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Implementing Competitive Bidding in the Medicare Program: An Expressway to Solvency

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Abstract

The Medicare program faces increasing budgetary pressures, with recent estimates suggesting that the Medicare Hospital Insurance Trust will be insolvent as soon as 2028. Simultaneously, the Medicare Advantage (MA) program, a managed competition model, continues to grow its market penetration as beneficiaries increasingly choose private plans over traditional fee for service (FFS) Medicare. With the relative cost of the 2 forms of Medicare a subject of debate, policy experts have proposed a variety of policy options to address the program's budgetary pressures and place it on a firmer fiscal footing. This paper explores the implementation of one of these proposals in greater detail: fully transitioning the entire Medicare program to a competitive bidding model in order to reduce overall program costs and improve price competition. Current MA plan bidding methodology is explored, followed by a description of prior proposed competitive bidding models. Implementation challenges are addressed, along with specific policy considerations to protect beneficiaries who wish to remain in FFS Medicare.

Keywords

medicare, medicare advantage, competition policy, payment policy, fee for service, medicare solvency, budgeting

What do we already know about this topic?

The Medicare program faces increasing budgetary pressures, with recent estimates suggesting that the Medicare Hospital Insurance Trust will be insolvent as soon as 2028. Now representing over half of enrolled beneficiaries, Medicare Advantage benchmark policy remains anchored in an administrative fee for service pricing benchmark, raising costs for the Medicare Advantage program and preventing taxpayers from benefitting fully from market competition.

How does your research contribute to the field?

This paper explores the implementation of one of the many proposals to promote fiscal responsibility in greater detail: fully transitioning the entire Medicare program to a competitive bidding model in order to reduce overall program costs and improve price competition. Current MA plan bidding methodology is explored, followed by a description of prior proposed competitive bidding models. Implementation challenges are addressed, along with specific policy considerations to protect beneficiaries who wish to remain in FFS Medicare

What are your research's implications toward theory, practice, or policy?

This paper describes tradeoffs inherent in and policy challenges with implementation of Medicare Advantage competitive bidding models. Distinct from prior policy analysis, this paper explores specific regulatory policy and operational steps that policymakers can undertake to operationalize competitive bidding and improve benchmark policy in the Medicare program in order to support programmatic fiscal solvency.

The Medicare program has long faced projections of insolvency.[1] The 2022 Medicare Trustees report notes a revenues shortfall of 10% by the year 2028[2] and subsequent insolvency of the Medicare Hospital Insurance Trust Fund, supercharging pre-existing debate[3] amongst policy experts as to the best mechanisms to stabilize programmatic funding. Recognizing the growth of the Medicare Advantage (MA) program, now half of Medicare enrollment,[4] coupled with

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questions about its relative cost compared to fee for service (FFS) Medicare,[5,6] experts have suggested a variety of policy options[7] from increasing payroll taxes to modifying risk adjustment in order to improve Medicare's fiscal stability. This paper explores the implementation of one of these proposals in greater detail: fully transitioning the entire Medicare program to a competitive bidding model in order to reduce overall program costs and improve price competition. Current MA plan bidding methodology is explored, followed by a description of prior proposed competitive bidding models. Implementation challenges are addressed, along with specific policy considerations to protect beneficiaries who wish to remain in FFS Medicare.

The Current State of Medicare Advantage Plan Bidding

MA plans are currently paid based upon a bidding and benchmark system anchored around an administrative benchmark. Payment benchmarks are statutorily defined as a percentage (95%-115%) of the per capita FFS Medicare spending,[8] permanently anchoring MA in the FFS administrative pricing model. In order to attract MA plans to regions with lower FFS spending, plans receive a higher reimbursement rate (115%) while areas with the highest FFS spending receive a lower reimbursement rate (95%), with other counties grouped at quartiles of FFS spending.[9] MA plans submit sealed county-level bids for an average risk beneficiary. If the plan bid is above the benchmark rate, the enrollee must pay the difference in the form of a higher premium on top of the standard Part B premium. If the bid is below the benchmark, CMS returns a portion (tied to the plan's star rating) of the difference to the plan, which rebates the savings to beneficiaries in the form of reduced cost sharing and/or supplemental benefits.[10] Benchmarks are further adjusted based on MA plan star ratings, ranked 1 to 5 stars.[11] Average bids for Part A/B services are at 87% of local FFS spending,[12] driving increased rebates that plans use to offer supplemental benefits and reduced beneficiary cost-sharing as opposed to total programmatic savings for all taxpayers

MA plans then decide how to distribute and manage risk using insurance tools such as risk corridors, episode or time-driven bundles, and capitation; in addition to or in place of FFS payment. Plans also engage in strategies to manage the total cost of care, including care coordination, disease management, and automation. In contrast, FFS Medicare can only change payment methodologies through an act of Congress, while MA plans can respond to changes in clinical practice and market needs in near real-time, in addition to serving as a buffer between beneficiaries and the political class.

The current system limits competition between FFS Medicare and MA, preventing beneficiaries and taxpayers from fully capturing the gains resulting from market competition. In a competitive market, bids are based on the cost of services, including a return on capital. If MA were a perfectly competitive, frictionless market, plans would bid according to costs, with benchmark adjustments resulting in no change in plan bids. Empirical research suggests otherwise, with researchers finding that for every $1 increase or decrease in benchmark, consumers experienced only $0.49 to 0.60 increase or decrease in plan bids.[13,14] Explanations vary from plan deployment of savings to finance managed care tools (eg, utilization management) to other administrative functions that are not frictionless to plan profits, albeit this remains an open question. Increasing price competition would reduce frictions and direct a greater share of savings to beneficiaries and taxpayers.

The Medicare FFS program—upon which the MA plan benchmark is based—is built on an administrative pricing model, relying upon a physician practice survey that has a response rate of 2.2%.[15,16] The administrative physician fee schedule does not take into account technologic advancements, changes in clinical operations, or varying modalities of care delivery. For example, an MRI is currently billed for 31 minutes despite new imaging software allows a physician to quickly scroll through a large set of images in 10 minutes,[17] with well-documented differences in valuation between procedural and cognitive services.[18]

MedPAC recently recommended updating the administrative benchmark, proposing a new benchmark with an equal blend of per capita local area FFS and standardized national FFS spending, a rebate of at least 75%, a discount rate of at least 2%, applying multi-county geographic payment markets, and eliminating benchmark caps.[19] The blend of local and national spending would address concerns of discouraging excessive plan pressure in low spending areas or favoring areas with high spending.

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Competitive Bidding Models for the Medicare Program

Like other markets such as the Affordable Care Act exchanges and the Part D prescription drug benefit, the MA program is built upon sealed competitive bidding, a model that economic literature suggests is an efficient way to determine prices[20] and promote price competition.[21] While other health insurance markets utilize a competitively set benchmark, MA utilizes an administratively set benchmark. To improve price competition and taxpayer savings, several competitively-set benchmark bidding models for the overall Medicare program have been proposed, including setting the benchmark at the average, lowest, or second-lowest bid.

The Part D program currently uses an average bid model, with beneficiary premiums computed as the difference between the plan bid and the nationwide average bid added to a base premium.[22] Song and colleagues modeled the application of this average bid methodology to MA, yielding projected savings of 0.8% to 11.3% depending upon the degree of a buffer added to the average bid,[23] suggesting that an average plan bid in many counties is only slightly lower than the current FFS Medicare benchmark.

An alternative to promote greater programmatic savings would be to utilize the lowest-plan bid as a benchmark, which was noted during prior health reform discussions in the early 2000s to be approximately 87% of the average FFS Medicare cost.[24] Critics appropriately note that this could result in disruption of beneficiary benefits as plans rapidly exit the marketplace as plans "race to the bottom," with remaining market participants eventually charging rising premiums. Finally, recent proposals advocate a compromise between the average bid and the lowest bid through the use of the second-lowest bid as a benchmark, an idea originally proposed by Senator Wyden (D-OR) and Speaker Ryan (R-WI) in 2011 and projected to have saved $339 billion over a decade.[25]

Budgetary modeling supports significant savings with competitive bidding as opposed to an administrative benchmark. Prior CBO modeling[26,27] denotes programmatic savings with either a second-lowest bid or average bid. According to the 2017 CBO Report, without grandfathering, the second-lowest-bid option would have reduced net federal spending for Medicare by $419 billion between 2022 and 2026 while the average-bid option would have reduced such spending by $184 billion.

CBO modeling is distinct from other proposals, as prior discussions of competitive bidding models excluded FFS Medicare,[28] limiting programmatic savings. Yet, the CBO's models leave many questions unaddressed, remaining silent as to its inclusion of Employer Group Waiver Plans (EGWP) beneficiaries, a large retiree health benefits market now numbering 5 million members.[29] Also excluded were dual-eligible beneficiaries, one of the highest cost populations in the Medicare program. Finally, the CBO only considered grandfathering all current beneficiaries which would reduce savings $50 billion, as opposed to grandfathering of a select sub-population with a transition over a pre-determined time period, for example, 5-year.

Implementing Competitive Bidding in Medicare

As the MA program is on a path to surpass the FFS program in size and in some markets is already the dominant model, anchoring MA around an administrative benchmark increases program costs for taxpayers and prevents full programmatic competition on the basis of price, quality, and beneficiary satisfaction. Conservative[30] and liberal[31,32] health policy analysts alike note the need for increased competition and challenges with administratively-based bid benchmarks, while simultaneously continuing to debate the need to modernize risk-adjustment methodologies,[33] address coding intensity in MA,[34] or combat under coding in the FFS program. Given bipartisan agreement and pre-existing applications of competitively set benchmarks in other health insurance markets, we explore a path forward for competitive bidding in the Medicare program, inclusive of FFS Medicare, while addressing specific concerns such as price shocks, star ratings, risk adjustment, and grandfathering of existing beneficiaries. Both MA plans and FFS Medicare would submit program bids, ensuring fair and robust competition to drive down program costs and place Medicare on an expressway to solvency.

Implementation of competitive bidding would focus solely on how plans are paid. To ensure that markets remain competitive, ACA benchmark floors and caps would be eliminated. Instead, the benchmark would be set to the second-lowest bid (ie, either an MA plan or FFS Medicare) in markets with 3 or more competitors,[35] with local MA or FFS beneficiary premiums set relative to the benchmark. Special Need Plans and EGWPs would be included in plan bidding, requiring specific technical accommodations. FFS Medicare would be included as a plan bid to promote competition. By including FFS in the marketplace, MA plans would be paid the FFS rate if the FFS plan were the second-lowest bid, facilitating robust and direct competition between public and private models. Beneficiaries would continue to choose the program that best fits their needs, with the federal government continuing to fund beneficiary health benefits at a rate equal to the bid benchmark.

FFS Medicare as a program would remain unchanged with respect to its benefit structure, provider payment methodology, and network design. It would remain as an any-willing provider network without utilization controls and with preserved monopsony power deployed through its administrative pricing model, as opposed to the provider price negotiation model deployed by MA plans. Rather, the beneficiary/government split of the FFS premium would change in some county-level markets.

To further counterbalance expected reductions in plan payments and to drive the overall Medicare toward value-based care through risk-adjusted capitation, benchmark adjustments could be coupled with default or auto-enrollment for undecided beneficiaries[36] (ie, those who do not make an active choice) into the 2 lowest price plans, be they FFS Medicare or an MA plan, a change from current policy that defaults beneficiaries solely into FFS Medicare. Further, beneficiaries eligible for dual-eligible or D-SNP plans would be preferentially enrolled in a D-SNP if one were available in their county of residence. Historical experience suggests that the 2 lowest price plans would be "zero premium" plans, thus avoiding incurring costs beyond the standard Part B beneficiary premium. This policy would apply to both new beneficiaries entering the program in addition to current beneficiaries.

Private plans will likely dominate in counties in which they know they can underbid traditional Medicare, which would remain an option in all counties. To mitigate the risks of inadequate plan participation in other regions and to counteract the harms of limited competition, in counties with fewer than 3 health plan participants we recommend that the bid benchmark be set to the second lowest priced plan for a larger geographic market, such as the state, 1 of the 34 regions used for Part D prescription drug plans[37] or 1 of the 26 regions for regional MA PPOs.[38] As more than 70% of Medicare Advantage enrollees live in highly concentrated markets where 2 to 3 insurers dominate the marketplace,[39] a benchmark adjustment for less competitive markets is critical to ensure that taxpayers fully benefit from programmatic savings due to competition.

Protections for FFS Beneficiaries

FFS Medicare would participate as a plan choice in a competitive bidding model, with its bid set to the average FFS spending in the prior year, adjusted by a fixed percentage for administrative costs and inflation. Yet, FFS Medicare would remain disadvantaged with MA plan payments subject to upward adjustment for risk adjustment and star ratings. While MedPAC reports have consistently expressed concerns about the meaningfulness of star ratings[40] and methodological adjustments would be required, applying star ratings to FFS Medicare to drive pragmatic comparisons on the basis of both price and quality is critical to facilitating beneficiary choice. In order to ensure a level playing field, risk adjustment would also be applied to the FFS bid, noting that the accuracy of risk adjustment will improve with CMS' recent transition to an encounter-based risk adjustment model.[41,42] FFS Medicare would—for the first time—be given a star rating with according adjustment to the plan rebate. Plan "rebates" for FFS Medicare, when applicable, would be distributed as a reduction in beneficiary Part B premiums. Thus, FFS Medicare would compete with MA plans on the basis of cost, quality, and consumer experience, the latter 2 through star ratings.

Regardless, despite an expected reduction in MA plan payments, some beneficiaries would still experience significant projected increases in the premium of FFS Medicare[43] with CBO projecting FFS premium increases of 35%, necessitating a graduated phase-in of the new competitive bidding model. Risks include projections that a second-lowest bid model would produce FFS premium increases of 35%. The Medicare marketplace could gradually transition a competitive bidding model as a graduated implementation over 5 years, with benchmark reductions or increases limited to no more than 5% or 10% year over year (with a 3-year rolling average). In the long run, despite the application of star ratings and risk adjustment, increased FFS premiums in some counties may drive beneficiaries into MA plans as an administrative pricing model competes directly with a managed Medicare model. This is not dissimilar from the existing trend.

Lastly, grandfathering is typically utilized when implementing significant policy initiatives. Recognizing the special vulnerability of those with significantly advanced age and multiple health problems, we suggest partial grandfathering of currently enrolled beneficiaries over the age of 80 years of age who would be able to opt out into FFS Medicare and pay the standard Part B premium without a financial penalty—even if FFS Medicare were more expensive—anytime during the 5-year transition period.

Implementation Challenges Remain

Rural geographies remain a challenge for both plans and providers, with potential decrements in rural plan quality bonus payments[44] or rural MA plan payments potentially promoting plan exit. With recent research demonstrating fewer plan choices and less availability of supplemental benefits in non-core counties,[45] a transition to a competitive bidding model has the potential to reduce payments and promote plan exit. Rural provider consolidation presents another challenge, as many providers possess monopoly pricing power, creating barriers to constructing networks compliant with CMS network access standards, a concern only partially alleviated by MA plans' ability to pay out-of-network providers at FFS Medicare rates. To address these and other concerns, policymakers could ask the CBO or MedPAC to examine this question, simultaneously evaluating interventions such as the proposed default enrollment or so-called "auto assignment" of undecided beneficiaries who do not select FFS Medicare or an MA plan into the 2 lowest-priced MA plans, a rural bonus (eg, 2% bonus for Census Bureau-designated rural counties for 4-star or higher plans), permitting multi-year plan bids in rural areas, or other incentives to drive plan participation in rural areas.

To avoid marketplace shocks to beneficiaries, providers, and plans; a graduated rollout will be undertaken, with populations transitioned over 5 years. In the first year, while the second-lowest bid would be identified. In order to avoid price shocks, the benchmark would be set to the rolling

3-year average with a maximal a decrease in plan payment to a maximum of 5% from the prior year's benchmark. This premium change cap would be increased from 5% to 10% in years 4 and 5, and eliminated thereafter.

Specialized populations would have delayed entry to allow time for market adjustment. Transition of EWGP plan members to competitive bidding would occur with the rest of the Medicare population. In contrast, representing amongst the most vulnerable and complex populations and excluded from prior CBO examinations of competitive bidding, dual-eligible enrollees, and D-SNP plans would begin a 5-year transition to a competitive bidding model after the final year of the transition of other beneficiary populations. This would facilitate coordination and planning between the Medicare and Medicaid programs.

Finally, long-term cost estimates of significant changes to health benefits program present unique challenges for economists and policymakers, with most estimates agreeing on directionality and differing in magnitude. The Medicare Part D prescription drug plan (PDP) market demonstrates this challenge: originally projected with a programmatic cost of $407 billion in the first decade of its existence,[46] the actual cost of the new Part D benefit was half that.[47] To both project and measure the success or failure of this model, CBO, MedPAC, and private stakeholders should undertake serial cost analyses comparing current, projected, and eventually historical costs of a competitive bidding Medicare model in comparison to the existing administrative benchmark model. While imperfect, quality measures and assessments of beneficiary satisfaction (eg, complaint rates, enrollment changes, etc.) can serve as lagging and directional indicators of value.

Conclusions

Elimination of the administrative benchmark and transitioning the Medicare program to a second lowest bid system would likely lead to significant reductions in total program cost. Concerns about plan exit in rural markets remain, with auto-enrollment of beneficiaries into the 2 lowest-priced plans or a rural plan bonus presenting potential counterbalancing mechanisms. For counties with limited competition, either a state-wide or regional geography would be required for a competitive benchmark. Policymakers could implement changes to the plan bidding system, over 5 years, limiting potential market shocks to both beneficiaries and plans. FFS Medicare in its current form would remain a plan choice in every county. Finally, while a longstanding source of tension between government and industry[48,49] providing a standardized per beneficiary cost comparison between FFS and MA would allow for better evaluations of future MA program modifications.

With the Medicare program overall facing pressing fiscal challenges, now is the time for bipartisan Congressional action to place the MA and FFS Medicare programs on equal footing.

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Ethical Approval

Our study did not require an ethical board approval as no human subjects or clinical data were involved.

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