

CHAPTER

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**Competitively determined  
plan contributions**

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# Competitively determined plan contributions

## Chapter summary

The traditional fee-for-service (FFS) benefit design has not changed significantly since Medicare was enacted in 1965. In our June 2012 report, the Commission recommended changes to improve the FFS benefit to give beneficiaries better protection against high out-of-pocket (OOP) spending, such as adding an OOP maximum, and give beneficiaries incentives to make better decisions about their use of discretionary services, such as imposing an additional charge on supplemental coverage.

The Commission recognizes the limitations of benefit changes alone in the Medicare FFS environment with open-ended service use and broad provider participation. Changes in the benefit design would work more effectively in conjunction with other management tools. Therefore, the Commission thinks it is important to explore alternative approaches that align providers' incentives for efficient and appropriate use of health care services, give beneficiaries incentives to make cost-conscious choices, and encourage innovative delivery systems and care management techniques.

Consistent with the goal of encouraging beneficiaries to make cost-conscious choices, this chapter presents an overview of a model based on government contributions toward purchasing Medicare coverage—an approach we call competitively determined plan contributions (CPCs). The Commission uses the term CPC to broadly describe a federal contribution toward coverage of the

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Medicare benefit based on the cost of competing options for the coverage, including those offered by private plans and the traditional FFS program. Specifically, CPC has two defining principles: First, beneficiaries receive a competitively determined federal contribution to buy Medicare coverage; second, beneficiaries' individual premiums vary depending on the option they choose.

This chapter focuses on key design elements Medicare would have to consider in adopting such a model. We illustrate implications of certain design elements using an analysis of private plan bids under the current Medicare Advantage program as a proxy. We also discuss key issues specific to low-income beneficiaries under a CPC approach. The purpose of this chapter is to focus on a few first-order questions and issues that must be addressed in designing a CPC model and on their implications for beneficiaries, private plans, and the Medicare program. It is not meant to be a definitive or comprehensive treatise on the CPC approach but a guide to focus discussion of the concept.

A CPC model could be designed to maximize its budgetary impact. To achieve large upfront savings, for example, a CPC model could set the federal contribution for Medicare coverage based on the minimum bid in an area but only up to the current level of program spending. But that is not the Commission's primary objective. Even if the upfront savings were modest, the potential of a CPC approach to change the underlying incentives of plans, providers, and beneficiaries over time and to achieve savings in the long run is worth investigating. The Commission has not evaluated any specific legislative proposals or expressed a position with respect to any specific CPC design. ■

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## Introduction

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The Commission uses the term “competitively determined plan contribution” (CPC) to broadly describe a federal contribution toward coverage of the Medicare benefit based on the cost of competing options for the coverage, including those offered by private plans in addition to the traditional fee-for-service (FFS) program. (Throughout this chapter, “plans” refer to various types of private health plans as well as traditional FFS Medicare.) Specifically, CPC has two defining principles: First, beneficiaries receive a federal contribution to buy Medicare coverage, and the contribution amount is competitively determined; second, beneficiaries’ individual premiums vary depending on their choice of coverage and the level of the federal contribution. CPC encompasses a set of concepts related to premium support or defined contributions. CPC and the related concepts represent a fundamental departure from current FFS Medicare, which pays for a defined benefit package and bears the risk of financing the benefit. Additionally, it differs from FFS Medicare because the federal contribution is based on competitive bidding rather than administratively set prices.

An argument for a CPC approach is that a market-based model in which private plans compete for enrollment might do better at keeping overall spending—and hence, premiums—down in certain markets than a model based on unrestricted FFS with open-ended provider participation and administered prices. A successful CPC model depends on strong competition among private plans offering lower premiums and more attractive benefits and on informed beneficiaries who respond to those offerings. Competing private plans, however, do not necessarily lower the cost to the Medicare program if the rules defining how they get paid do not encourage them to compete based on cost or premiums. For example, the current Medicare Advantage (MA) program produces a higher cost to Medicare than the traditional FFS program. Therefore, whether a CPC approach can lower overall Medicare spending depends on the specific design of the model and how different components of the model interact.

In its most basic form, a CPC approach consists of three main actors with different roles. The Medicare program designs the system and makes the rules that result in the CPC contribution amount and payments to plans. (The program also continues to administer the FFS benefit and set FFS payment rates.) Private plans, the second actor, use those rules to guide their business decisions, such as whether to enter or exit a particular market, how

much to bid (which in turn is a factor in determining the level of the government contribution amount), and what benefit designs or products to offer. Beneficiaries, the third actor, then make their purchasing decision and choose a plan or FFS for their Medicare coverage based on the premiums and other attributes of offered plans. Their choice of coverage determines the premiums they pay. In this chapter, we discuss elements of CPC most relevant to decisions made by each of the three actors: design questions for the Medicare program, plan bids for private plans, and premiums associated with different options of Medicare coverage for beneficiaries.

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## Part D as an example of a CPC approach

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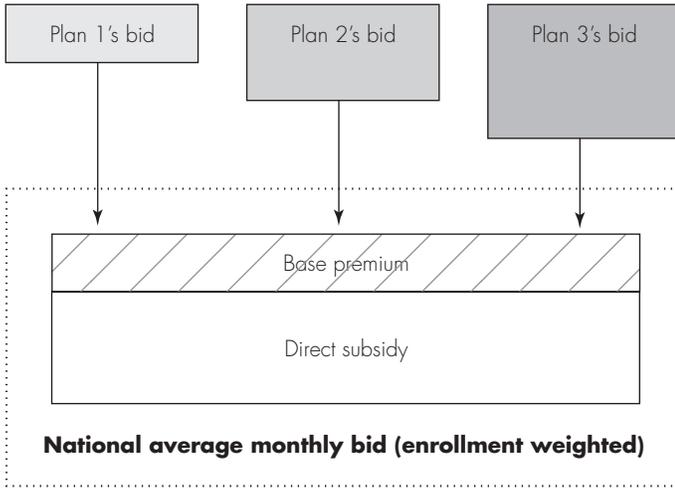
CPC is not a new concept. In fact, Medicare Part D provides a working example of a CPC approach and illustrates the range of the detail and specificity of the rules that a CPC approach requires. Under Part D, prescription drug plans and MA plans bid to provide a drug benefit within 1 or more of 34 prescription drug regions. The law provides for a standard benefit, but, within limits, plans can offer benefit designs that are actuarially equivalent to the standard benefit. Plans can offer enhanced benefits if they also offer a plan with the standard benefit in the same region.

Figure 1-1 and Figure 1-2 illustrate how a CPC design works in Part D. As shown in Figure 1-1 (p. 6), the national average monthly bid is divided into two parts—base beneficiary premium and direct subsidy. (Throughout this chapter, we use “premiums” to refer to beneficiary premiums and “plan bids” to refer to plans’ total costs in providing the benefit.) The base premium is what an enrollee pays to the plan each month, on average, and equals 25.5 percent of the average benefit cost. The direct subsidy is the federal contribution Medicare pays to plans each month for each of the plan’s enrollees and equals 74.5 percent of the average benefit cost. Because the base premium and direct subsidy are set nationally, they do not vary across plans. A more detailed description of the Part D payment system can be found at [http://www.medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_12\\_PartD.pdf](http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_PartD.pdf).

Under Part D, plan enrollees pay the base premium plus the difference between their plan’s bid and the national average bid (Figure 1-2, p. 6). Therefore, although the base premium is the same for all beneficiaries, individual beneficiaries’ premiums vary, depending on how their

**FIGURE 1-1**

**How CMS calculates national average monthly bid (enrollment weighted) under Part D**



Note: Under Part D, the national average monthly bid is divided into two parts—base beneficiary premium and direct subsidy. The base premium is what an enrollee pays to the plan each month, on average, and equals 25.5 percent of the average benefit cost. The direct subsidy is the federal contribution Medicare pays to plans each month for each of the plan’s enrollees and equals 74.5 percent of the average benefit cost.

plan’s bid compares with the national average bid. If a plan’s bid is equal to or less than the direct subsidy amount, a beneficiary will pay no premium to enroll. If a plan’s bid is higher than the direct subsidy and base premium amounts combined, an enrollee will pay the base premium plus the additional cost above the national average.

One aspect of the CPC design for Part D ensures that beneficiaries eligible for the low-income subsidy (LIS) have premium-free plans available to them. CMS establishes a separate low-income threshold in each prescription drug region, calculated as the LIS enrollment-weighted average premium in the drug region with some modifications. Plans with bids up to this regional benchmark are premium-free for LIS beneficiaries. As a result, LIS beneficiaries have access to at least one premium-free stand-alone drug plan even in regions where the average bid is higher than the national average.

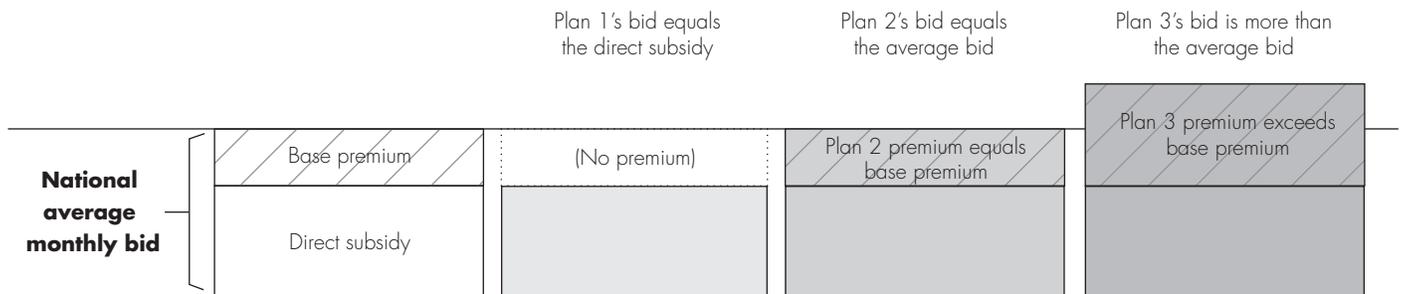
The Federal Employees Health Benefits (FEHB) Program also illustrates different applications of the CPC principles (see text box). Under FEHB, the federal government contributes 75 percent of health insurance premiums up to a maximum amount. Therefore, among plans subject to the maximum contribution amount, enrollees pay the full difference between the plan premium and the maximum contribution amount. Otherwise, enrollees pay a proportional 25 percent of plans’ premiums.

**Design questions under the CPC approach**

The above discussion of Part D highlights two defining principles of a CPC approach: Beneficiaries receive a federal contribution to buy Medicare coverage, and their individual premiums depend on their choice of coverage. However, there are different ways to apply the principles in designing

**FIGURE 1-2**

**Plan sponsors’ bids determine enrollee premiums under Part D**



Note: Under Part D, the national average monthly bid is divided into two parts—base beneficiary premium and direct subsidy. The base premium is what an enrollee pays to the plan each month, on average, and equals 25.5 percent of the average benefit cost. The direct subsidy is the federal contribution Medicare pays to plans each month for each of the plan’s enrollees and equals 74.5 percent of the average benefit cost. Under Part D, plan enrollees pay the base premium plus the difference between their plan’s bid and the national average bid.

## Federal Employees Health Benefits Program

The Federal Employees Health Benefits (FEHB) Program is the nation's largest employer-sponsored health insurance program. Eligible individuals include current employees, annuitants (retired employees entitled to an immediate pension), and their dependents. Active employees and retirees pay the same premium amounts. The FEHB Program is administered by the Office of Personnel Management (OPM), which has wide authority to implement regulations, contract with plans, and establish benefits. In 2013, there are about 230 different plan choices, typically up to 15 plans available in a given area.

Calculation of the federal government's contribution to health insurance premiums has certain characteristics of a CPC approach. Under the current rules, the government's share of premiums is set at 75 percent of a given plan's premium up to a maximum of 72 percent of the weighted average premium of all plans in the

program. Employees who enroll in a more expensive plan pay the full amount by which the plan's premium exceeds the government's maximum contribution amount. For about 40 percent of plans in 2013, the government contribution toward biweekly premiums is a maximum of \$190.84 for single coverage and \$424.95 for family coverage. The government contribution is determined separately for single and family coverage but does not vary geographically. Unlike Medicare Part D, the FEHB Program does not have a standard benefit package. However, OPM specifies benefit parameters, including certain required benefits and changes in benefits, through the annual call letter for benefit and rate proposals from plans. Within those parameters, plan premiums that make up the weighted average premium can vary widely in their benefit packages and cost-sharing requirements, ranging from high-deductible plans to wide-network preferred provider organizations. ■

a CPC model, and those differences have important implications for beneficiaries and the Medicare program.

In this section, we focus on four basic design questions any CPC model in Medicare must address:

- Should the benefit package be standardized?
- Should a CPC model be based on competitive bidding?
- Should a CPC model include FFS Medicare?
- How should the federal contribution be determined?

There are no right or wrong answers to these questions, but there are different answers depending on the policy priorities of the program and the desired responses from plans and beneficiaries. Under a CPC approach, specific details of the design are critical because Medicare cannot dictate the decisions made by private plans and beneficiaries. Medicare must rely on the incentives it creates in the design, but there is no guarantee that it will achieve the desired behavioral responses from plans and beneficiaries.

The above four questions do not, by any means, make up a definitive or exhaustive list. There are additional design questions we do not consider in this section—such as, how does the federal contribution grow over time? Nonetheless,

the list represents first-order questions that must be addressed in designing a CPC model. For simplicity, we limit our discussion to applying a CPC approach for services provided under Part A and Part B of Medicare.

### **Should the benefit package be standardized?**

Under CPC, standardization can be interpreted in at least three ways. All plans could be required to cover the same defined set of services with specified cost sharing, cover the same defined set of services but vary cost sharing (like MA), or provide benefit packages that are actuarially equivalent to a set value (like Part D), with benefits and cost sharing being allowed to vary from plan to plan.

The purpose of standardization is to make plans compete largely on the basis of their price by requiring them to bid on a standardized package of benefits. Choosing health insurance is notoriously complicated because plans differ in multiple dimensions simultaneously. Even under the strictest interpretation of standardization, plans differ in important and meaningful ways, including provider networks, level of utilization management, customer service, and convenience. Nevertheless, if plans compete largely on the basis of price for a set product, beneficiaries can reduce the degree of complexity, compare plans on fewer dimensions, and simplify their decision making.

## Lessons learned from previous demonstrations of competitive bidding for Part C

In previous demonstrations of competitive bidding for Part C, certain themes became evident:

- Stakeholders were united in opposing the demonstrations.
- Plans wanted to have benchmarks set in advance.
- Plans resisted being judged on the level of their premiums rather than on the benefits they offered.
- Plans objected to third-party marketing.
- Some thought Medicare fee-for-service (FFS) should be included as a plan for bidding purposes.

In 1996, the Health Care Financing Administration (HCFA, now CMS) began developing a demonstration of competitive pricing. Baltimore was selected as the site for the demonstration because of the large number of available plans, the small number of beneficiaries enrolled in the plans at the time, and the relatively high adjusted average per capita cost rates that allowed plans to offer a substantial level of enhanced benefits. The latter feature of the Baltimore market was important because the demonstration had to be budget neutral, and no additional Medicare dollars could be used to finance extra benefits that would attract enrollment.

The design of the bidding process called for plans to bid on a standard benefit package that HCFA specified. On receiving the bids, HCFA would determine the level

of the government contribution, and plans with bids above that level would charge a premium. HCFA did not specify the level of the government contribution in advance but stated that it would not be set at the lowest bid for the standard benefit package. Marketing and enrollment would be through a third party, not through the health plans.

The demonstration ended before implementation because of unified opposition from stakeholders. The industry objected to certain design features, including not knowing the government contribution in advance, using member premiums as the basis for distinguishing among bidding plans in the market, and using a third party for marketing and enrollment. Dowd and colleagues state that “plans repeatedly asked HCFA to forgo the competitive bidding process and simply to announce an administrative price that achieved whatever cut in payment the agency sought. HCFA rejected this approach as just another variant of administrative pricing, which would not produce information on the efficient price of the standard benefit package” (Dowd et al. 2000).

HCFA then chose Denver as the demonstration site. The Denver market was similar to Baltimore in the number of plans, enrollees, and benefits offered. One design feature was changed: Plans that had to charge premiums when their bids exceeded the government contribution were allowed to waive all or some of the

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Standardization also limits the opportunity for risk selection because plans cannot design benefit packages aimed at enrolling only the healthiest beneficiaries. For example, setting high coinsurance rates for expensive chemotherapy treatments is likely to deter cancer patients from enrolling or staying enrolled. (Conversely, standardization also limits beneficiaries’ opportunity to choose their desired benefit designs based on their preferences and needs.<sup>1</sup>) However, standardizing the benefit packages could make it more difficult for plans to innovate and respond quickly to changes in medical practice.

The medigap market provides precedent for standardizing the benefit package. In 1990, policymakers reformed the medigap market by imposing standardized plans that vary

in how they wrap around Medicare’s cost sharing and benefits. Before 1990, beneficiaries shopping for Medicare supplemental policies faced an array of duplicative, confusing offerings. Reports of marketing abuses were frequent. Legislation restricted insurers to a limited menu of medigap options, identified by the letters A through J. For example, all C policies provide exactly the same benefits, and insurers selling those policies compete on the basis of price alone.

Under current law, MA plans are required to cover all Medicare Part A and Part B benefits except hospice. Plans may supplement Medicare benefits by reducing cost-sharing requirements, providing coverage of non-Medicare benefits, or providing a rebate for all or part

## Lessons learned from previous demonstrations of competitive bidding for Part C (cont.)

premium if they also accepted a payment reduction equal to the waived amount. Plans opposed the Denver demonstration for the same reasons as in Baltimore, with the added concern that FFS Medicare was not being considered a bidding plan. As they did in Baltimore, plans also asked HCFA to set administered pricing rates if the goal was to reduce plan payments. Some of the Denver HMOs initiated a lawsuit that resulted in a temporary restraining order just as plan bids were being submitted, and opposition led to the end of the demonstration before full implementation.

From the Denver demonstration, HCFA learned the range of plan bids for the enriched standard benefit package (which included drug coverage) and the Medicare Part A and Part B benefit package. According to Dowd, “HCFA ... made it known that the ... bids they examined in Denver for the standard benefit package (the ‘market norm’ benefit package that included prescription drugs) were 5 percent to 17 percent below the published Balanced Budget Act (BBA) payment rates, which reflect the cost of entitlement benefits (that is, no drugs) in FFS Medicare. The ... bids for the entitlement benefit package [Medicare Part A and Part B] were 25 percent to 38 percent below the BBA rates” (Dowd 2001).

The Balanced Budget Act of 1997 mandated competitive pricing demonstrations at various sites, with the design of the demonstrations to be determined by a national Competitive Pricing Advisory Committee

(CPAC) with additional input from Area Advisory Committees (AACs). Under the CPAC design, FFS Medicare was excluded as a bidding plan because no statutory authority allowed its inclusion, but CPAC urged the Congress to consider including FFS. CPAC established a national standard enhanced benefit package that included drug coverage, but each AAC could further enhance the benefit if the local standard was to have a more generous benefit package in Medicare plans. CPAC specified that the government contribution should be at the median bid (adjusted for plan capacity) or at the enrollment-weighted average bid. At each of the two demonstration sites (Kansas City and Phoenix), the AAC chose the amount resulting in a higher government contribution. Plans bidding above the contribution level would charge a premium; plans bidding below that amount could retain the difference or provide extra benefits. CPAC also considered ways to have financial incentives to promote quality of care. In addition to decisions about the standard benefit package and the level of the government contribution, the AACs would determine whether plans would bid on a county-by-county basis (separate bids for each county) or on a “reference” county, with ratios established for payments in each county.

After a number of delays, the Kansas City and Phoenix demonstrations also ended before implementation because of mounting stakeholder opposition. ■

of the Part B or Part D premium. An MA plan’s bid reflects its costs to provide the Part A and Part B benefit package for a beneficiary of average health status, and the plan’s payment from Medicare depends on how its bid compares with the local MA benchmark. The cost-sharing component of the bid for the standard benefits must be actuarially equivalent to FFS cost sharing in total.<sup>2</sup> For the Part A and Part B benefit package, beneficiaries will pay the Part B premium and any additional premium if they choose a plan with a higher bid. A lower bid may result in savings for the beneficiary, including lower cost sharing or a reduced Part B premium. A more detailed description of the MA program can be found at [http://www.medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_12\\_MA.pdf](http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_MA.pdf).

When Part D plans offer a standard benefit, plans can vary their benefit packages within limits as long as they are actuarially equivalent to the defined standard benefit. (Part D plans can also offer enhanced benefits as long as they offer a standard benefit.) Few beneficiaries are in plans with a standard benefit design—that is, almost all Part D plans offer plans different from the standard benefit. However, plans must meet certain requirements that limit variation. For example, all plans have the same limit on out-of-pocket spending. They must cover at least two drugs in each therapeutic category and class unless only one drug is available. Moreover, they must cover all or substantially all drugs in certain protected classes such as cancer drugs and antidepressants. Furthermore, CMS is

## Relationship between fee-for-service Medicare and Medicare Advantage plan bids

To understand the effect of fee-for-service (FFS) Medicare and private-sector payment rates on Medicare Advantage (MA) plan bids, we analyzed the relationship between the MA plan bid as a share of FFS spending in 2008, for HMO and preferred provider organization (PPO) plans separately, as well as the following five variables:

- ***an index of payment rates for hospital services in the non-Medicare market (adjusted for the Medicare hospital wage index)***—Hospital services represent roughly 30 percent of Medicare spending; therefore, if MA plans paid non-Medicare market prices, we would expect a 1 percent increase in hospital prices to increase MA plan bids by 0.30, all else equal;
- ***an index of payment rates for physician services in the non-Medicare market (adjusted for the Medicare physician fee schedule index)***—Physician fee schedule services represent roughly 12 percent of Medicare spending, so we would expect a 1 percent increase in physician prices to increase MA bids by 0.12 percent, all else equal;
- ***the MA benchmark, the maximum program payment for Part A and Part B services***—In areas with higher benchmarks, plan bids relative to FFS spending may be higher because plans feel less pressure to control their costs, spend more on broader networks and marketing, and use less utilization review;
- ***an index of FFS Medicare service use per beneficiary***—In areas with higher service use, plans may have more opportunities to reduce spending on discretionary services and fraud and abuse in certain markets; and

- ***a measure of insurer market power using the Herfindahl index derived from American Medical Association data on insurer market shares.***

The results of the above model are shown in Table 1-1.

Overall, MA plan bids have little relationship to private-sector payment rates. The hospital price variable has no effect in the HMO model and has a small effect of roughly 0.04 in the PPO model, which is much smaller than the value of 0.30 that would be predicted if MA prices followed non-Medicare private insurer prices. This fact suggests that MA plan hospital prices are not tied to prices in the non-Medicare market, which is consistent with what we have heard from plans and other market participants. Non-Medicare physician payment rates also appear to have at most a modest relationship to MA bids, suggesting that physician payment rates may be partly anchored to FFS prices. There is more uncertainty regarding the prices MA plans pay physicians given the inconsistency of the regression results and less corroborating data than we have in the case of hospitals. It is possible that physician payment is less consistently anchored to FFS payment rates than hospital prices.

The coefficient in the third row of Table 1-1 (–0.49) tells us that in markets where FFS beneficiaries’ service use is 1 percent higher than average, MA bids are expected to be roughly 0.49 percent lower than the FFS costs on average, all else equal. Conversely, in markets where FFS beneficiaries’ service use is 1 percent below average, MA bids are expected to be roughly 0.49 percent higher than FFS costs, all else equal. Some caution should be taken in interpreting this variable in that the model forces linearity on the service-use variable, and the exact coefficient can change with the functional form of the model. However, across

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required to monitor plan submissions to ensure that benefit designs are not constructed to discriminate against certain beneficiaries. (This is also true in MA.)

If benefits were standardized in a CPC model for Part A and Part B of Medicare, policymakers would have

to determine the composition of the standard benefit. Whether defined as the current-law benefit or changed to a different benefit design, decisions about how the benefit package should be standardized will be necessary in designing a CPC model.

# Relationship between fee-for-service Medicare and Medicare Advantage plan bids (cont.)

**TABLE 1-1**

**Non-Medicare prices have little effect on MA HMO and PPO bids**

Categories and variables (enrollment-weighted MSA-level mean values)	Expected coefficient if prices equal non-Medicare market prices	Regression results		
		Coefficient	Standard error	P value
<b>Dependent variable:</b>				
<b>HMO bid for Part A and Part B services relative to FFS cost</b>				
Hospital price index (non-Medicare 2008)	0.30	-0.00	0.02	0.8160
Physician price index (non-Medicare 2008)	0.12	0.06	0.03	0.0697
Index of FFS Medicare service use (MSA 2006-2008)	< 0	-0.49	0.05	<0.0001
Benchmark-to-FFS ratio (based on 2008 data)	> 0	0.26	0.07	0.0001
Insurer market power (HHI/10,000 in 2008)	Unclear	-0.01	0.03	0.8027
$R^2 = 0.52$				
N=199				
Mean weighted HMO bid in the 199 areas=99% of FFS				
Median weighted HMO bid in the areas=100% of FFS				
<b>Dependent variable:</b>				
<b>PPO bid for Part A and Part B services relative to FFS cost</b>				
Hospital price index (non-Medicare 2008)	0.30	0.04	0.02	0.0053
Physician price index (non-Medicare 2008)	0.12	-0.02	0.02	0.3905
Index of FFS Medicare service use (MSA 2006-2008)	< 0	-0.24	0.04	0.0005
Benchmark-to-FFS ratio (based on 2008 data)	> 0	0.26	0.05	<0.0001
Insurer market power (HHI/10,000 in 2008)	Unclear	-0.05	0.02	0.0092
$R^2 = 0.47$				
N=181				
Mean weighted PPO bid in the 181 areas=105% of FFS				
Median weighted PPO bid in the areas=105% of FFS				

Note: MA (Medicare Advantage), PPO (preferred provider organization), MSA (metropolitan statistical area), FFS (fee-for-service), HHI (Herfindahl index of competition in the core-based statistical area). The HHI variable is normalized to a 0 to 1 scale where a monopoly market has an HHI of 1. Variables are expressed in log form, so the coefficients represent the effect of a 1% increase in non-Medicare prices or a 1% increase in the benchmark above FFS payments on the HMO or PPO bids. Our analysis is based on MA plan bid data for the 2010 contract year, submitted by plans in June of 2009. The MA bids submitted in June 2009 presumably would be based on the claims history from 2008 and earlier years. The 2008 claims history underlying the 2010 bids matches the time frame of our earlier analysis on private payment rates, which was based on the actual private-sector claims from calendar year 2008. For our enrollment weighting of the MA bid data by geographic area, we use the November 2010 county-level actual enrollment files from CMS, rather than plans' projections of enrollment by county. For service use, we use historical FFS levels from 2006 to 2008. P value refers to the statistical significance of the coefficient; it is the probability that the coefficient could be different from zero purely due to random variation. Expected effect of insurer market power is unclear given that insurer power may lead to lower prices for nonphysician and nonhospital services, which are not controlled for in the regression, but it could also lead to more insurer profit or less efficiency, which could increase bids.

Source: MedPAC analysis of Medicare Advantage bid data.

different functional forms, we consistently find that high-service-use markets tend to have bids below FFS, and low-service-use markets tend to have bids above FFS after controlling other factors such as the effect

of Medicare policy on benchmarks. For example, the Oklahoma City metropolitan statistical area is a high-service-use area. Its FFS service use is 16 percent above the national average; therefore, we would expect

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## Should a CPC model be based on competitive bidding?

In theory, the cost of Medicare coverage and the federal contribution under a CPC approach could be based either on the bids of competing plans or on an administratively

set amount independent of plan bids. As discussed earlier, Part D is based on a competitive bidding system. In contrast, the cost of Medicare coverage under MA is administratively set at predetermined benchmarks based

## Relationship between fee-for-service Medicare and Medicare Advantage plan bids (cont.)

the MA HMO bids to be about 8 percent lower ( $16\% \times -0.49$ ) than FFS costs in this market on average, all else equal. In contrast, in an area with very low spending like Fargo, ND, where FFS service use is 12 percent below average, we would expect MA HMO bids to be roughly 6 percent higher ( $-12\% \times -0.49$ ) than FFS costs, all else equal. Bids will also be affected by other factors (including individual HMO efficiency), but these two examples provide some intuition about the magnitude of the model's findings on the average effect of variation in service use on the competitiveness of HMO bids relative to FFS costs.

Two possible factors drive these results. First, MA HMOs will have an easier time reducing service use below FFS service use in markets where there are higher volumes of unnecessary services and fraudulent FFS claims. In markets where service use is low, there may be few opportunities to reduce service use further. Second, MA HMOs tend to have higher overhead (some of which may be used to coordinate care or control service use); in areas with low service use, this fixed overhead is a larger share of total costs, making it more difficult to compete with FFS on price. The overarching idea is that MA HMOs will be more

competitive relative to FFS Medicare in markets with high service use.

In the PPO regression, our results suggest that PPO bids are 0.24 percent lower than average markets where FFS use is 1 percent above average, and PPO bids are 0.24 percent higher than the average bid in markets where FFS service use is 1 percent below average. This suggests that PPO plans can control use in some markets but tend to have less of an effect on service use than HMOs. This result is consistent with the average bid data, which show PPO bids being roughly 5 percent higher than MA HMO bids.

The fourth row of Table 1-1 shows that for every 1 percent increase in the benchmark above FFS costs, HMO and PPO bids increase by 0.26 percent.<sup>3</sup> This result indicates that MA plan bids can be influenced by Medicare policy that changes payment rates to the MA plans. The last row of Table 1-1 shows that insurer market power has little effect on HMO bids, but it may have a slightly negative effect on PPO bids, possibly due to greater economies of scale with respect to administrative costs such as developing a network of providers. ■

on—although not always equal to—past Medicare FFS spending projected to the current year.

The main argument for basing a CPC model on competitive bidding is that a competitive market would provide price information, and getting bids on a set benefit package (such as the Medicare Part A and Part B benefit) is as close as we can come to a competitive market. In theory, allowing those entities with the best, most up-to-date information on the cost of providing a set benefit to determine the market price would result in more accurate pricing that can readily incorporate market changes. In practice, however, past attempts at competitive bidding in Medicare Part C suggest that plans might not welcome such a process. Previous demonstrations from the 1990s ended before implementation because of unified opposition from stakeholders, including the private plans that would have been participants (see text box, pp. 8–9).

Whether a CPC model is based on, or independent of, plan bids may have significant effects on Medicare spending. If the federal contribution were based on plan bids each year, changes in the underlying costs of providing the Medicare benefit would be incorporated into those bids, and the Medicare program would bear most of the risk in year-to-year fluctuations in costs. On the other hand, if the federal contribution were set at a predetermined amount (e.g., average FFS spending per beneficiary in the base year) and indexed to grow at a predetermined rate (e.g., the rate of gross domestic product), program spending would be predictable. However, beneficiaries would bear the risk of unexpected increases in costs for Medicare coverage if the increase in the federal contribution is insufficient for plans to cover their costs. If beneficiaries could not or would not pay all of the resulting increase in premiums, plans would have to find ways of lowering their premiums to maintain enrollment.

## Should a CPC model include FFS Medicare?

FFS Medicare can be a part of a CPC model in two ways. More narrowly, FFS Medicare can be one of the plan bids in calculating the federal contribution under CPC. There are several reasons for FFS Medicare to remain as a plan option. First, in some areas FFS Medicare might be the low-cost option of Medicare coverage compared with options offered by private plans. In those areas, not including FFS Medicare would result in higher spending by the program, the beneficiary, or both, depending on the level of the federal contribution.<sup>4</sup> Moreover, the existence of FFS Medicare in those areas may put downward pressure on plan bids that need to compete with low FFS spending. Second, FFS Medicare guarantees at least one option of Medicare coverage in all areas because private plans might not be available everywhere, such as in some rural areas. Third, some beneficiaries might prefer FFS Medicare for its wider network of providers and would pay higher premiums for that choice if FFS Medicare were not the low-cost option.

More broadly, FFS Medicare can coexist along with private plans in a CPC model even if it is not included in the calculation of the federal contribution. Maintaining FFS Medicare could be important beyond its role as an option for Medicare coverage. Because FFS Medicare could indirectly affect the payment rates that private plans pay providers, the existence of FFS Medicare could ultimately affect plan bids in a CPC model. Currently, FFS Medicare payment rates overall are about 20 percent lower for physician services and over 30 percent lower for hospital services compared with payment rates in the private sector (American Hospital Association 2012, Medicare Payment Advisory Commission 2013). Under a CPC model without FFS Medicare, dramatically higher payment rates for Medicare services could result in higher plan bids if private plans pay the rates that currently prevail in the private sector.

An analysis of the relationship between plan bids under the current MA program and FFS Medicare shows that MA plan bids are more strongly correlated with FFS Medicare than with payment rates in the private sector (see text box, pp. 10–12). In addition, conversations with hospital executives and actuaries suggest that MA payment rates for hospital services are closely anchored to FFS Medicare payment rates in contract negotiations. Consequently, if FFS Medicare payment rates are reference prices in negotiations between providers and plans, maintaining FFS Medicare may have a noticeable impact on plan bids in a CPC model.

There are a couple of reasons why private plans could pay providers less in the MA market compared with the private sector. Under current law, providers must accept the MA plan's payment for certain services (such as emergency services and other covered services from providers that are not under a contract with the MA plan) as payment in full as long as it is at least the amount that would have been paid in FFS Medicare plus any allowed cost sharing. For those services, therefore, FFS payment rates directly affect MA payment rates. In addition, MA plans compete with FFS Medicare for beneficiaries. In other words, providers are paid either at the FFS payment rate or at the payment rate negotiated with the MA plan for Medicare services. As mentioned previously, this fact could play a role in contract negotiations between MA plans and providers. For example, a hospital may decide that payments from MA plans are preferable to FFS Medicare if the MA payment rates are just slightly higher than FFS payment rates or if they are equal to FFS Medicare but with additional volume of patients from being an in-network provider. In this case, FFS payment rates indirectly affect MA payment rates.

## How should the federal contribution be determined?

Under a CPC model, beneficiary premiums would depend on how plan bids compare with the federal contribution amount. If plan bids are higher than the federal contribution amount, beneficiaries will pay the difference in a premium, whereas if plan bids are lower, beneficiaries will receive the difference in a premium rebate. (For simplicity, one can think of the difference between the federal contribution and a lower plan bid as a cash rebate.) Therefore, the rules used to calculate the federal contribution have very important implications for beneficiaries' premiums and program spending.

In particular, we focus on the level at which the federal contribution is determined. It is a key design question regardless of the exact formula of the contribution. Whether the federal contribution is calculated nationally, as in Part D, or is allowed to vary across geographic regions and plans, as in Part C, has significant distributional effects.

Consider the following illustrative example. Suppose the national average cost of providing Medicare Part A and Part B services is \$800 per month. Further, suppose there are three areas with equal numbers of beneficiaries but different levels of average Medicare cost per month: \$680, \$800, and \$920 (i.e., the second column in Table 1-2, p. 14).

**TABLE  
1-2**

**Illustrative example: Federal contribution is set nationally**

	<b>Average monthly cost for Part A and Part B benefit</b>	<b>Federal contribution: 87.5% of national cost</b>	<b>Beneficiary premium: Monthly cost - federal contribution</b>
Area 1	\$680	\$700	-\$20
Area 2	800	700	100
Area 3	920	700	220

Note: In this illustrative example, we assumed the following: The national average cost of providing Medicare Part A and Part B services is \$800 per month; there are three areas with equal numbers of beneficiaries but different levels of average Medicare cost per month—\$680, \$800, and \$920 (i.e., the second column); and the federal contribution amount is set at 87.5 percent of the national average cost of the Medicare benefit, or \$700 per month in all three areas (i.e., the third column). As a result, beneficiary premiums in the three areas are -\$20 (premium rebate), \$100, and \$220 (the fourth column in the table—i.e., the second column minus the third column).

One can think of the level of Medicare cost as the area’s representative plan bid for providing the Part A and Part B benefit or the area’s FFS spending. The purpose of this example is to illustrate how different rules for calculating the federal contribution affect beneficiary premiums when Medicare costs vary across areas.

Specifically, consider the following three rules for calculating the federal contribution amount:

1. 87.5 percent of the national average cost of the Medicare benefit,
2. 87.5 percent of the local average cost of the Medicare benefit, or
3. the residual after the beneficiary pays 12.5 percent of the national average cost of the Medicare benefit.

Under current law, the standard Part B premium represents roughly 12.5 percent of total Medicare spending and the program’s share is roughly 87.5 percent.

Under the first rule, or the “national” option, beneficiaries in all three areas receive \$700 per month as the federal

contribution for their Medicare benefit (i.e., the third column in Table 1-2). Therefore, beneficiary premiums in the three areas are -\$20 (premium rebate), \$100 (average premium), and \$220 (the fourth column in Table 1-2—i.e., the second column minus the third column).

In contrast, under the second rule, or the “local” option, beneficiaries in the three areas receive different contribution amounts because the federal contribution is tied to the area-specific cost of the Medicare benefit (i.e., the second column in Table 1-3). For example, in area 1, the federal contribution is lower, at \$595 (87.5 percent of \$680) compared with \$805 (87.5 percent of \$920) in area 3. As a result, the beneficiary premium is \$85 in area 1 compared with \$115 in area 3 (the fourth column in Table 1-3).

Finally, under the third rule, beneficiaries in all areas pay 12.5 percent of the national average cost, or \$100 in premiums (the fourth column in Table 1-4). It represents the inverse of the first rule in that it sets the beneficiary premium nationally. Whereas the federal contribution does not vary across areas in Table 1-2, the beneficiary

**TABLE  
1-3**

**Illustrative example: Federal contribution is set locally**

	<b>Average monthly cost for Part A and Part B benefit</b>	<b>Federal contribution: 87.5% of local cost</b>	<b>Beneficiary premium: Monthly cost - federal contribution</b>
Area 1	\$680	\$595	\$85
Area 2	800	700	100
Area 3	920	805	115

Note: In this illustrative example, we assumed the following: The national average cost of providing Medicare Part A and Part B services is \$800 per month; there are three areas with equal numbers of beneficiaries but different levels of average Medicare cost per month—\$680, \$800, and \$920 (i.e., the second column); and the federal contribution amount is set at 87.5 percent of the local average cost of the Medicare benefit (i.e., the third column). As a result, beneficiary premiums in the three areas are \$85, \$100, and \$115 (the fourth column in the table—i.e., the second column minus the third column).

**TABLE  
1-4**

**Illustrative example: Federal contribution and beneficiary premiums under current law**

	<b>Average monthly cost for Part A and Part B benefit</b>	<b>Federal contribution: Monthly cost – beneficiary premium</b>	<b>Beneficiary premium: 12.5% of national cost</b>
Area 1	\$680	\$580	\$100
Area 2	800	700	100
Area 3	920	820	100

Note: In this illustrative example, we assumed the following: The national average cost of providing Medicare Part A and Part B services is \$800 per month; there are three areas with equal numbers of beneficiaries but different levels of average Medicare cost per month—\$680, \$800, and \$920 (i.e., the second column); and the federal contribution amount is set at the residual after the beneficiary pays 12.5 percent of the national average cost of the Medicare benefit (i.e., the third column). In other words, beneficiaries in all areas pay 12.5 percent of the national average cost, or \$100 in premiums (i.e., the fourth column).

premium does not vary across areas in Table 1-4. In fact, this rule describes how the standard Part B premium is calculated under current law, which equals 25 percent of national average Part B spending.

Differences among the three rules for calculating the federal contribution illustrate how the difference in the average monthly cost of the Medicare benefit across areas is shared between the program and the beneficiary. In Table 1-2, the beneficiary pays the entire difference, whereas in Table 1-4, the program pays the entire difference. In Table 1-3, the program and the beneficiary divide the difference proportionately based on the 87.5/12.5 percent split.

There are additional issues related to the federal contribution amount. For example, if the contribution is based on competitive bids, a decision must be made on whether it should be based on the lowest bid, an average bid, or some other formulation. Setting benchmarks at the lowest local bids would minimize Medicare spending, but beneficiaries would have to pay additional premiums to join all but the lowest cost plan. However, there are also capacity concerns: The lowest bidder may not be able to enroll all beneficiaries who wish to join the low-cost plan. Alternatively, setting benchmarks high enough so that multiple plans in a local area can meet the benchmark should facilitate access to relatively low-premium plans in a market area but will be more costly to Medicare. In general, the formula for calculating the federal contribution will affect both beneficiary and plan behavior. Different formulas will redefine the set of lower cost options for beneficiaries and, as a result, change their choice for Medicare coverage. Similarly, different formulas for calculating the federal contribution will alter private plans' decisions about where and how to compete.

## Analysis of plan bids and availability

In response to the specific design of the CPC model, private plans will need to make their business decisions—whether to enter or exit a particular market, how much to bid, and what benefit designs or products to offer. In this section, we focus on one such decision and simulate plan availability and beneficiary premium impacts under a CPC model using MA plan bids for 2013 as a proxy. Although the current MA program is not a competitive system, in that benchmarks for calculating payments to MA plans are not based on their bids, MA bids represent a measure of the total cost of providing the Medicare benefit by private plans and can inform how plans might act in a CPC model.<sup>5</sup>

## Adjusting MA plan bids for payment areas

In our analysis, we adopt the definition of payment areas that is larger than the county definition currently used in the MA program. Using counties as payment areas results in many areas with a small number of FFS beneficiaries, and there can be instances of adjacent counties with very different levels of FFS spending. However, if payment areas are too large, the cost of serving beneficiaries can vary widely within payment areas.

To mitigate these problems and define an appropriate payment area that best matches the insurance markets served by private plans, the Commission recommended combining counties into larger payment areas for MA as follows (Medicare Payment Advisory Commission 2005):

- Among counties in metropolitan statistical areas (MSAs), payment areas should be collections of counties located in the same state and the same MSA.<sup>6</sup>

**TABLE  
1-5****Distribution of payment areas by average monthly FFS spending per beneficiary, 2013**

Average monthly FFS spending per beneficiary	Number of payment areas	Share of beneficiaries (in percent)	Top 5 payment areas by number of beneficiaries
\$540–\$645	102	5%	Buffalo; Rochester (NY); Honolulu; Albany (NY); Albuquerque
\$645–\$690	193	10	Sacramento; Portland (OR); Virginia Beach; Greensboro; Portland (ME)
\$690–\$750	396	23	Seattle; St. Louis; VA suburbs of Washington, DC; Milwaukee; Charlotte
\$750–\$825	337	30	Philadelphia; Atlanta; Riverside–San Bernardino (CA); Pittsburgh; Detroit
\$825–\$900	145	22	Chicago; New York; Boston; Phoenix; Tampa
\$900–\$1,335	56	9	Los Angeles; Houston; Dallas; Baltimore; Miami
Overall average (\$781)	1,229	100	

Note: FFS (fee-for-service). Percentages do not sum to 100 due to rounding.

Source: MedPAC analysis of Medicare Advantage plan bids for 2013.

- Among counties outside MSAs, payment areas should be collections of counties in the same state that are accurate reflections of health care market areas, such as health service areas.<sup>7</sup>

The purpose of our analysis is to simulate plan availability and beneficiary premium impacts under a CPC model, based on current MA bids. We did not model CPC plan bids, nor did we model changes in beneficiary choice among plans. That is, we did not model behavioral responses to the CPC incentives by plans or beneficiaries.

Specifically, we made the following assumptions in our analysis:

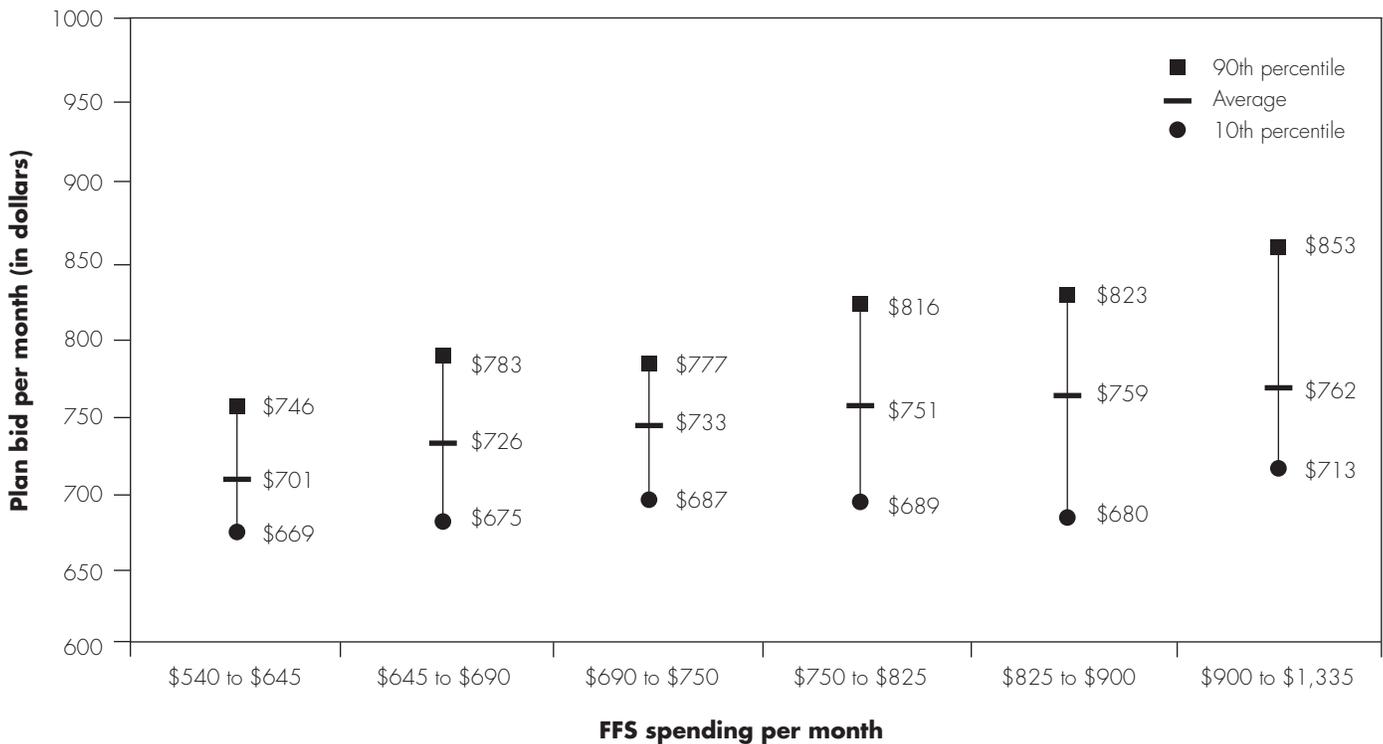
- We assumed that plan bids were constant over the entire plan-defined service areas, where service areas can be larger or smaller than payment areas.
- We assumed that if a plan is currently offered to at least half of all the Medicare beneficiaries in a payment area (as defined in the Commission's recommendation), the plan would serve the entire payment area with its current bid. If the plan is not

offered to at least half of the beneficiaries, we assumed that it would not bid to serve that payment area.

- We excluded plans that were not open to all beneficiaries in a service area, such as employer-sponsored plans and special needs plans.
- We excluded bids from MA-only plans that do not offer Part D drug coverage since there may be positive risk selection in those plans, and those plans all have companion MA–Prescription Drug plans that do include Part D coverage.
- We excluded bids for plans in specific payment areas with little or no projected enrollment because those bids would not reflect costs for those specific areas.

The sample of data used in our analysis included 1,229 payment areas in the 50 states and the District of Columbia, with an average of 4.5 bids per payment area (Table 1-5).<sup>8</sup>

Table 1-5 shows the distribution of payment areas by average monthly FFS spending per beneficiary for 2013, ranging from \$540 to \$1,335. More than half of Medicare beneficiaries live in areas with FFS spending between

**FIGURE 1-3****Distribution of MA plan bids by average FFS spending in payment area, 2013**

Note: MA (Medicare Advantage), FFS (fee-for-service).

Source: MedPAC analysis of Medicare Advantage plan bids for 2013.

\$690 and \$825 a month. (The overall average monthly FFS spending is \$781.) In lower spending areas, 15 percent of beneficiaries live in areas with FFS spending below \$690 a month; in higher spending areas, 31 percent of beneficiaries live in areas with FFS spending above \$825.

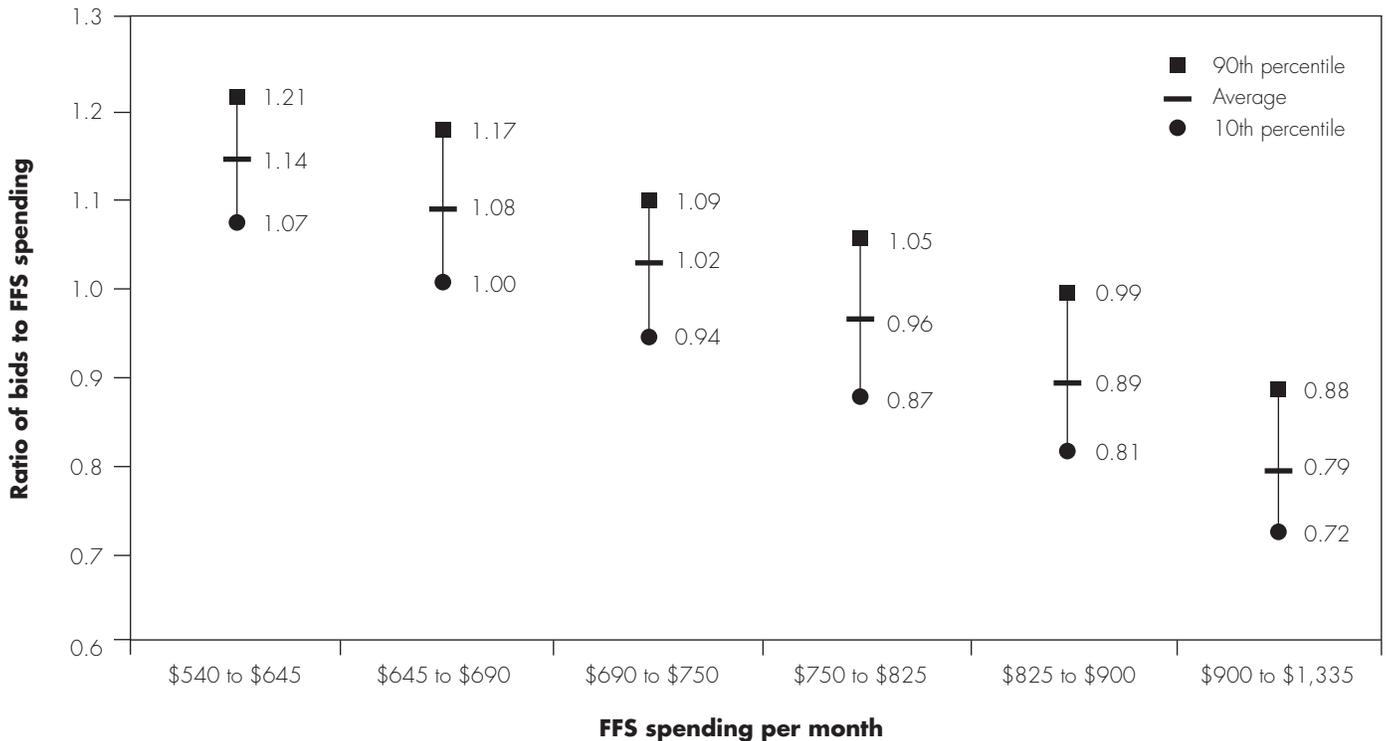
Overall, MA plan bids in payment areas increase with the average FFS spending per beneficiary (Figure 1-3). However, within each payment area, there is a noticeable range in plan bids. For example, in one high-spending payment area with average FFS spending equal to \$1,335, there were 37 total bids, ranging from just under \$500 to just under \$1,100. The average bid for that area was about \$800. Similarly, in a low-spending area with average FFS spending equal to \$650, the average bid from 24 total bids, ranging from just under \$700 to about \$850, was \$750.

Although plan bids tend to increase as FFS spending increases, the ratio of plan bids to FFS spending in their payment area decreases as FFS spending increases (Figure 1-4, p. 18). For areas with FFS spending below \$750 per

month, the average bid to provide the Part A and Part B benefit is greater than FFS spending (the ratio is greater than 1.00). For example, in areas with average per capita FFS spending less than \$645 per month, the average bid was 1.14 times FFS spending. In areas with FFS spending between \$645 and \$690 a month, the average bid was 1.08 times FFS spending. In higher spending areas, those with FFS spending at or above \$750, average bids were lower than FFS spending. For example, in areas with FFS spending between \$750 and \$825, the average bid was 96 percent of FFS spending. Still, there were bids above FFS spending in those areas, as noted by the ratio of 1.05 at the 90th percentile of bids.

### Illustrative options for calculating the federal contribution using MA plan bids

We considered three illustrative options for calculating the federal contribution. We used MA bids for 2013 as plan bids. In all three options, the federal contribution is set locally at the payment area level and the base premium is set nationally to the standard Part B premium under

**FIGURE 1-4****Distribution of plan bids relative to FFS, by average FFS spending in payment area, 2013**

Note: FFS (fee-for-service).

Source: MedPAC analysis of Medicare Advantage plan bids for 2013.

current law, following the general approach described in Table 1-4. We compare the federal contribution amounts and changes in beneficiary premiums compared with current law under each of the three options.

Under the first option, the federal contribution equals the average FFS spending in the local payment area. Local FFS spending ranges from \$540 to \$1,335, averaging \$781 per month. The overall average contribution amount under this option is \$781, or the overall average FFS spending (Table 1-6).

Under the second option, the federal contribution equals the weighted average of plan bids and FFS spending in the local payment area. (In other words, FFS Medicare is considered one of the plan bids.) The overall average contribution amount under this option is \$769, or 98 percent of average FFS. In low-spending areas, where plan bids are generally higher than FFS spending, this option would raise the contribution amount above FFS spending.

By contrast, in high-spending areas, where plan bids are lower than FFS spending, this option would lower the contribution amount below FFS spending.

Under the third option, the federal contribution equals the lesser of the average private plan bids (FFS Medicare is not included as a plan bid) and FFS spending in the local payment area. In low-spending areas where plan bids are higher than FFS spending, this option would limit the contribution amount at FFS spending, whereas in high-spending areas, this option would set the contribution amount at the average plan bid and below FFS spending. The overall average contribution amount under this option is \$726, or 93 percent of FFS.

Table 1-6 also shows that under the first and third options, in which the federal contribution is limited at the high end to local FFS spending, 85 percent of Medicare beneficiaries live in areas with at least one private plan whose bid is at or below the contribution amount. Under

**TABLE  
1-6**

**Range of federal contributions under three illustrative options, 2013**

Illustrative scenario for determining federal contribution	Federal contribution (in dollars per month)			Federal contribution relative to FFS			At least one private plan at federal contribution amount (percent of beneficiaries)
	Minimum	Average	Maximum	Minimum	Average	Maximum	
100% local FFS	\$540	\$781	\$1,335	1.00	1.00	1.00	85%
Average of bids and FFS	589	769	1,131	0.79	0.98	1.11	89
Lesser of average bid and local FFS	540	726	1,110	0.61	0.93	1.00	85

Note: FFS (fee-for-service). Our analysis assumes no behavioral responses from plans and beneficiaries. Federal contribution excludes quality bonus payments to plans.

Source: MedPAC analysis of Medicare Advantage plan bids for 2013.

the option in which the federal contribution is set at the average of FFS spending and the plan bids, 89 percent of beneficiaries live in areas where at least one private plan bid is at or below the contribution amount.

The federal contribution calculated under each illustrative option has different implications for beneficiaries depending on their choice of Medicare coverage and area. For this analysis, we assumed that any change in the federal contribution would be fully offset by a change in the plan premiums paid by beneficiaries. The numbers in Table 1-7 reflect only the changes in the federal contribution; we assumed no changes in plan offerings, no beneficiary response to the contribution changes, and that all beneficiaries continue to pay their Part B premium. It is very likely that beneficiaries would move to less expensive plans if they were available. The results here, however,

also assume that beneficiaries stay in whatever private plan or FFS Medicare they were in before the federal contribution was changed.

Under the first option, in which the federal contribution equals the average FFS spending in the local payment area, no FFS beneficiaries would pay additional premiums for the Medicare Part A and Part B benefit (Table 1-7). However, beneficiaries enrolled in private plans may pay additional premiums depending on how the specific plan bid compares with the contribution amount, which equals FFS spending under this option. Because relatively more beneficiaries live in areas where the average plan bid is below FFS spending, the median premium difference is -\$38 per month, assuming that current MA beneficiaries enroll in the same plan. This means that half of private plan enrollees would receive a rebate of \$38 or more per

**TABLE  
1-7**

**Premium differences assuming beneficiaries remain in FFS or current MA plan, 2013**

Illustrative scenario for determining federal contribution	Average federal contribution relative to FFS	Premium difference per month assuming beneficiaries remain in FFS or current plan					
		Current FFS beneficiaries			Current plan enrollees		
		10th percentile	Median	90th percentile	10th percentile	Median	90th percentile
100% local FFS	1.00	\$0	\$0	\$0	-\$202	-\$38	\$82
Average of bids and FFS	0.98	-14	3	49	-138	-26	66
Lesser of average bid and local FFS	0.93	0	17	149	-51	13	98

Note: FFS (fee-for-service), MA (Medicare Advantage). Payments to plans for their Medicare Part A and Part B cost equals the federal contribution plus a beneficiary premium. Under these scenarios where we assume plan bids do not change and beneficiaries remain enrolled in their original plans or Medicare FFS, a change in the federal contribution would produce an equal and opposite change in the beneficiary premium. This table illustrates the premium changes from current law that would result from calculating the federal contributions under these scenarios. Our analysis assumes no behavioral responses from plans and beneficiaries. Federal contribution excludes quality bonus payments to plans. All beneficiaries are assumed to continue to pay their Part B premium.

Source: MedPAC analysis of Medicare Advantage plan bids for 2013.

month. In general, if the federal contribution is set at the local FFS spending, enrolling in a private plan would be a lower cost option for beneficiaries, on average, assuming the current level of bids from private plans. However, this relationship would vary across the country. Ten percent of plan enrollees would see premium rebates of at least \$202 a month, while 10 percent of plan enrollees would see premium increases of at least \$82 a month, assuming none switched plans.

Under the second option, the overall federal contribution is slightly lower, at \$769 per month compared with \$781 under the first option. As a result, 10 percent of current FFS beneficiaries would receive premium rebates of at least \$14 a month, and 10 percent would pay premium increases of \$49 per month or more. Ten percent of current plan enrollees would receive premium rebates of at least \$138 a month, and 10 percent of enrollees would see additional premiums of at least \$66 a month if they chose to remain in their current plan.

Under the third option, in which the overall federal contribution is \$726 a month, most FFS beneficiaries and plan enrollees would pay additional premiums—\$17 or more per month for half of FFS beneficiaries and \$13 or more per month for half of plan enrollees. Finally, 10 percent of current plan enrollees would see their premiums decrease by at least \$51 a month, and 10 percent of plan enrollees would see their premiums increase by at least \$98 a month if they did not switch plans.

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## Issues related to low-income beneficiaries

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Currently, low-income beneficiaries receive financial assistance in paying for their Medicare premiums and cost sharing for Medicare-covered services. Most beneficiaries with incomes no greater than 100 percent of the federal poverty level and with assets no greater than \$2,000 for individuals (\$3,000 for couples) are also entitled to full Medicaid benefits in their state.<sup>9</sup> Under the current system, federal and state governments share the cost of subsidizing financial assistance for Medicare–Medicaid dually eligible beneficiaries.<sup>10</sup> It is likely that current rules governing such additional subsidies and benefits for low-income beneficiaries will need to be modified under a CPC approach. We discuss two specific issues.

The current standard Part B premium, which Medicaid programs pay on behalf of certain low-income individuals,

is a uniform national amount. If some CPC designs result in a Part B premium that would vary across geographic areas, federal and state expenditures for dually eligible beneficiaries and other low-income beneficiaries could change significantly, raising expenditures in some areas and lowering them in other areas. Total expenditures in a given state may be very different from current expenditure levels.

Another issue—the treatment of Medicare cost sharing—arises in MA today and has a potential effect under CPC. For dually eligible beneficiaries receiving assistance with Medicare cost sharing, providers receive Medicare’s standard program payment for the service, but payment of cost-sharing amounts (such as Medicare’s 20 percent coinsurance for physician services) is the responsibility of the Medicaid program. This is true currently under both MA and FFS Medicare. Providers are not permitted to bill dually eligible beneficiaries for such cost sharing. However, most states pay less than the amount of cost sharing allowed under Medicare. States can choose to limit their cost-sharing liability to the difference between the Medicare allowed amount and the Medicaid payment rate for a given service. For example, if a physician bills \$100 for an office visit, and Medicare pays \$80 with \$20 allowed as cost sharing, a state will not pay the \$20 on behalf of a dually eligible beneficiary if the state Medicaid payment rate for the physician office visit is \$80 or less. If the state Medicaid rate is \$90, the state will reduce its payment of Medicare cost sharing to \$10. Dually eligible beneficiaries enrolled in MA plans are subject to the same cost-sharing rules the state applies to FFS Medicare beneficiaries in the state.

The policies on Medicare cost sharing for low-income beneficiaries can affect the bidding process under a CPC model and the ability of plans to establish adequate networks. Plans with a large proportion of dually eligible enrollees may have higher bids than plans with fewer dually eligible beneficiaries because providers may be less willing to accept dually eligible beneficiaries if the state refuses to pay the cost sharing. Consider the following example of two plans. Plan 1 has no dual-eligible enrollment and pays its physicians \$100 per office visit, consisting of \$80 from the plan and \$20 in beneficiary cost sharing. In contrast, Plan 2 has 100 percent dual-eligible enrollment and has physicians receiving a total of \$80 per office visit because no cost sharing can be collected. Each plan’s bid for the Medicare Part A and Part B benefit package shows physician office visits costing the plan \$80—in the same way that the Medicare FFS plan “bid”

would have program payments of \$80 for office visits. In a state that does not pay Medicare cost sharing above Medicaid payment levels, the physicians in Plan 2 may demand total revenue of \$100 per office visit from the plan. Consequently, Plan 2 would then have to increase its bid to take into account the \$100 per office visit it must pay physicians. Anecdotal evidence suggests that MA plan providers that currently have a large influx of new dually eligible beneficiaries are concerned about the reduced revenue.

To the extent that low-income beneficiaries will receive full subsidies only if they enroll in the lowest cost plans—or, as in Part D, are assigned to such plans with a choice to opt out—plan capacity is also an issue. The lowest cost plans may not be able to accommodate all low-income beneficiaries in an area, and they also may not wish to have an enrollment consisting exclusively or primarily of low-income beneficiaries. Moreover, if the composition of the lowest cost plans in an area changes from year to year, care transitions are an issue as low-income beneficiaries move back and forth between FFS and a private plan or among private plans. Part D has specific rules governing transitions, but transitions with a drug benefit are probably more manageable than transitions in medical care for a population that includes sicker beneficiaries with high levels of service use.

How a CPC model for Medicare benefits can interact with Medicaid benefits for dually eligible beneficiaries presents a particularly thorny issue. Some have suggested that Medicare Part D provides an example for incorporating Medicaid benefits under a CPC model. (Part D involved federalizing some part of the Medicaid benefit and “clawing back” financing from the states.) However, managing a drug benefit is much simpler and more straightforward than managing a medical benefit, which has more intrinsic variation. Moreover, there are a number of complicated issues related to the dually eligible population. It is a very heterogeneous population, and many of the beneficiaries are either physically or cognitively limited in significant ways. Such issues raise concerns that plans may not have the initial capacity to serve these unique populations. Consequently, a CPC approach that is primarily an insurance model does not address the medical care needs and social service issues for dually eligible beneficiaries. Those issues are very different from the issues related to integrating the dual-eligible population in the Part D program.

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## Additional considerations

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This chapter represents the Commission’s initial exploration of a CPC approach and is not intended to be a definitive or comprehensive discussion. Instead, we have focused on a few first-order questions and issues that must be addressed in designing a CPC model to understand their implications for beneficiaries, private plans, and the Medicare program.

As a result, important additional issues are not discussed in this chapter. Our analysis of plan bids and availability is based on current MA plan bids because they represent the best available measure of the total cost of providing the Medicare benefit through private plans. However, those bids might be an unreliable proxy for how plans would actually bid in a CPC model because its design is likely to differ from the current MA program. For example, under competitive bidding, private plans are likely to make different decisions regarding whether to enter or exit a particular market, how much to bid, and what benefit designs to offer.

We also did not address in this chapter how beneficiaries’ choice of plans for Medicare coverage might change in a CPC model. Our analysis of beneficiary premium impacts suggests that any changes in the calculation of the federal contribution can affect beneficiaries financially. How beneficiaries respond to those changes by switching among plans and what factors affect their decisions are important issues. For example, beneficiaries’ sensitivity to changes in premiums and their ability to meaningfully trade off premiums and other aspects of the benefit package can have important implications for their choice of plans and for the Medicare program.

Finally, under a CPC approach, decisions by private plans and beneficiaries may change or evolve over time. If they fluctuate from one year to the next, then the federal contribution amount, beneficiary premiums, and program spending could also fluctuate. Whether to moderate such fluctuations—or more generally, how to manage those changes over time—is an additional issue to consider. ■

## Endnotes

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- 1 Despite their desire, beneficiaries may not be very good at “optimizing” their choices. Expected need for health care is quite unpredictable, and decision making under uncertainty is difficult. Moreover, beneficiaries’ ability to choose can diminish if they have too many choices. The psychological and economic literature on decision making suggests that the benefit of additional choices follows an inverted-U shape: Neither too few nor too many choices is ideal.
- 2 When MA plans bid on the standard Part A and Part B benefit package, the statute specifies that a standard level of cost sharing for covered services assumed in the bid is equal to Medicare FFS cost sharing. In addition, a separate statutory provision limits the actual cost sharing that beneficiaries would have to pay in a plan to no more than the actuarial value of Medicare FFS cost sharing. Although MA plan bids are determined based on Medicare FFS cost-sharing levels, MA plans have significant leeway in determining how cost sharing will work in a plan. For example, while FFS Medicare has coinsurance for physician services, MA plans typically charge fixed copayments.
- 3 This is directionally consistent with a study by Song et al. (2012), which used a similar regression model. However, the Song study’s coefficient on the benchmark variable was 0.49, almost double the coefficient in this study. The difference could be that our regression model included service use as a covariate rather than using Medicare spending as a covariate as Song did. When we dropped service use from the regression, our coefficient rose to 0.49, matching that in the Song et al. study. The correlation between service use and the benchmark relative to FFS is  $-0.52$ , which explains the sensitivity of the model to the inclusion or the exclusion of the variable.
- 4 Certainly, the opposite may also be true. In some areas, FFS Medicare might be the high-cost option compared with options offered by private plans, and including FFS Medicare could increase program spending. One design solution to overcome this problem is to set the maximum federal contribution equal to FFS spending in a given area. This approach is discussed further later in the chapter.
- 5 Under the MA program, private plans submit a bid to cover the Part A and Part B benefit for a beneficiary of average health status in counties they want to serve. The bid is the dollar amount of revenue that the plan estimates it needs to provide the benefit and includes plan administrative cost and profit. The plan’s actual payment rate, however, is only partly determined by the bid: It also takes into account the relationship between the bid and the local MA benchmark and adjusts for enrolled beneficiaries’ demographics and health risk characteristics. It should be noted that for regional PPOs, their benchmarks are a blend of the MA county benchmarks and regional PPO bids.
- 6 As of 2005, for the market areas, we are using core-based statistical areas, which is a collective term for metropolitan (50,000 or more in population) and micropolitan (10,000 to 49,999 in population) areas. Each area consists of one or more counties and includes the counties containing the core urban area as well as any adjacent counties that have a high degree of social and economic integration with the urban core as measured by commuting to work.
- 7 Health service areas are defined by the National Center for Health Statistics and consist of collections of counties where most of the short-term hospital care received by beneficiaries living in those counties occurs in hospitals in the same collection of counties.
- 8 Out of the 1,229 total, our analysis excluded 167 payment areas because we had no MA bids for those areas that met our criteria. The excluded areas contain about 2 percent of Medicare beneficiaries.
- 9 Fully dually eligible beneficiaries are entitled to Medicaid services not covered by Medicare. Such services include long-term care services and supports, behavioral health services, vision and dental care, and other wraparound services. Additionally, Medicare Savings Programs help beneficiaries with limited incomes pay for Medicare premiums and cost sharing. Beneficiaries with incomes up to 100 percent of the federal poverty level who meet their state’s resource limits can enroll in the qualified Medicare beneficiary program with Medicaid covering their Part B premium and cost sharing, and beneficiaries with incomes below 135 percent of the poverty level can have their Part B premium covered under the specified low-income beneficiary or the qualifying individual program. See Chapter 6 of this report for more details on different categories of dually eligible beneficiaries.
- 10 Under the qualifying individual program, financial assistance is entirely federally funded.

## References

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- American Hospital Association. 2012. *Hospital statistics. Aggregate hospital payment-to-cost ratios for private payers, Medicare, and Medicaid, 1990–2010*. Chicago, IL: AHA. <http://www.aha.org/research/reports/tw/chartbook/ch4.shtml>.
- Dowd, B. 2001. More on Medicare competitive pricing. Letter to the editor. *Health Affairs* 20, no. 1 (January–February): 206–207.
- Dowd, B., R. Coulam, and R. Feldman. 2000. A tale of four cities: Medicare reform and competitive pricing. *Health Affairs* 19, no. 5 (September–October): 9–29.
- Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2005. *Report to the Congress: Issues in a modernized Medicare program*. Washington, DC: MedPAC.
- Song, Z., M. B. Landrum, and M. E. Chernew. 2012. Competitive bidding in Medicare: Who benefits from competition? *American Journal of Managed Care* 18, no. 9: 546–552.