans whose bids were below the benchmark would receive 75 percent of the difference as a premium rebate or additional benefits. Beneficiaries who enrolled in plans whose bids were equal to the benchmark would be required to pay a national Part B premium that would be determined in the same manner as under current law, CBO assumed.

CBO assumed that payments to plans under premium support would be adjusted, using the HCC risk adjuster, to account for differences in beneficiaries' health status. For this analysis, CBO assumed that the HCC risk adjuster would fully control for differences in health status between enrollees in private plans and those in the FFS program. CBO further assumed that the HCC risk adjuster would be fully implemented in the Medicare Advantage program prior to the introduction of premium support. Thus, CBO first projected the effects of fully implementing the HCC risk adjuster in the Medicare Advantage program⁹ and then used the resulting estimates as the starting point from which to examine the implications of alternative approaches to setting benchmarks under premium support.

Assumptions About Beneficiaries' Response to Premium Support

With some approaches to setting benchmarks, beneficiaries' decisions to switch plans in one year can influence benchmarks in the following year.¹⁰ Consequently, CBO developed a multiperiod simulation model to project the benchmarks that would prevail after those enrollment shifts had had their full effect. The analysis used estimates from the research literature on the responsiveness of the elderly population to changes in health insurance premiums to project the shifts in enrollment between the FFS program and private plans that would occur in response

6. However, even if premium support reduced the level of federal spending but not its long-term growth, the savings would continue indefinitely because spending would grow from a lower base.

7. PFFS plans are not required to have provider networks, their enrollees may obtain care from any provider who will furnish it, and they are permitted to use Medicare FFS rates to pay providers. Thus, under current law, their greatest potential for success is in areas where Medicare Advantage benchmarks are much higher than per capita FFS expenditures.

8. The ACR data used in the analysis were submitted by plans that participated in Medicare in early 2005. The data do not include plans that entered Medicare later in the year.

9. CBO projects that fully implementing the HCC risk adjuster would reduce per capita payments to private plans and reduce enrollment in those plans.

10. For example, if the benchmark was set equal to the enrollment-weighted average bid in each county, enrollment shifts in the first year of the program would alter the weights that were used to compute benchmarks in the second year.

to the changes in financial incentives that beneficiaries would face under premium support.¹¹

To model changes in enrollment under premium support, CBO first estimated the average premium rebate or surcharge of private plans in each county in the period before premium support would be implemented.¹² That estimate provided a measure of the initial average “relative premium” of private plans, which reflects beneficiaries’ incentive to enroll in those plans. (For example, an average rebate of \$50 in private plans implies that the average premium of those plans is \$50 less than that of the FFS program.) CBO then modeled the implementation of premium support and estimated the new average relative premium of private plans in each county, which depends on the average rebate or surcharge of private plans as well as that of the FFS program. CBO then modeled the shift in enrollment between private plans and the FFS program on the basis of the change in the average relative premium of private plans.¹³

As noted previously, many enrollees in the FFS program have limited information on the additional benefits or premium rebates that private plans offer. Under premium support, increases in premiums for the FFS program are likely to be more noticeable—and thus could have a greater effect on beneficiaries’ behavior—than changes in the additional benefits or premiums of private plans. Given the uncertainty regarding that issue, CBO conducted its analysis under two alternative assumptions about beneficiaries’ responsiveness to changes in premiums. Under the first assumption, beneficiaries’ responsiveness to increases in the premium of the FFS program is assumed to be 50 percent greater than their responsiveness to changes in the additional benefits or premiums of

private plans or to decreases in the premium of the FFS program.¹⁴ Under the second assumption, beneficiaries’ responsiveness to changes in the premium of the FFS program is assumed to be the same as their responsiveness to changes in the additional benefits or premiums of private plans. Projected enrollment in private plans is greater under the first assumption than under the second, but the two assumptions yield similar projections of benchmarks and federal savings.¹⁵

The Analysis of Different Approaches to Determining the Government’s Contribution

In the rest of this chapter, CBO analyzes three approaches to determining benchmarks in a premium support system based on competitive bidding: setting benchmarks equal to the minimum bid in each county, to the average bid in each county, and to the national average bid.

Setting Benchmarks Equal to the Minimum Bid in Each County

The effects of setting benchmarks equal to the minimum bid in each county are highly uncertain because of CBO’s uncertainty in predicting plans’ minimum bids.¹⁶ Nevertheless, under the methods and assumptions used in this analysis, CBO estimates that this approach to setting benchmarks would reduce net federal spending on Medicare by about 8 percent to 11 percent if plans’ bids were standardized using the 2004 risk-adjustment data.¹⁷ Net federal spending would fall by about 4 percent to 6 percent if plans’ bids were standardized using the 2003 risk-adjustment data.

There are two sources of federal savings under the minimum-bid approach to setting benchmarks. First, in

11. For example, see Thomas C. Buchmueller, “Price and the Health Plan Choices of Retirees,” *Journal of Health Economics*, vol. 25, no. 1 (January 2006), pp. 81–101; and Adam Atherly, Bryan E. Dowd, and Roger Feldman, “The Effects of Benefits, Premiums, and Health Risk on Health Plan Choice in the Medicare Program,” *Health Services Research*, vol. 39, no. 4, Part I (August 2004), pp. 847–864.

12. CBO defined a rebate to include either a premium rebate or additional benefits and did not distinguish between the two.

13. CBO’s model assumes that beneficiaries may enroll either in the FFS program or in a private plan whose bid is equal to the average bid of all private plans in the county. CBO did not project the bids of individual plans in counties that have multiple private plans or model changes in enrollment among those plans.

14. Thus, under the first assumption, an increase in the premium for the FFS program has a 50 percent greater weight than other changes in premiums or additional benefits.

15. The estimates of benchmarks, federal savings, and beneficiaries’ premiums presented in the next section were obtained under the first assumption.

16. CBO’s approach to projecting minimum bids at the county level is described in Appendix A.

17. Because the effect of premium support on federal Medicare spending is subject to great uncertainty, all such estimates in this study are rounded to the nearest percent.

Table 5-1.

Projected Benchmarks If Benchmarks Were Set Equal to the Minimum Bid in Each County in 2006 and Plans' Bids Were Standardized Using 2004 Risk-Adjustment Data

Average Per Capita FFS Expenditure in County in 2006 (Dollars)	Percentage of Medicare Beneficiaries	Average Ratio of Projected Benchmarks to Per Capita FFS Expenditures		Average Ratio of Projected Benchmarks to Medicare Advantage Benchmarks	
		If Plans' Bids Were the Same as Under Medicare Advantage	If Plans Reduced Their Bids by 5 Percent	If Plans' Bids Were the Same as Under Medicare Advantage	If Plans Reduced Their Bids by 5 Percent
Less Than 550	15.0	1.00	0.99	0.79	0.79
550 to 599	20.1	0.98	0.98	0.86	0.85
600 to 649	23.5	0.94	0.93	0.87	0.85
650 to 699	15.2	0.92	0.89	0.88	0.85
700 and Higher	26.3	0.86	0.83	0.83	0.80
National Average	n.a.	0.94	0.92	0.85	0.83

Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services.

Note: FFS = fee for service; n.a. = not applicable.

counties where the benchmark is lower than per capita FFS expenditures, net federal spending on enrollees in the FFS program would be reduced by an amount equal to the difference between the benchmark and per capita FFS expenditures. (That difference would be paid by beneficiaries who enrolled in the FFS program, as an additional premium.) Thus, on a per capita basis, federal savings on beneficiaries who enrolled in the FFS program—and on those who would have enrolled in that program if premium support had not been introduced—would be greatest in areas where benchmarks are lowest relative to per capita FFS expenditures. The second source of federal savings is lower per capita payments to private plans. In all counties, benchmarks set equal to the minimum bid would be lower than benchmarks in the Medicare Advantage program. Moreover, the government-funded additional benefits and premium rebates that many private-plan enrollees currently receive would be eliminated because, by definition, no plan's bid would be below the benchmark.

Under this approach to setting benchmarks, the federal savings do not depend on the number of beneficiaries who switch plans. In each county, the federal government's spending on Medicare would be determined by the benchmark. All beneficiaries would be required to pay the national Part B premium, and those who enrolled in a plan whose bid exceeded the benchmark would be required to pay the difference between the bid and the

benchmark as an additional premium. In contrast, the effects of the program on total systemwide costs (including the premiums paid by beneficiaries) would depend on the extent to which beneficiaries switched to lower-cost plans. Predicting such behavior is subject to considerable uncertainty, however, so CBO did not estimate the effects on total systemwide costs in this study.¹⁸

Standardizing Plans' Bids Using 2004 Data. If plans' bids were standardized using the 2004 risk-adjustment data, benchmarks set equal to the minimum bid in each county would be an average of 6 percent to 8 percent below per capita FFS expenditures nationally (see Table 5-1). Benchmarks would be lowest relative to per capita FFS expenditures in areas where those expenditures are high, because private plans have the greatest potential to achieve savings relative to the FFS program in those areas. The projected benchmarks in the highest-spending counties (those in which projected per capita FFS spending in 2006 is at least \$700 per month) are 14 percent to 17 percent lower than per capita FFS expenditures, on average. Consequently, beneficiaries' premiums for the FFS program in those counties would

18. In counties with multiple private plans, the effects on total systemwide costs would depend on the bid of each private plan and on the amount that each plan's enrollment changed under premium support. As noted previously, CBO did not model such outcomes.

Table 5-2.

Projected Monthly Beneficiaries' Premiums for the FFS Program If Benchmarks Were Set Equal to the Minimum Bid in Each County in 2006 and Plans' Bids Were Standardized Using 2004 Risk-Adjustment Data

Average Per Capita FFS Expenditure in County in 2006 (Dollars)	Projected Average Monthly Premium for FFS Program (Dollars)		Average Percentage Change in Part B Premium		Average Premium for FFS Program as a Percentage of Per Capita FFS Expenditures	
	If Plans'	If Plans	If Plans'	If Plans	If Plans'	If Plans
	Bids Were the Same as Under Medicare Advantage	Reduced Their Bids by 5 Percent	Bids Were the Same as Under Medicare Advantage	Reduced Their Bids by 5 Percent	Bids Were the Same as Under Medicare Advantage	Reduced Their Bids by 5 Percent
Less Than 550	82	82	-7	-7	16	16
550 to 599	90	93	2	6	16	16
600 to 649	116	126	32	43	19	20
650 to 699	135	154	53	75	20	23
700 and Higher	200	228	127	159	26	29
National Average	131	144	49	64	20	21

Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services.

Notes: FFS = fee for service.

The percentage change in the Part B premium is computed relative to the estimated value of that premium after the Hierarchical Condition Codes (HCC) risk adjuster was fully implemented in the Medicare Advantage program. Fully implementing that risk adjuster would reduce federal Medicare spending and therefore reduce the Part B premium below what it otherwise would be. Throughout this analysis, CBO assumed that the HCC risk adjuster would be fully implemented before premium support was introduced.

rise substantially under this system of premium support (see below).

On average, projected benchmarks are higher relative to FFS expenditures in counties where those expenditures are low. Private plans are less likely to deliver Medicare benefits at a lower cost than the FFS program in those areas, and CBO projects that the FFS program would be the lowest bidding plan in many such areas. The projected benchmarks in the lowest-spending counties (those in which per capita FFS spending is less than \$550 per month) are approximately equal to per capita FFS expenditures, on average (see Table 5-1).

Projected benchmarks nationally are an average of 15 percent to 17 percent lower than benchmarks for the Medicare Advantage program (see Table 5-1). On average, projected benchmarks are about 21 percent lower than Medicare Advantage benchmarks in the lowest-spending counties and 17 percent to 20 percent lower than Medicare Advantage benchmarks in the highest-spending counties. Thus, the Medicare program's per capita payments for enrollees in private plans would decline substantially under this system of premium support.

If plans' bids were standardized using the 2004 risk-adjustment data, setting benchmarks equal to the minimum bid in each county would increase beneficiaries' premiums for the FFS program nationwide by an average of 49 percent to 64 percent (see Table 5-2). Those premiums would vary greatly across geographic areas, however, and beneficiaries who live in the highest-spending counties would face the greatest increase in premiums. In the highest-spending counties, the monthly premium for beneficiaries who wanted to enroll in the FFS program would more than double, increasing to an average of \$200 to \$228.¹⁹ Beneficiaries' premiums for the FFS program would increase by smaller amounts, on average, in counties with moderate levels of per capita FFS expendi-

19. Those estimates measure the premiums that would prevail in 2006 if premium support had been fully implemented in that year and if the system had fully adjusted to the change in policy. In computing the average beneficiary's premium for the FFS program, CBO weighted the premium in each county by the number of beneficiaries in that county. The percentage change in premiums was computed relative to the premium that would prevail after the HCC risk adjuster was fully implemented. That premium is projected to be somewhat lower than the current Part B premium (\$88.50 per month in 2006).

tures. In the lowest-spending counties, those premiums would decline by an average of about 7 percent because the FFS program would be the lowest-bidding plan in virtually all of those counties (and thus enrollees in that program would not face a premium surcharge), and the national Part B premium would fall as a result of the reduction in gross Medicare spending.

Those changes in premiums would substantially alter the geographic cross-subsidies in the Medicare FFS program. Currently, because the Part B premium is uniform nationally, beneficiaries in the lowest-spending counties pay a higher share of their spending through Part B premiums than beneficiaries in the highest-spending counties do. Specifically, among enrollees in the FFS program, Part B premiums are currently 17 percent of FFS spending in the lowest-spending counties, on average, but only about 12 percent of FFS spending in the highest-spending counties. If benchmarks were set equal to the minimum bid in each county, however, beneficiaries' premiums for the FFS program in the highest-spending counties would increase to an average of 26 percent to 29 percent of FFS spending, while such premiums in the lowest-spending counties would fall to an average of 16 percent of FFS spending (see Table 5-2).

Those estimates assume that per capita spending levels in the fee-for-service program would not be affected by the implementation of premium support. In principle, if premium support was accompanied by federal policies that reduced FFS expenditures in areas where those expenditures are high, the increases in premiums for the FFS program could be reduced. However, although analysts and policymakers have proposed various approaches for reducing spending in the FFS program, they remain untested on a broad scale and their effect on spending is uncertain.²⁰

Standardizing Plans' Bids Using 2003 Data. The projected benchmarks are higher if plans' bids are standardized using the 2003 risk-adjustment data rather than the 2004 data, and the projected increases in beneficiaries'

premiums for the FFS program are therefore lower.²¹ Using the 2003 risk-adjustment data yields projected benchmarks that are an average of 3 percent to 5 percent lower than per capita FFS expenditures nationally (see Table B-1 in Appendix B).

In the highest-spending counties, the projected benchmarks are 8 percent to 11 percent lower than per capita FFS expenditures when the 2003 risk-adjustment data are used to standardize plans' bids. The monthly premium for beneficiaries in those counties who wanted to enroll in the FFS program would increase to an average of \$148 to \$174, an increase of 70 percent to 100 percent (see Table B-2). Although those increases in premiums are substantial, they are much lower than the increases that are projected using the 2004 risk-adjustment data.

Setting Benchmarks Equal to the Average Bid in Each County

Based on the methods and assumptions used in this analysis, CBO projects that setting benchmarks equal to the average bid in each county (with each plan's bid weighted by its enrollment in the previous year) would reduce net federal spending on Medicare by about 1 percent to 2 percent if plans' bids were standardized using the 2004 risk-adjustment data. Net federal spending would fall by less than 1 percent if those bids were standardized using the 2003 risk-adjustment data.

The sources of federal savings under this approach to setting benchmarks are the same as those under the minimum-bid approach—namely, lower federal contributions for enrollees in the FFS program and for enrollees in private plans. The benchmarks would be substantially higher under the average-bid approach than under the minimum-bid approach, however, so the federal savings would be much smaller. With benchmarks set equal to the enrollment-weighted average bid in each county, the bid of the FFS program would initially have a dominant effect on the benchmark in most counties, because the great majority of beneficiaries are enrolled in that pro-

20. Approaches that have been proposed for reducing spending in the FFS program include establishing payment rates through competitive bidding, requiring prior authorization to reduce inappropriate use of services, covering case management services for people with multiple chronic conditions, and giving beneficiaries financial or other incentives to obtain care from the most efficient providers.

21. Plans' standardized bids are higher when the 2003 risk-adjustment data are used because those data imply that enrollees in private plans are healthier than the 2004 data do (and both sets of data imply that enrollees in private plans are healthier than those in the FFS program). Therefore, standardizing plans' bids to remove the influence of health status requires a greater upward adjustment when the 2003 data are used.

Table 5-3.

Projected Benchmarks If Benchmarks Were Set Equal to the Enrollment-Weighted Average Bid in Each County in 2006 and Plans' Bids Were Standardized Using 2004 Risk-Adjustment Data

Average Per Capita FFS Expenditure in County in 2006 (Dollars)	Percentage of Medicare Beneficiaries	Average Ratio of Projected Benchmarks to Per Capita FFS Expenditures		Average Ratio of Projected Benchmarks to Medicare Advantage Benchmarks	
		If Plans' Bids Were the Same as Under Medicare Advantage	If Plans Reduced Their Bids by 5 Percent	If Plans' Bids Were the Same as Under Medicare Advantage	If Plans Reduced Their Bids by 5 Percent
Less Than 550	15.0	1.00	1.00	0.79	0.80
550 to 599	20.1	1.00	1.00	0.87	0.87
600 to 649	23.5	1.00	1.00	0.92	0.91
650 to 699	15.2	1.00	0.99	0.95	0.94
700 and Higher	26.3	0.99	0.98	0.95	0.95
National Average	n.a.	1.00	0.99	0.90	0.90

Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services.

Note: FFS = fee for service; n.a. = not applicable.

gram. To the extent that beneficiaries switched to lower-cost plans, future benchmarks would be reduced, because such switching would increase the weight that was applied to the bids of lower-cost plans. Moreover, under the program design that CBO assumed for this analysis, the federal government would capture part of the savings when beneficiaries switched to plans whose bids are below the benchmark, because the rebate for such beneficiaries would be 75 percent of the difference between the bid and the benchmark (with the government retaining the other 25 percent).

Standardizing Bids Using 2004 Data. When plans' bids are standardized using the 2004 risk-adjustment data, projected benchmarks nationally are approximately equal to, or 1 percent lower than, per capita FFS expenditures, on average (see Table 5-3). In the highest-spending counties, where private plans' bids are lowest relative to FFS expenditures, projected benchmarks are an average of 1 percent to 2 percent lower than per capita FFS expenditures. That relatively small difference implies that beneficiaries in the highest-spending counties who wanted to enroll in the FFS program would face much smaller increases in their premiums than if benchmarks were set equal to the minimum bid in each county (see below). In all of the other counties, benchmarks are approximately equal to per capita FFS spending, on average. In many of those counties, the projected average bid of private plans is higher than per capita FFS expenditures. For that rea-

son, CBO projects that many private-plan enrollees in those counties would switch to the FFS program under this system of premium support.

Nationally, the projected benchmarks are an average of about 10 percent lower than the Medicare Advantage benchmarks (see Table 5-3). Projected benchmarks are about 5 percent lower than the Medicare Advantage benchmarks in the highest-spending counties, on average, and about 20 percent lower than those benchmarks in the lowest-spending counties. Those lower benchmarks would substantially reduce—and, in many cases, eliminate—the premium rebates and additional benefits that would be available to enrollees in private plans.

Setting benchmarks equal to the enrollment-weighted average bid in each county would result in much smaller changes in beneficiaries' premiums for the FFS program than setting benchmarks equal to the minimum bid in each county would, CBO projects. When plans' bids are standardized using the 2004 risk-adjustment data, the projected premiums for the FFS program increase by 2 percent to 5 percent nationally (see Table 5-4). The greatest increases in beneficiaries' premiums for the FFS program would be in the highest-spending counties, where such premiums are projected to increase by an average of 9 percent to 17 percent. In the two lowest-spending categories of counties (those in which per capita spending in 2006 is less than \$600 per month), beneficia-

Table 5-4.

Projected Monthly Beneficiaries' Premiums for the FFS Program If Benchmarks Were Set Equal to the Enrollment-Weighted Average Bid in Each County in 2006 and Plans' Bids Were Standardized Using 2004 Risk-Adjustment Data

Average Per Capita FFS Expenditure in County in 2006 (Dollars)	Projected Average Monthly Premium for FFS Program (Dollars)		Average Percentage Change in Part B Premium		Average Premium for FFS Program as a Percentage of Per Capita FFS Expenditures	
	If Plans'	If Plans	If Plans'	If Plans	If Plans'	If Plans
	Bids Were the Same as Under Medicare Advantage	Reduced Their Bids by 5 Percent	Bids Were the Same as Under Medicare Advantage	Reduced Their Bids by 5 Percent	Bids Were the Same as Under Medicare Advantage	Reduced Their Bids by 5 Percent
Less Than 550	87	86	-1	-2	17	17
550 to 599	87	86	-1	-2	15	15
600 to 649	87	88	-1	0	14	14
650 to 699	89	93	1	6	13	14
700 and Higher	96	103	9	17	12	13
National Average	90	92	2	5	14	14

Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services.

Notes: FFS = fee for service.

The percentage change in the Part B premium is computed relative to the estimated value of that premium after the Hierarchical Condition Codes (HCC) risk adjuster was fully implemented in the Medicare Advantage program. Fully implementing that risk adjuster would reduce federal Medicare spending and therefore reduce the Part B premium below what it otherwise would be. Throughout this analysis, CBO assumed that the HCC risk adjuster would be fully implemented before premium support was introduced.

ries' premiums for the FFS program would fall by an average of 1 percent to 2 percent.

Those changes in premiums would have little effect on the geographic cross-subsidies in the Medicare FFS program. The premiums of FFS enrollees in the lowest-spending counties would remain at about 17 percent of average spending in those areas, while the premiums of FFS enrollees in the highest-spending counties would increase slightly to 12 percent to 13 percent of average spending (see Table 5-4).

Standardizing Plans' Bids Using 2003 Data. When plans' bids are standardized using the 2003 risk-adjustment data, projected benchmarks nationally are approximately equal to per capita FFS expenditures, on average (see Table B-3). Even in the highest-spending counties, projected benchmarks are equal to per capita FFS expenditures. Consequently, using the 2003 risk-adjustment data, CBO estimates that beneficiaries' premiums for the FFS program would remain approximately the same as under current law, on average (see Table B-4).

Projected benchmarks nationally are about 9 percent lower than the Medicare Advantage benchmarks, on average (see Table B-3). Those lower benchmarks would reduce Medicare's payments for enrollees in private plans, which would be the principal source of federal savings under this system of premium support.

Setting Benchmarks Equal to the Median Bid in Each County

In general, setting benchmarks equal to the median bid in each county would reduce net federal Medicare spending by more than would setting benchmarks equal to the enrollment-weighted average bid but by less than would setting benchmarks equal to the minimum bid. Likewise, beneficiaries' premiums for the FFS program would be somewhere between the projected premiums that would be required under those other two methods of setting benchmarks.

CBO did not quantify the precise effects of setting benchmarks equal to the median bid for this study because of the uncertainty associated with projecting median bids at the county level. Projecting how median

Table 5-5.

Projected Benchmarks If Benchmarks Were Set Equal to the National Average Bid in 2006, Adjusted to Account for Geographic Variation in Input Prices, and Plans' Bids Were Standardized Using 2004 Risk-Adjustment Data

Average Per Capita FFS Expenditure in County in 2006 (Dollars)	Percentage of Medicare Beneficiaries	Average Ratio of Projected Benchmarks to Per Capita FFS Expenditures		Average Ratio of Projected Benchmarks to Medicare Advantage Benchmarks	
		If Plans' Bids Were the Same as Under Medicare Advantage	If Plans Reduced Their Bids by 5 Percent	If Plans' Bids Were the Same as Under Medicare Advantage	If Plans Reduced Their Bids by 5 Percent
Less Than 550	15.0	1.16	1.16	0.92	0.92
550 to 599	20.1	1.05	1.05	0.91	0.91
600 to 649	23.5	1.01	1.01	0.92	0.92
650 to 699	15.2	0.96	0.95	0.91	0.91
700 and Higher	26.3	0.92	0.91	0.89	0.88
National Average	n.a.	1.01	1.00	0.91	0.91

Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services.

Note: FFS = fee for service; n.a. = not applicable.

bids might change over time as some private plans enter or exit the program would be subject to much greater uncertainty than projecting how enrollment-weighted average bids might change. For example, decisions by plans with small enrollments to enter or exit the program could have a much greater effect on the median bid in a given county than on the enrollment-weighted average bid.

Setting Benchmarks Equal to the National Average Bid

The effects of setting benchmarks equal to the national average bid, with each plan's bid weighted by its enrollment in the previous year, would depend on the extent to which benchmarks were adjusted to account for geographic variation in per capita Medicare spending. For this analysis, CBO assumed that benchmarks would be adjusted to account for geographic variation in the prices of inputs that are used to provide Medicare services but not for geographic variation in beneficiaries' use of services. That approach was contained in the premium support proposal in the Medicare Preservation and Improvement Act of 2001 (S. 357).

To measure geographic variation in input prices, CBO used a weighted average of two price indexes that are used by CMS to adjust payment rates in the fee-for-service program. The first is the hospital wage index, which measures geographic variation in the wages of hospital

employees and is used by the Medicare program to adjust payments to hospitals. The second is the geographic adjustment factor (GAF), which is a weighted average of three indexes that measure geographic variation in different inputs for physicians' services, which are used by the Medicare program to adjust payment rates to physicians.²² In constructing an average of those indexes, CBO weighted the hospital wage index by the proportion of Medicare expenditures nationally that is covered under Part A and the GAF by the proportion of Medicare expenditures nationally that is covered under Part B.

Standardizing Plans' Bids Using 2004 Data. If plans' bids were standardized using the 2004 risk-adjustment data, benchmarks would be approximately equal to per capita FFS expenditures nationally. Projected benchmarks are an average of 8 percent to 9 percent lower than per capita FFS expenditures in the highest-spending counties and an average of 16 percent higher than per capita FFS expenditures in the lowest-spending counties (see Table 5-5). Consequently, enrollees in the FFS program who live in the highest-spending counties would be required to pay premium surcharges, on average, while

22. The three indexes measure geographic variation in three components of physicians' input costs: physicians' work (measured by the hourly earnings of workers in selected professions), practice expense (which includes employees' wages, office rents, and other expenses), and malpractice insurance costs.

those who live in the lowest-spending counties would receive rebates.

Under this approach to setting benchmarks, the geographic variation in the ratio of benchmarks to per capita FFS expenditures depends on the geographic adjustment that is applied to the national average bid. Because the national average bid is adjusted to account for geographic differences in input prices but not for differences in the level and intensity of service utilization, benchmarks are lower than per capita FFS expenditures in the highest-spending counties and higher than per capita FFS expenditures in the lowest-spending counties.

The effects of this approach to setting benchmarks on federal spending and on beneficiaries' premiums for the FFS program would depend on another feature of the program's design—namely, the rules for determining the premiums of beneficiaries who live in areas that are not served by private plans. For this analysis, CBO assumed that no restrictions would be placed on the premiums of such beneficiaries. Thus, the premiums of beneficiaries who live in areas that are not served by private plans would be determined in the same manner as the premiums of enrollees in the FFS program who live in areas that are served by private plans.²³

Based on the methods and assumptions used in this paper, CBO estimates that a premium support program designed in that manner would reduce net federal spending on Medicare by about 2 percent if plans' bids were standardized using the 2004 risk-adjustment data. Beneficiaries' premiums for the FFS program would increase by 7 percent to 9 percent nationally (see Table 5-6).²⁴ The changes to those premiums would vary greatly across geographic areas, however. In the highest-spending counties, beneficiaries' premiums for the FFS program would rise by more than 75 percent, to an average of \$155 to \$158. In the lowest-spending counties, in contrast, beneficiaries' premiums for the FFS program would fall by at least 70 percent, to an average of \$24 to \$26.

23. Specifically, if the average FFS expenditure in the county was above the benchmark, beneficiaries would have to pay a premium surcharge equal to the difference between the two. Conversely, if the average FFS expenditure in the county was below the benchmark, beneficiaries would receive a premium rebate equal to 75 percent of the difference between the two.

In the lowest-spending counties, the premiums of enrollees in the FFS program would fall from 17 percent of spending to 5 percent, on average (see Table 5-6). In the highest-spending counties, the premiums of enrollees in the FFS program would increase from an average of about 12 percent of spending to an average of about 20 percent.

Other design choices are possible for determining the premiums of beneficiaries who live in areas that are not served by private plans. One approach is to constrain the premiums of such beneficiaries to not exceed the national Part B premium. Under that approach, beneficiaries who live in areas that are not served by private plans would not be required to pay a premium surcharge if the average FFS expenditure in their county exceeded the benchmark, but they would be eligible to receive a premium rebate if the opposite was true. That approach is analogous to a provision in the proposal in the Medicare Preservation and Improvement Act of 2001.²⁵

That alternative approach to determining beneficiaries' premiums in counties that are not served by private plans would result in higher net federal spending than the approach described above in which no constraints are placed on the premiums of such beneficiaries. In fact, a premium support system with such a design could result in little or no federal savings—and perhaps even an increase in federal spending. In counties that are not served by private plans and in which per capita FFS spending exceeds the benchmark, federal spending under the alternative approach would be determined by per capita spending in the FFS program, not by the (lower) benchmark. The effect of that approach to determining beneficiaries' premiums on federal spending is highly uncertain because it depends greatly on the number of counties that would be served by private plans, and

24. Although benchmarks nationally are approximately equal to per capita FFS spending, on average, beneficiaries' premiums for the FFS program would increase by an average of 7 percent to 9 percent nationally because of how CBO assumed that premium surcharges and rebates would be determined. In particular, CBO assumed that the premium surcharge for a plan whose bid exceeds the benchmark would equal the full difference between the two, whereas the premium rebate for a plan whose bid is less than the benchmark would equal 75 percent of the difference between the two (with the government retaining the other 25 percent).

25. As noted in Box 3-1, the Senate bill would have combined the Part A and Part B Medicare trust funds and replaced the Part B premium with a Medicare premium.

Table 5-6.

Projected Monthly Beneficiaries' Premiums for the FFS Program If Benchmarks Were Set Equal to the National Average Bid in 2006, Adjusted for Geographic Variation in Input Prices, and Plans' Bids Were Standardized Using 2004 Risk-Adjustment Data

Average Per Capita FFS Expenditure in County in 2006 (Dollars)	Projected Average Monthly Premium for FFS Program (Dollars)		Average Percentage Change in Part B Premium		Average Premium for FFS Program as a Percentage of Per Capita FFS Expenditures	
	If Plans'	If Plans	If Plans'	If Plans	If Plans'	If Plans
	Bids Were the Same as Under Medicare Advantage	Reduced Their Bids by 5 Percent	Bids Were the Same as Under Medicare Advantage	Reduced Their Bids by 5 Percent	Bids Were the Same as Under Medicare Advantage	Reduced Their Bids by 5 Percent
Less Than 550	24	26	-73	-70	5	5
550 to 599	63	65	-28	-26	11	11
600 to 649	83	85	-6	-3	13	14
650 to 699	117	119	33	35	17	18
700 and Higher	155	158	76	80	20	20
National Average	94	96	7	9	14	14

Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services.

Notes: FFS = fee for service.

Estimates in this table were calculated under the assumption that there would be no restrictions on the premiums of beneficiaries who live in areas not served by private plans.

The percentage change in the Part B premium is computed relative to the estimated value of that premium after the Hierarchical Condition Codes (HCC) risk adjuster was fully implemented in the Medicare Advantage program. Fully implementing that risk adjuster would reduce federal Medicare spending and therefore reduce the Part B premium below what it otherwise would be. Throughout this analysis, CBO assumed that the HCC risk adjuster would be fully implemented before premium support was introduced.

projections of plan participation at the county level are highly uncertain.²⁶ Therefore, the effects of such a program design are not quantified in this analysis.

26. The simulation model used in this study predicts enrollment in private plans under premium support. For computing benchmarks under this system of premium support, the results do not change very much under differing assumptions about whether some counties would have small enrollments in private plans or whether such enrollment would fall to zero. Predicting whether private plans would remain in such counties under a particular premium support design is subject to considerable uncertainty, however.

Standardizing Plans' Bids Using 2003 Data. If plans' bids were standardized using the 2003 risk-adjustment data, net federal spending on Medicare would fall by about 1 percent (under the assumption that the program used the main approach to determining beneficiaries' premiums described above). The 2003 risk-adjustment data result in higher standardized bids than the 2004 data; those higher bids would in turn result in slightly higher benchmarks and slightly lower beneficiaries' premiums for the FFS program (see Tables B-5 and B-6).

Technical Aspects of the Analysis

This appendix describes the Congressional Budget Office's (CBO's) approach to two components of its analysis of alternative methods of setting benchmarks under premium support. The first section describes CBO's approach to estimating private plans' costs of delivering Medicare benefits at the county level. The Adjusted Community Rate (ACR) reports contain plans' projections of their cost per enrollee of delivering Medicare benefits in their service area. Many plans include more than one county in their service area, however, and plans are not required to report costs by county. For this study, therefore, CBO developed an approach to estimating each plan's cost per enrollee at the county level from the costs each plan projected for its entire service area. The second section describes CBO's approach to projecting plans' bids under premium support from the estimates of plans' costs.

How CBO Estimated County-Level Costs from Plan-Level Data

The objective of the analysis described in this appendix is to develop county-level estimates of each plan's cost per enrollee of delivering Medicare benefits, using data on each plan's projected costs for its entire service area. To estimate how costs vary across counties for a given plan, CBO first examined how costs vary across plans that serve different geographic areas. The relationships revealed through that analysis were then used to estimate county-level costs for each plan.

For the initial analysis of plan-level data, plans were classified by the per capita fee-for-service (FFS) expenditure in their service area. For plans that serve more than one county (which is true of most plans), the per capita FFS expenditure for the *plan* was computed as a weighted average of per capita FFS expenditures in the *counties* in the plan's service area, and the weights were based on the distribution of the plan's enrollees across counties.

CBO used data on plans' projected costs (including administrative costs and normal profits) that were contained in the plans' ACR reports for 2005. CBO standardized plans' costs using risk scores based on the Hierarchical Condition Codes model that were included in those ACR reports. (For most plans, those risk scores were probably based on 2003 risk-adjustment data, since the 2005 ACR reports were due to the government by September 2004). The county-level estimates of per capita FFS expenditures in 2005 were standardized by the Centers for Medicare and Medicaid Services (CMS).

The analysis of plan-level data found that, on average, plans' costs per enrollee were 11 percent higher than per capita FFS expenditures in the plans' service areas (see Table A-1). Plans that served areas where FFS spending is low had much higher relative costs than plans that served areas where FFS spending is high.¹ On a per capita basis, private plans' costs were an average of 34 percent higher than FFS expenditures in service areas with a per capita FFS expenditure of less than \$500 and equal to FFS expenditures in service areas with a per capita FFS expenditure of at least \$750. Private plans have greater potential to achieve savings in areas with high FFS spending levels because expensive services that plans seek to limit are used at a higher rate in those areas.

To estimate county-level costs for individual plans, CBO assumed that the factors that contribute to variation in costs across *counties* served by a particular plan are the same factors that contribute to the variation in costs across *plans* that serve different geographic areas. Therefore, CBO used the plan-level relative cost ratios in Table A-1 to allocate costs across counties for each plan.

1. The relative cost refers to the plan's cost per enrollee relative to per capita FFS expenditures.

Table A-1.

Private Plans' Per Capita Costs of Providing Medicare Benefits Relative to Those of the FFS Program, Based on Plan-Level Estimates, 2005

Average Per Capita FFS Expenditure in Plan's Service Area (Dollars)	Percentage of Private-Plan Enrollees	Average Ratio of Plans' Costs to Per Capita FFS Expenditures
Less Than 500	4.3	1.34
500 to 549	8.7	1.25
550 to 599	19.6	1.14
600 to 649	26.3	1.10
650 to 699	13.7	1.08
700 to 749	11.9	1.09
750 and Higher	15.6	1.00
National Average	n.a.	1.11

Source: Congressional Budget Office based on data submitted by private plans to the Medicare program for 2005.

Note: Plans' costs and average fee-for-service (FFS) expenditures in plans' service areas were standardized using risk scores from the Hierarchical Condition Codes model. Estimates for private-plan enrollees are based on risk scores derived from 2003 risk-adjustment data.

To illustrate the approach, consider a plan that serves three counties.² Let:

C = the cost per enrollee reported by the plan for its service area

C_i = the (unobserved) cost per enrollee for the plan in county i

P_i = the proportion of the plan's enrollees who live in county i

F_i = per capita FFS expenditures in county i

The total cost per enrollee for the plan is a weighted average of its county-level costs:

$$(1) P_1 * C_1 + P_2 * C_2 + P_3 * C_3 = C$$

Assume that the per capita FFS expenditures in counties 1, 2, and 3 are \$525, \$675, and \$800, respectively. Then, using the estimates in Table A-1:

$$(2) C_1 / F_1 = (1.25 / 1.08) * C_2 / F_2$$

$$(3) C_1 / F_1 = (1.25 / 1.00) * C_3 / F_3$$

2. The approach is valid for a plan that serves any number of counties.

The values 1.25 and 1.08 appear in equation (2) because they are the relative cost ratios in Table A-1 that correspond to the assumed per capita FFS expenditures in counties 1 and 2 (\$525 and \$675, respectively). The values 1.25 and 1.00 appear in equation (3) for analogous reasons.

Equations (1), (2), and (3) have three unknowns—the three county-level costs per enrollee (C_1 , C_2 , and C_3).³ Once those equations are rearranged, the cost per enrollee in each county can be computed.

That approach yields county-level estimates of relative costs that exhibit the same pattern with respect to FFS expenditures that the corresponding plan-level estimates do—that is, the county-level relative cost ratios in Table 2-1 (based on 2003 risk-adjustment data) are very similar to the plan-level estimates in Table A-1.

CBO considered and rejected two alternative assumptions before using the more complex approach described above. The first alternative that was rejected is that a plan's costs per enrollee do not vary across counties. That

3. Another equation could be written expressing the relationship between the relative cost ratios in counties 2 and 3, but that would not be an independent equation because it could be derived directly from equations (2) and (3).

assumption is not appropriate because the service areas of some plans include counties that vary greatly with respect to per capita FFS expenditures and other local market characteristics that influence plans' costs. The second alternative that was rejected is that a plan's costs vary across counties in the same proportion as the variation in per capita FFS expenditures. That assumption was rejected because the plan-level estimates indicate that plans' costs exhibit less variation across geographic areas than per capita FFS expenditures do.

After CBO had allocated plans' costs by county, CMS announced that risk scores for private-plan enrollees computed from 2004 risk-adjustment data were significantly higher relative to those of the FFS population than the risk scores computed from 2003 data, which CBO had used. Because such differences in risk scores could significantly affect the findings of the analysis, CBO developed an alternative set of estimates based on the more recent risk scores. To do so, CBO obtained from CMS county-level estimates of the average risk scores for private-plan enrollees based on 2004 data. (Plan-level estimates of risk scores based on those data were not available.) CBO adjusted the county-level estimates of plans' standardized costs (which it had computed using risk scores from 2003 data) by multiplying the estimate for each county by the ratio of the average risk score for private-plan enrollees in that county estimated from 2003 data to the corresponding estimate from 2004 data. The result was a set of county-level estimates of plans' standardized costs based on risk scores from the 2004 data.

How CBO Projected Plans' Bids Under Premium Support

CBO used the county-level estimates of private plans' costs of delivering Medicare benefits in 2005 to project plans' bids under premium support. CBO computed the average bid of private plans in each county, with each plan's bid weighted by its enrollment in the previous year, and used those average bids to analyze premium support proposals in which benchmarks were set equal to the average bid in each county or the national average bid.

To analyze a premium support system in which benchmarks are set equal to the minimum bid in each county, CBO projected minimum bids at the county level. Projecting minimum bids is subject to greater uncertainty than projecting average bids because the minimum plan cost estimated for some counties could reflect errors in the data. For example, if costs or risk scores are misreported on some plans' ACR submissions, those plans' estimated costs could be lower or higher than their actual costs. In some counties, the estimated costs of the minimum-cost plans were so much lower than the costs of other local plans as to raise suspicions about the data. Consequently, CBO "trimmed" the data to remove the influence of extreme values.

To trim the data, CBO used the plan/county estimates of per capita costs—that is, the estimates of each plan's cost in each county in its service area. Each plan/county observation was assigned to a category of counties on the basis of per capita FFS spending in the county.⁴ For each plan/county observation, CBO computed the ratio of the plan's cost in that county to the per capita FFS expenditure in the county. Next, CBO examined the distribution of that cost ratio for each category of counties. Those distributions were close to the normal distribution. Within each category of counties, plan/county observations in which the cost ratio was more than 2.5 standard deviations from the mean were identified. For observations in which the cost ratio was below the mean by more than 2.5 standard deviations, CBO "recoded" the cost ratio for that observation to equal the mean minus 2.5 standard deviations. Similarly, for observations in which the cost ratio was above the mean by more than 2.5 standard deviations, CBO recoded the cost ratio for that observation to equal the mean plus 2.5 standard deviations. Overall, about 2 percent of plan/county observations were recoded. Changing the cutoff point to 3 standard deviations from the mean reduced the number of observations that were recoded but did not affect the results presented in the study.

4. For this analysis, CBO defined the same categories that were used in Table A-1.

Supplementary Tables

This appendix contains tables illustrating the potential effects of different approaches to setting benchmarks under premium support. The tables reflect the assumption

that plans' bids are standardized using the 2003 risk-adjustment data. (For estimates made using the 2004 risk-adjustment data, see Chapter 5.)

Table B-1.

Projected Benchmarks If Benchmarks Were Set Equal to the Minimum Bid in Each County in 2006 and Plans' Bids Were Standardized Using 2003 Risk-Adjustment Data

Average Per Capita FFS Expenditure in County in 2006 (Dollars)	Percentage of Medicare Beneficiaries	Average Ratio of Projected Benchmarks to Per Capita FFS Expenditures		Average Ratio of Projected Benchmarks to Medicare Advantage Benchmarks	
		If Plans' Bids Were the Same as Under Medicare Advantage	If Plans Reduced Their Bids by 5 Percent	If Plans' Bids Were the Same as Under Medicare Advantage	If Plans Reduced Their Bids by 5 Percent
Less Than 550	15.0	1.00	1.00	0.79	0.79
550 to 599	20.1	0.99	0.99	0.87	0.86
600 to 649	23.5	0.97	0.96	0.89	0.88
650 to 699	15.2	0.96	0.94	0.92	0.89
700 and Higher	26.3	0.92	0.89	0.89	0.86
National Average	n.a.	0.97	0.95	0.88	0.86

Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services.

Note: FFS = fee for service; n.a. = not applicable.

Table B-2.

Projected Monthly Beneficiaries' Premiums for the FFS Program If Benchmarks Were Set Equal to the Minimum Bid in Each County in 2006 and Plans' Bids Were Standardized Using 2003 Risk-Adjustment Data

Average Per Capita FFS Expenditure in County in 2006 (Dollars)	Projected Average Monthly Premium for FFS Program (Dollars)		Average Percentage Change in Part B Premium		Average Premium for FFS Program as a Percentage of Per Capita FFS Expenditures	
	If Plans'	If Plans	If Plans'	If Plans	If Plans'	If Plans
	Bids Were the Same as Under Medicare Advantage	Reduced Their Bids by 5 Percent	Bids Were the Same as Under Medicare Advantage	Reduced Their Bids by 5 Percent	Bids Were the Same as Under Medicare Advantage	Reduced Their Bids by 5 Percent
Less Than 550	83	83	-5	-5	16	16
550 to 599	87	89	0	2	15	15
600 to 649	100	108	15	24	16	17
650 to 699	108	124	24	43	16	18
700 and Higher	148	174	70	100	19	22
National Average	109	120	25	38	17	18

Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services.

Notes: FFS = fee for service.

The percentage change in the Part B premium is computed relative to the estimated value of that premium after the Hierarchical Condition Codes (HCC) risk adjuster was fully implemented in the Medicare Advantage program. Fully implementing that risk adjuster would reduce federal Medicare spending and therefore reduce the Part B premium below what it otherwise would be. Throughout this analysis, CBO assumed that the HCC risk adjuster would be fully implemented before premium support was introduced.

Table B-3.

Projected Benchmarks If Benchmarks Were Set Equal to the Enrollment-Weighted Average Bid in Each County in 2006 and Plans' Bids Were Standardized Using 2003 Risk-Adjustment Data

Average Per Capita FFS Expenditure in County in 2006 (Dollars)	Percentage of Medicare Beneficiaries	Average Ratio of Projected Benchmarks to Per Capita FFS Expenditures		Average Ratio of Projected Benchmarks to Medicare Advantage Benchmarks	
		If Plans' Bids Were the Same as Under Medicare Advantage	If Plans Reduced Their Bids by 5 Percent	If Plans' Bids Were the Same as Under Medicare Advantage	If Plans Reduced Their Bids by 5 Percent
Less Than 550	15.0	1.00	1.00	0.80	0.80
550 to 599	20.1	1.00	1.00	0.87	0.87
600 to 649	23.5	1.00	1.00	0.92	0.92
650 to 699	15.2	1.00	1.00	0.95	0.95
700 and higher	26.3	1.00	1.00	0.96	0.96
National Average	n.a.	1.00	1.00	0.91	0.91

Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services.

Note: FFS = fee for service; n.a. = not applicable.

Table B-4.

Projected Monthly Beneficiaries' Premiums for the FFS Program If Benchmarks Were Set Equal to the Enrollment-Weighted Average Bid in Each County in 2006 and Plans' Bids Were Standardized Using 2003 Risk-Adjustment Data

Average Per Capita FFS Expenditure in County in 2006 (Dollars)	Projected Average Monthly Premium for FFS Program (Dollars)		Average Percentage Change in Part B Premium		Average Premium for FFS Program as a Percentage of Per Capita FFS Expenditures	
	If Plans'	If Plans	If Plans'	If Plans	If Plans'	If Plans
	Bids Were the Same as Under Medicare Advantage	Reduced Their Bids by 5 Percent	Bids Were the Same as Under Medicare Advantage	Reduced Their Bids by 5 Percent	Bids Were the Same as Under Medicare Advantage	Reduced Their Bids by 5 Percent
Less Than 550	86	86	-1	-1	17	17
550 to 599	86	86	-1	-1	15	15
600 to 649	86	86	-1	-1	14	14
650 to 699	86	87	-1	0	13	13
700 and Higher	86	88	-1	1	11	11
National Average	86	87	-1	0	14	14

Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services.

Note: FFS = fee for service.

The percentage change in the Part B premium is computed relative to the estimated value of that premium after the Hierarchical Condition Codes (HCC) risk adjuster was fully implemented in the Medicare Advantage program. Fully implementing that risk adjuster would reduce federal Medicare spending and therefore reduce the Part B premium below what it otherwise would be. Throughout this analysis, CBO assumed that the HCC risk adjuster would be fully implemented before premium support was introduced.

Table B-5.

Projected Benchmarks If Benchmarks Were Set Equal to the National Average Bid in 2006, Adjusted to Account for Geographic Variation in Input Prices, and Plans' Bids Were Standardized Using 2003 Risk-Adjustment Data

Average Per Capita FFS Expenditure in County in 2006 (Dollars)	Percentage of Medicare Beneficiaries	Average Ratio of Projected Benchmarks to Per Capita FFS Expenditures		Average Ratio of Projected Benchmarks to Medicare Advantage Benchmarks	
		If Plans' Bids Were the Same as Under Medicare Advantage	If Plans Reduced Their Bids by 5 Percent	If Plans' Bids Were the Same as Under Medicare Advantage	If Plans Reduced Their Bids by 5 Percent
Less Than 550	15.0	1.16	1.16	0.92	0.92
550 to 599	20.1	1.05	1.05	0.92	0.92
600 to 649	23.5	1.02	1.01	0.93	0.93
650 to 699	15.2	0.96	0.96	0.91	0.91
700 and Higher	26.3	0.92	0.92	0.89	0.89
National Average	n.a.	1.01	1.01	0.91	0.91

Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services.

Note: FFS = fee for service; n.a. = not applicable.

Table B-6.

Projected Monthly Beneficiaries' Premiums for the FFS Program If Benchmarks Were Set Equal to the National Average Bid in 2006, Adjusted for Geographic Variation in Input Prices, and Plans' Bids Were Standardized Using 2003 Risk-Adjustment Data

Average Per Capita FFS Expenditure in County in 2006 (Dollars)	Projected Average Monthly Premium for FFS Program (Dollars)		Average Percentage Change in Part B Premium		Average Premium for FFS Program as a Percentage of Per Capita FFS Expenditures	
	If Plans'	If Plans	If Plans'	If Plans	If Plans'	If Plans
	Bids Were the	Reduced	Bids Were the	Reduced	Bids Were the	Reduced
	Same as Under	Their Bids by	Same as Under	Their Bids by	Same as Under	Their Bids by
	Medicare Advantage	5 Percent	Medicare Advantage	5 Percent	Medicare Advantage	5 Percent
Less Than \$550	23	23	-74	-74	4	4
550 to 599	61	61	-30	-30	11	11
600 to 649	80	81	-8	-7	13	13
650 to 699	114	114	31	31	17	17
700 and Higher	150	150	73	73	19	19
National Average	91	92	5	6	13	13

Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services.

Notes: FFS = fee for service.

Estimates in this table were calculated under the assumption that there would be no restrictions on the premiums of beneficiaries who live in areas not served by private plans.

The percentage change in the Part B premium is computed relative to the estimated value of that premium after the Hierarchical Condition Codes (HCC) risk adjuster was fully implemented in the Medicare Advantage program. Fully implementing that risk adjuster would reduce federal Medicare spending and therefore reduce the Part B premium below what it otherwise would be. Throughout this analysis, CBO assumed that the HCC risk adjuster would be fully implemented before premium support was introduced.