

BRING MARKET PRICES TO MEDICARE!

Essential Reform at a Time of Fiscal Crisis

by

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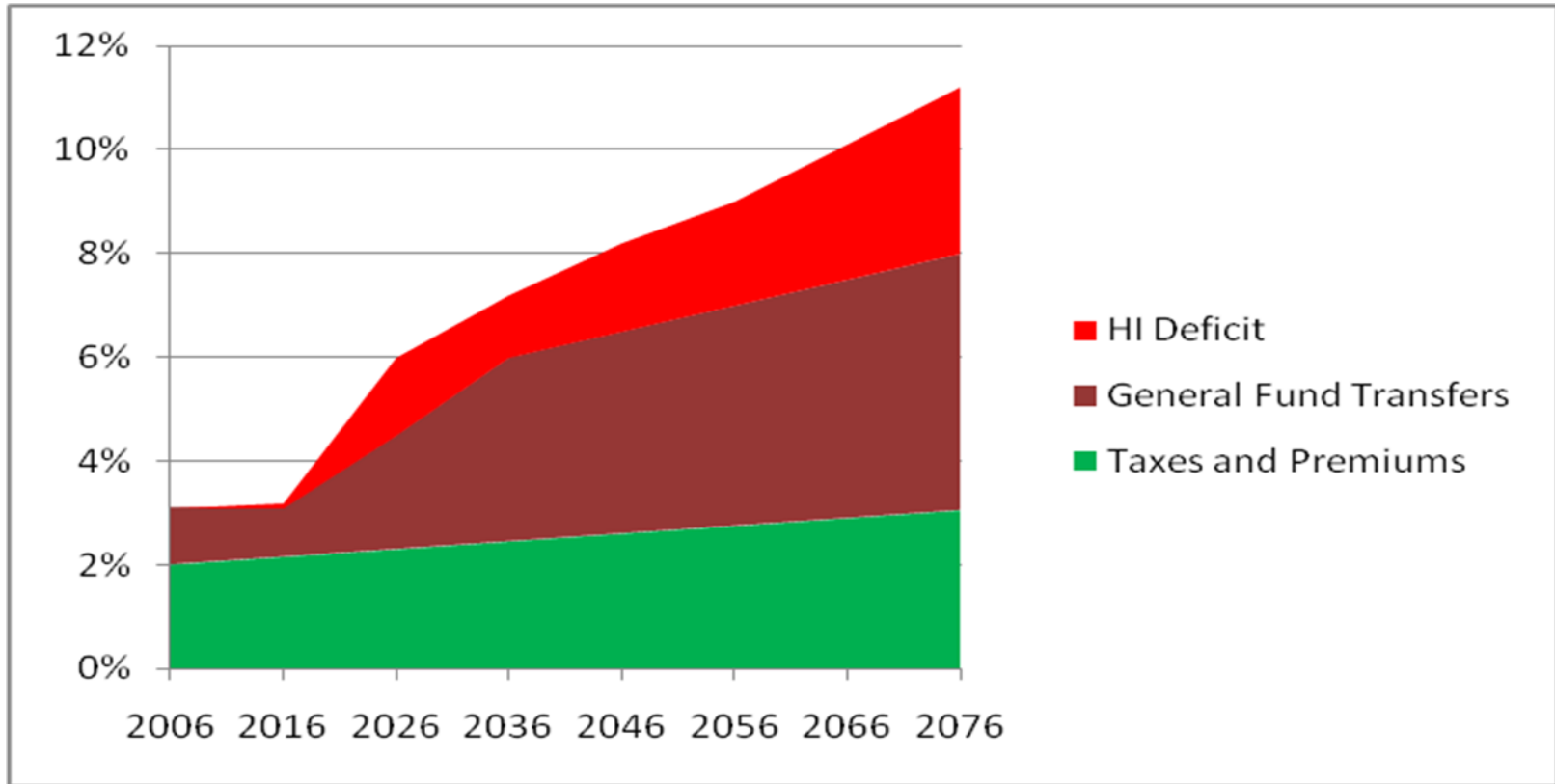
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Why competitive pricing?

- Our proposal: Use competitive pricing to set Medicare payments for traditional fee for service as well as Medicare Advantage
 - Ignore Medicare prescription drug coverage – already uses competitive pricing
- The political wisdom of our approach – two views:
 - DHHS legislative liaison: “Bidding for fee-for-service is out of the question. Politically, it’s a non-starter.”
 - Old Washington policy hand: “Are you nuts?”
- Why are we pushing this unrealistic idea?

Medicare's fiscal crisis



Source: 2009 Medicare Trustees Report

Severe!

Effects of fiscal crises

- Facing serious fiscal problems, Congress has acted to impose politically difficult changes: e.g., PPS, BBA 1997
- This crisis is much worse
- “Muddling through” with incremental changes is expedient politics, but is very risky
 - Fewer degrees of freedom in future
 - Medicare Trustees (2009): “Delaying action would constrain the options for addressing Medicare’s problems...”
- Response to political difficulties of reform
 - Don’t minimize the extent of the reform
 - Recognize reasonable beneficiary needs and expectations in the transition to reform

We make three key assumptions

1. Medicare is a defined benefit program
 - Settle what the benefit is and do not use overpayments to enrich benefit for some beneficiaries or for some policy purposes
2. Government should buy that benefit at the economical cost to produce it in each area
 - Pay only what the most efficient qualified plan requires
3. Entitlement is to that benefit, not to a particular plan that offers it – traditional FFS and MA plans treated together

Five ways* to pay Medicare health plans

1. Current system – MMA ‘overpayments’ to encourage MA plan enrollment
2. MedPAC: FFS levels
3. Berenson: adjustments to FFS levels
4. Obama proposal: competitive pricing only for MA plans
5. Our proposal: competitive pricing for all health plans, including FFS

* In savings estimates, we address a sixth way, a variant of #5 – CCA 2010 demonstration.

1. Current system

- MMA 2003: deliberate increase in MA plan payments
- Advantage: wider availability of health plans, increase in enrollment to 23% of all beneficiaries
- Problems:
 - Fastest growing type is Private FFS – least policy justification
 - Payments exceed FFS Medicare costs by average 14 percent
 - “This added cost contributes to the worsening long-range financial sustainability of the Medicare program ” [MedPAC]

2. MedPAC alternative: pay FFS costs in each county

- Reduce payments to FFS levels
 - As with all payment reforms, eliminates enhanced benefits funded by current overpayments
- Politically practical (vs. competitive pricing)
- Simple and intuitive, but a bad idea
 - “Here we go again” – the old AAPCC system albeit with better risk adjustment
 - Paying FFS levels creates big winners and losers
 - In a few years: the same dissatisfaction as with AAPCC?
 - Why is FFS the gold standard?
 - Average FFS spending has inconsistent relationship to MA plans’ costs
 - Overpays MA plans or FFS in every payment area

What does it mean to “overpay” FFS?

- FFS is overpaid if the same quality services are available to the Medicare program at less cost through MA plans – and vice versa.
- If Medicare is in financial distress, why pay more than the most efficient quality plan can offer?
- Private health plans are cheaper than FFS in some areas
 - Average private plan bid > FFS in areas where 59% of beneficiaries live, though
 - Lowest private plan bid < FFS in most areas.

More on this later.

3. Berenson: Adjust FFS levels

- Adjust FFS based on cost reports/other administrative data
- FFS levels create arbitrary winners/losers – this approach corrects some of that
 - Cuts MA payments in high payment areas.
 - MA payments closer to the plan’s actual costs.
 - This is as good as you can do with administrative pricing.
- FFS left out
 - Again, why should Medicare overpay FFS?
 - Creates opening for political meddling in the adjustments – so much for the “level playing field”!

4. Obama Administration Competitive Pricing: MA Only

- Take bids from MA plans, compare, set benchmark at weighted average of bids
 - Saves money
 - Get plans to reveal their costs
- Similar to the bidding model used in HMO demonstration efforts in late 1990s
- Problems
 - “Average of bids” benchmark rule → lesser incentive for plans to reveal costs than under alternative rules.
 - Why overpay FFS?
 - Industry opposition from excluding FFS

5. Competitive pricing for all Medicare plans – FFS and MA

- Same as Obama proposal, but FFS included in the bidding
 - FFS “bid” = average FFS cost of care for standardized enrollee in each county
 - Benchmark = lowest bid of qualified plan health plan with sufficient capacity
- Advantages:
 - Greater incentive for plans to bid their cost of providing the entitlement benefit package in each market area
 - Saves the most money
 - Eliminates overpayments to all health plans including FFS
 - Gives beneficiaries price signals to use cheaper ways of delivering the Medicare benefit
 - No different than what employers commonly do – use competitive bidding to set payments to health plans.

5. Competitive pricing for all Medicare plans [continued]

- Disadvantage – BIG political problems:
 - Most important: Some FFS beneficiaries would have to pay extra premium for first time.
- MA plans have vigorously opposed the idea of direct price competition on a standard benefit package
 - 1996-1999 Competitive Pricing Demonstration: visceral, angry response
 - Prefer benefit competition within an administrative price known in advance
- Different response when FFS included?

Competitive pricing and Medicare: lessons in history and law [handout]

- Since 1980: ~10 efforts to demonstrate/phase-in competitive pricing for some part of Medicare benefit, including MA plans
 - Not due to practical problems or failure to save money -- political opposition has been the key obstacle to competitive pricing.
- One effort to implement competitive pricing was a success: Part D drug pricing. But:
 - New – not a substitute for existing administrative pricing system.
 - Reached an agreement with industry
 - Thought experiment: imagine Part D benefit already existed, with an administrative pricing system in place that's created winners and losers. Along come economists urging competitive pricing....
- Why would Congress take on this political problem?
 - The fiscal crisis!

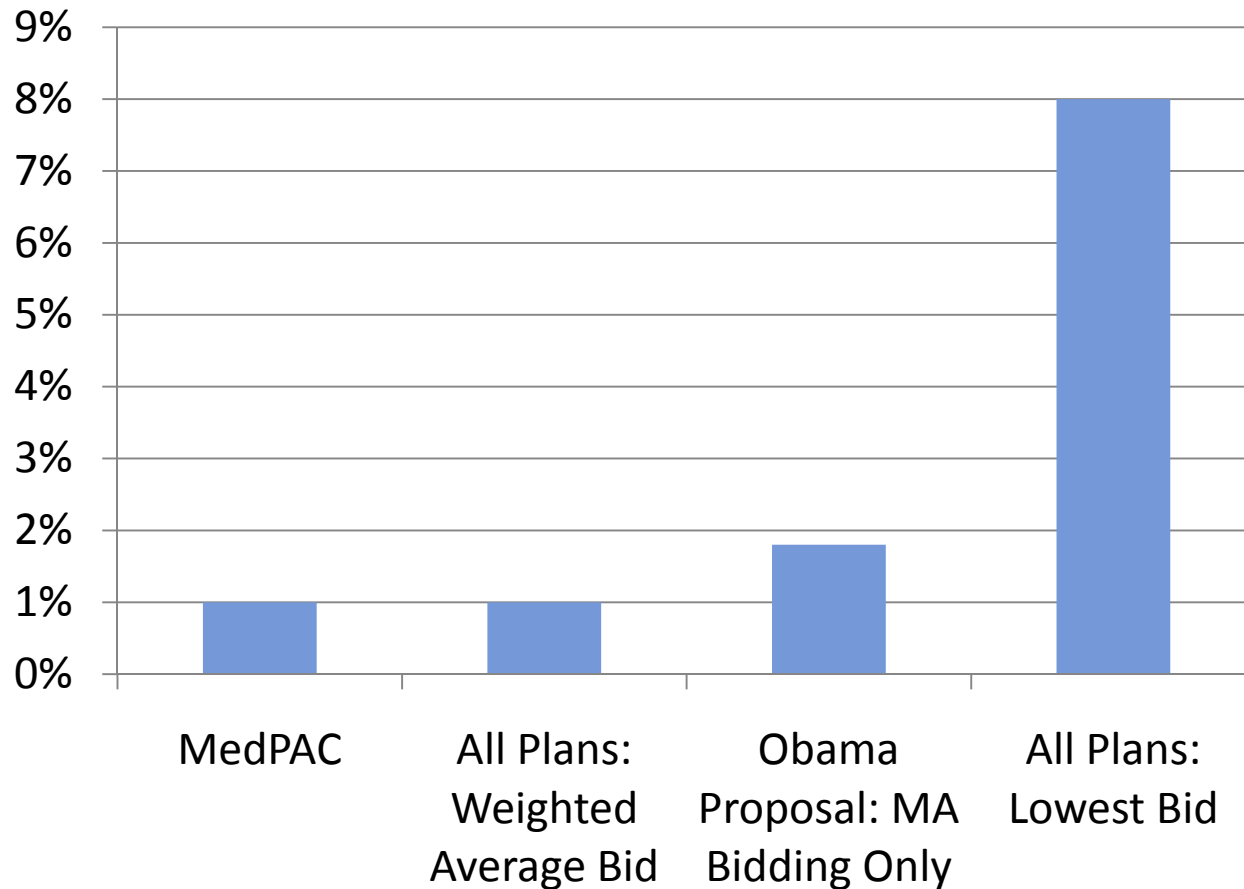
Savings estimates from Medicare payment reform proposals

- MedPAC's proposal to pay all Medicare health plans at level of FFS cost
- Competitive pricing that uses the weighted average bid from FFS and MA plans to set the payment rate for all plans (CCA design)
- Obama proposal for bidding only among MA plans
- Competitive pricing that uses the lowest bid from any qualified Medicare plan to set the payment rate for all plans

Assumptions

- All bids at county level as in current payment system
- All bids adjusted for enrollees' risk
- All dollar figures are for 2005
 - No attempt to update
 - Understates savings because of growth in MA payments, MA market share, and FFS cost
- We assume plans' bids under reform are same as current bids
- No tax on plans bidding less than benchmarks
- No private plans exit from market

Savings estimates



Source: Authors' calculations based on MedPAC & CBO data

Comments on “all plans – weighted average bid”

- Design is like the CCA demonstration scheduled to begin in 2010
- 1% savings is very similar to MedPAC’s proposal to pay all plans at level of FFS cost
- Payment rate will be driven by FFS cost in most areas
 - Savings come almost entirely from reduced payments to MA enrollees in areas with low FFS cost
- Why do we need to demonstrate this?

Beneficiary disruption

- We estimated the amount of beneficiary disruption from each proposal, measured as the increase in out-of-pocket premium for the beneficiary's current plan
- Focus on our proposal, which has 3 sources of disruption:
 - Removes “floor” payments
 - MA enrollees pay more in areas with low FFS costs
 - FFS enrollees pay more when an MA plan is the low bidder

Disruption estimates

FFS Cost Range (\$PMPM)	FFS Disruption (\$PMPM)	MA Disruption (\$PMPM)
<\$550	\$0	\$129.26
\$550-\$599	\$11.50	\$78.86
\$600-\$649	\$37.80	\$77.39
\$650-\$699	\$54.40	\$70.78
>\$700	\$105.00	\$110.33

Source: Authors' calculations based on MedPAC & CBO data

No demonstration

- We know that bids will be lower than plan payments:
 - Denver bids were 24-38% below BBA payment rates
 - DME bids were 26% below prevailing levels
- We know that competitive pricing is administratively feasible
- We know a great deal about quality of care in MA plans – more than in FFS Medicare

MA plan exits

- HMOs would exit from areas with large reductions in payment rates
 - But payment is not the only factor in plans' decisions
 - Halpern (HCFA Review, 2005) showed that a 20% cut in payment increased the probability of an HMO dropping a county in 1999-2000 by 3 percentage points
 - These counties have low FFS costs, so our savings estimates are not very sensitive to plan exits
- Private fee-for-service plans would disappear if paid the same rate as FFS (Frakt, Pizer, and Feldman, HCFA Review, 2009)

MA enrollee disruption

- We know who will be disrupted and approximately how much when MA plans leave Medicare
- BBA provides a natural experiment of disruption:
 - Most enrollees were able to deal with the transition when their HMOs left Medicare in 1998-1999
 - Minorities and those with lower incomes and education may have more trouble finding a new MA plan or finding new doctors in FFS (Schoenbaum, et al., HCFA Review, 2005)
- CMS could target education and outreach to groups/areas likely to be affected

FFS enrollee disruption

- We don't have natural experiments to predict what would happen in areas where FFS is the high bidder
- But observational studies suggest most FFS enrollees would opt to pay higher premiums
- This would lead to financial disruption, but not disruption in quality and continuity of care
- Low-income beneficiaries are most likely to leave FFS, although many already have left

More flexibility for FFS?

- Our position: FFS Medicare should be allowed to do what any other health plan would do if it could:
 - Offer features that beneficiaries are willing to pay for, subject to offering the entitlement benefits
 - Make cost-saving decisions
 - Offer an alternative plan with selective provider contracting
 - Refuse to be first-payer for patients who have supplementary insurance
 - Most controversial: offer Part D coverage

Eliminating the Medigap spillover

FFS Cost Range (\$PMPM)	% of Beneficiaries	Minimum Bidder
<\$550	15%	FFS
\$550-\$599	20%	FFS
\$600-\$649	24%	FFS
\$650-\$699	15%	MA
>\$700	26%	MA

✓ FFS is the winning bidder in areas where 59% of beneficiaries live

✓ Total savings = 10% of Medicare costs (compared with 8% under our proposal with current FFS design)

Sources: A. Atherly, 2002, and Authors' calculations based on MedPAC & CBO data

Summary

- Different Congresses and Administrations have tilted the playing field in favor of one plan type or another
 - Predictable cycles in administrative payment formulae, from generosity to stringency
- Time to design a payment system that:
 - (a) Lets plans tell the government how much they want to be paid, not the other way around; and
 - (b) Subjects them to a predictable set of consequences if they submit low or high bids.
- Saves more money than any other proposal: 8%
- Is a tested method – no demonstration necessary

Summary [continued]

- Competitive pricing could end political bickering over private MA payments
- Best way to address opposition to needed reforms is not to minimize the extent of the reform, but rather to recognize reasonable beneficiary needs and expectations.
- With efficient provision of the Medicare entitlement, focus could be on a better question: what should the entitlement be?

Summary [continued]

- This presentation is based on our forthcoming book, Bring Market Prices to Medicare! by Robert Coulam, Roger Feldman, and Bryan Dowd, AEI Press
- We thank AEI for financial support and Joe Antos for arranging this meeting.
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