



Health Policy Brief

June 5, 2009

Competitive Bidding In Medicare Advantage: If health insurance companies submitted competitive bids to offer Medicare coverage, President Obama says, the government could save billions of dollars.

What's the issue?

President Barack Obama proposes to save \$177 billion over ten years through a new competitive-bidding system for “Medicare Advantage” plans. These are the private health plans that serve nearly one in four Medicare beneficiaries. In 2009 these private plans will receive an average 14 percent — or \$12 billion — more than the government would pay if beneficiaries enrolled in those plans had remained in the traditional Medicare program.

The Obama administration’s plan goes beyond other proposals to cut payments to Medicare Advantage plans. (See [Health Policy Brief: Medicare Advantage Plans](#), April 29, 2009, for a fuller description of these plans, how they are currently paid, other proposals to change the payment system, and arguments for and against doing so.)

Under the Obama administration’s proposal, companies in a given geographic area would submit bids to cover Medicare beneficiaries, as they do now. But they would then be paid the average of their bids, plus some additional amounts as detailed below. Insurers submitting below-average bids would receive the average payment; they could use the difference between their bids and the average payment amount to provide addition-

al benefits to enrollees. Companies with above-average bids would charge members a premium to make up the shortfall between the average payment and their bids.

“This approach will allow the market, not Medicare, to set [Medicare Advantage] payment rates,” the administration’s fiscal 2010 budget proposal says. The Obama administration hopes to use the savings to help pay for expanding health insurance coverage to uninsured Americans in the context of overall health reform. However, savings could also be used to shore up the finances of the Medicare program, which faces extremely large unfunded future liabilities.

But opponents say the large savings that the president’s plan proposes to generate could only be achieved through dramatic cuts in payments to the private insurers. If these large payment cuts took place, they say, the insurance plans would be forced to cut benefits, raise members’ fees, or simply drop out of the program.

What's the background?

The first private health plans within Medicare were introduced nearly three decades ago. At the time, supporters argued that health maintenance organizations, or HMOs, would provide better

health care at lower cost. Subsequently, new types of private plans were added to Medicare, including so-called preferred provider organizations, or PPOs, and private fee-for-service plans. There have been long-standing differences among policymakers over the merits of private plans.

Over the years, Congress has grappled with the problem of how to pay the plans, especially in relation to the traditional Medicare program (where health care providers are paid according to fee-for-service, or FFS, payments). Any system to pay private plans has to take many factors into account. Health care costs and medical practice vary widely across the country, so it wouldn't be feasible to have one level nationwide payment. What's more, the health conditions of Medicare beneficiaries are not the same; for various reasons, healthier people tend to join private plans. That means they need less medical care overall, so they generally cost less than do beneficiaries in traditional Medicare.

To address these variables, Congress devised a payment formula based on the average cost of caring for beneficiaries in traditional fee-for-service Medicare in a particular county. Congress has also provided additional money to plans that have older, sicker patients or that operate in rural areas. This overall payment system has created several problems. In particular, in areas where traditional Medicare program costs are high, private health plans are paid even more than what it would cost if the beneficiaries enrolled in private plans had stayed in traditional Medicare. These overpayments have driven up costs to U.S. taxpayers.

Medicare officials and members of Congress

have tried to resolve the situation by finding new ways to adjust the payment formula. President Obama's proposal, described below, represents still another approach.

This is not the first time competitive bidding has been proposed as a means of determining payment rates for private plans. In fact, the concept has a long and tortured history.

In the 1990s, the U.S. Health Care Financing Administration (HCFA), the predecessor of today's Centers for Medicare and Medicaid Services (CMS), tried several times to have private insurers bid competitively to provide Medicare coverage. One of the first attempts to establish a competitive-pricing experiment, or "demonstration project," was supposed to take place in Baltimore. Opposition arose from state officials and members of Congress, who feared that the pressure on private plans to produce low bids would prompt them to cut benefits to enrollees. The controversy caused HCFA to cancel the project in 1996.

The following year, HCFA attempted to test competitive bidding in Denver. However, insurers won a temporary court order to stop the project, arguing, among other things, that the government did not have authority to require all plans serving the Denver area to participate in the bidding demonstration project. Soon after, Congress passed a bill prohibiting it.

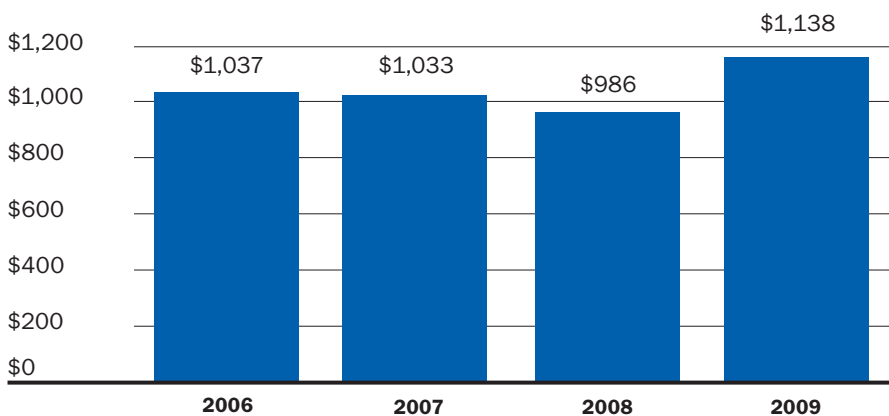
But already there were signs that the competitive-bidding process would actually work as intended to drive down payment rates to the plans. Before the Denver experiment was abandoned, HCFA received and opened some plan bids. They were 25–38 percent below the then-prevailing payment rate, according to a 2001 letter by Bryan Dowd published in *Health Affairs*.

Trying yet again, in the Balanced Budget Act of 1997, Congress directed the secretary of health and human services to conduct a competitive-pricing demonstration. Attempts were made to run competitive-bidding demonstration projects in Phoenix and Kansas City in 1999. But as Dowd and coauthors described in a 2000 *Health Affairs* article, opposition came from many quarters. In Arizona, for example, hospitals feared that private-plan payment rates would fall so low that the plans would then squeeze payments to hospitals. Amid the political ruckus, in 1999 Congress reversed itself and placed a moratorium on any further competitive-bidding demonstration projects.

Once more into the breach: In 2003 Congress mandated another competitive-bidding

EXHIBIT 1

Average Extra Payment per Medicare Advantage Member (Compared to Traditional Medicare)



Source: George Washington University for the Commonwealth Fund.

Projected Change in Medicare Advantage Enrollment, 2009–2019
(Congressional Budget Office)

Current payment system

+3.3 million

With competitive bidding

-7.0 million

With competitive bidding and bonus payments

-2.6 million

demonstration for the private plans scheduled for 2010. But as this policy brief is published in June 2009 — just a few months before the project is supposed to begin — information about it still is scarce. A Medicare spokesman says the agency is developing options for the project, including how it would align with administration and congressional health reform initiatives.

How it would work: The Obama proposal for competitive bidding is different in several ways from past attempts. Although some details of the proposal have not been made public, the plan avoids some of the controversial features that derailed past experiments. For one, competitive bidding would be rolled out nationwide and would not be a demonstration project limited to a few cities.

Strictly speaking, the Obama proposal is not competitive bidding in the usual sense. Under a classic competitive-bidding arrangement, the

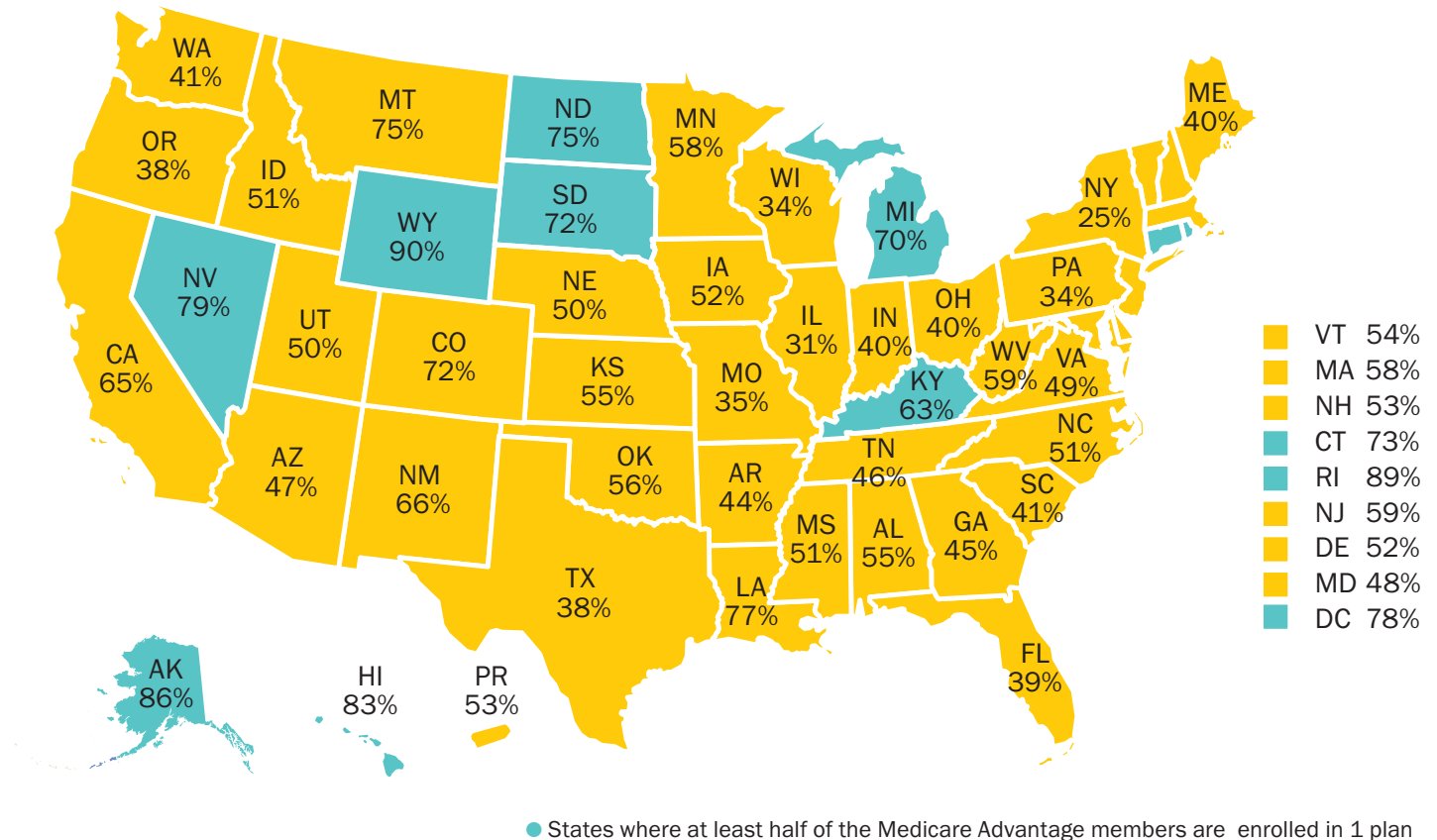
government may request bids from companies to repair a bridge or provide some other kind of good or service. Typically, only the company that meets all of the government's prerequisites, has the best performance record, and submits the lowest price for the work wins a contract.

By contrast, the Obama proposal would use competitive bidding to set payment rates — not to select a single “winner,” or otherwise narrow down the number of plans that could participate in the Medicare program. All qualified plans in a given geographic area would submit bids, and all qualified plans could enroll beneficiaries. The point of the competitive bidding is that the average of the bids would then become the basic payment rate to plans.

The major change the president's proposal would make from the existing payment system is to sever any link between private-plan payments and the costs of the traditional Medicare program.

EXHIBIT 2

Share of 2009 Enrollment in Each State's 2 Largest Medicare Advantage Plans



Source: Health Affairs analysis of May 2009 data from the U.S. Centers for Medicare and Medicaid Services (CMS).

Notes: Percentages may be understated because they reflect enrollment in specific plans, as defined by CMS, not their parent companies. Does not include plans with 10 members or fewer.

Estimated Average Monthly Value of Extra Medicare Advantage Benefits Not Available in Traditional Medicare, per Member, 2019 (Congressional Budget Office)

Under current payment system

\$135

Under competitive bidding

\$0

Under competitive bidding with bonus payments

\$46

In the current system, the government sets a rate, called a “benchmark,” for each county, which is based on the costs of traditional Medicare in that county. That amount is increased for plans with older, sicker members and other factors. The government pays the plans the amount they bid for providing hospital and ambulatory services under Medicare plus 75 percent of the difference between the bid and the adjusted benchmark, for bids below the benchmark. Since most bids fall below the benchmark, many plans receive these rebates. The plans must use the rebates to reduce beneficiary premiums or expand benefits.

Under President Obama’s proposal, no benchmark would be set in advance. Instead, plans would bid, as they do now, on how much they expect it will cost them to provide health care. The government then would calculate the average bid in a county or region. Each plan’s bid would be “weighted” by its number of enrollees, so that the bids of plans with greater numbers of enrollees would count more in terms of computing the average. Plans would then be paid the “weighted average” of the bids. Plans whose bids were above this number would have to charge enrollees additional premiums to make up the difference. Plans whose bids fell below the average would keep all of the difference to enhance benefits, reduce costs to enrollees, or some mix of both.

There are several additional wrinkles. The government would continue to adjust payments according to a plan member’s age and health conditions (a practice known as “risk adjustment”). This gives plans attracting older, sicker patients more money than plans with healthier, less costly members. There would also continue to be payment increases for insurers offering coverage in rural areas, where it can cost more to operate. But in any event, the new system would limit payments to no more than the 2009 benchmark amount under the current system indexed to the rate of growth in traditional Medicare spending.

What’s the argument?

In favor of competitive bidding: The president and his supporters say U.S. taxpayers can no longer afford to overpay health plans billions of dollars. A competitive-bidding system, they say, would save tens of billions of dollars annually and would bring Medicare Advantage payments closer to the private insurers’ actual costs. Back-

ers of the Obama proposal also argue that this approach would “level the playing field” between private plans and traditional Medicare.

Administration officials also say a competitive-bidding approach is the best way to reform payment to private health plans. They say it would save more than would be the case if Medicare Advantage payments were simply brought into line with the costs of traditional Medicare, as the Medicare Payment Advisory Commission, or MedPAC, has recommended. Administration officials estimate that their competitive-bidding approach would save an estimated \$177 billion over ten years. The reason, they contend, is that competitive bidding will drive Medicare Advantage payments below what traditional Medicare spends in some parts of the country — for example, where traditional Medicare program costs are high, and where there are more plans competing for enrollees’ business.

By contrast, the Congressional Budget Office (CBO) has estimated that competitive bidding would save \$159 billion over a decade. But the CBO assumes that insurers would submit bids similar to those submitted in the past, rather than significantly lower ones, as the administration forecasts. The CBO acknowledges that if the administration is correct, and companies’ competitive bids are significantly lower than previously, the savings would be greater.

Supporters of competitive bidding also point to the fact that the Obama administration’s proposal would retain several beneficial features of the current payment system. One is the current risk-adjustment mechanism. Under this, plans would continue to receive extra money for caring for older, sicker patients; this would encourage plans to care for these patients and not seek to avoid enrolling them. Supporters also say the new payment system would be good for Medicare beneficiaries in that it could provide them extra benefits or save them money. Plans that bid below the average bid amount could keep all of the difference — rather than the current 75 percent — as a rebate to be used for extra benefits for members, or could use the extra dollars to reduce members’ costs.

Against competitive bidding: The health insurance industry’s leading trade association, America’s Health Insurance Plans (AHIP), opposes the Obama administration’s proposal. An AHIP spokesman says competitive bidding will

Estimates of Savings with Competitive Bidding, 2010–2019

Obama administration

\$177 billion

Congressional Budget Office: competitive bidding only

\$159 billion

Congressional Budget Office: competitive bidding with bonus payments to plans achieving quality standards

\$108 billion

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vantage plans. That in turn could force plans to cut benefits or raise prices for members.

If, as the administration assumes, Medicare Advantage payments in some areas drop below the government's traditional Medicare spending, some plans will not be able to afford to offer more attractive coverage than traditional Medicare. If that happens, beneficiaries would have little reason to choose a private plan that costs more or offers less than traditional Medicare.

More broadly, congressional supporters of Medicare Advantage question whether a competitive-bidding system will ever be put in place, given the opposition that competitive-bidding demonstration projects encountered in the past. They also doubt whether such a system would really work as intended to achieve savings.

Others note that in some markets, only one or two plans dominate. A *Health Affairs* analysis of May 2009 current enrollment data shows that in 10 states and the District of Columbia, at least half of the Medicare Advantage members are in only one plan. In 30 states, at least half of the Medicare Advantage members are enrolled in that state's two largest plans (see Exhibit 2 map on page 3).

Competitive bidding may create political difficulties as well. The Obama administration proposes to subject only private Medicare plans to competitive bidding — rather than requiring traditional Medicare to compete on price with private plans as well. That could undermine the administration's argument that the government is creating a "level playing field" for public and private health plans.

What's next?

In June 2009, MedPAC is scheduled to provide Congress with a detailed analysis of alternative ways to revise the payment formula, including a competitive-bidding component. The commission has recommended since at least 2005 that the government pay private plans no more than what it spends in traditional Medicare.

Meanwhile, members of the Senate Finance Committee are weighing several options for reducing Medicare Advantage payments. Those options include combining the administration's competitive-bidding proposal with bonus payments for plans that improve the quality of their members' care. For example, there could be bonuses paid to plans that provide care coordination, use electronic health records, reduce hospital admissions, or undertake other quality-improving measures.

To some degree, congressional action is likely to be tied to overall health reform. The Obama administration and some members of Congress want to use savings from the Medicare Advantage program to help finance expansion of coverage to the uninsured. Others are likely to argue for putting these savings toward shoring up the Medicare program — for example, the Hospital Insurance, or Part A, Trust Fund, which under the most recent projections by Medicare trustees may be exhausted in 2017. Key congressional committees have vowed to have health reform legislation on the floor of Congress this summer, with the hope of passing bills before the August recess and enacting them into law later this year.

Resources

Robert A. Berenson and Bryan E. Dowd, "[Medicare Advantage Plans at a Crossroads — Yet Again.](#)" *Health Affairs* 28, no. 1 (2009): w29–w40 (published online November 24, 2008).

Congressional Research Service, [Medicare Advantage](#), March 3, 2009.

Bryan Dowd, Robert Coulam, and Roger Feldman, "[A Tale of Four Cities: Medicare Reform and Competitive Bidding.](#)" *Health Affairs* 19, no. 5 (2000): 9–29.

U.S. Senate Committee on Finance, "[Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs.](#)" April 29, 2009.

U.S. Government Accountability Office, "[Medicare HMOs: Setting Payment Rates through Competitive Bidding.](#)" Pub. no. GAO/HEHS-97-154R, June 12, 1997.