

Committee on Ways and Means

Medicare Prescription Drug and Modernization Act of 2003

FEHBP-STYLE COMPETITION IN 2010

Conservatives have maintained that the best way to reform Medicare is to provide beneficiaries with a choice of plans, similar to the choice available to members of Congress under the Federal Employees Health Benefits Program (FEHBP). The Bipartisan Commission on the Future of Medicare came to the same conclusion.

Bending the Growth Curve

Medicare must be transformed to bend the growth curve in expenditures to put the program on a sound financial footing. To reduce program growth, true competition, including both traditional fee-for-service (FFS) and private plans, would begin in 2010 under the Medicare Prescription Drug and Modernization Act of 2003, as passed by the House (H.R. 1). Medicare competition would mimic competition in FEHBP.

New Competition Including Traditional Fee-for-Service

Beginning in 2010, private plan bids and Medicare traditional fee-for-service rates would be averaged to set a competitive benchmark in certain competitive areas. A plan's contribution to the benchmark would be tied to its enrollment. The House bill includes several measures to prevent a shock to the system in 2010 in these competitive areas. First, the FFS plan's rate would be weighed at the national percent of beneficiaries enrolled in the FFS plan, or the local rate, if higher. Second, the benchmark for private plans would be a blend of the new competitive benchmark and the older style benchmark over the first 5 years as a competitive area. Third, the premium change for beneficiaries remaining in FFS Medicare would be phased in over a 5-year period.

The government would share in savings generated by beneficiaries choosing more efficient plans. Beneficiaries in private plans with bids below the benchmark, and beneficiaries in traditional fee-for-service with rates below the benchmark, would receive 75 percent of the difference between the bid (rates) and benchmark. The government would retain 25 percent of the savings. Beneficiaries in plans with bids (rates) above the benchmark would pay the entire difference between the bid (rate) and benchmark. (Beneficiaries in traditional FFS would have premium changes phased-in over 5 years.)

Benchmarks Would Fall as Beneficiaries Enroll in More Efficient Plans

This reform is the only provision in H.R. 1 that has the potential to produce the savings needed for long-term solvency. Although the bill provides for bidding against a benchmark prior to 2010, the benchmarks prior to 2010 increase each year, by the rate of growth in Medicare.

In contrast, under FEHBP-style competition, the benchmarks will decrease when beneficiaries switch from less efficient to more efficient plans. This would occur because, as enrollment in more efficient plans' rises, their influence on the size of the competitive benchmark rises. As beneficiaries move from less efficient plans to more efficient plans, the benchmark declines because the more efficient plans have greater enrollment.

Medicare Benefits Administration

H.R. 1 would create a new agency – the Medicare Benefits Administration (MBA) -- to oversee private plans in Medicare. The MBA would provide a more flexible and contemporary structure to avoid the conflict of interest that would result from running the government plan and also regulating its competition. It would provide for coordination between health plans and the new prescription drug benefit. Finally, the MBA would have the ability to attract and retain private sector-focused employees, by exempting them from the civil service laws.