



Statement before the House Ways and Means Committee, Subcommittee on Health

## **Improving Competition in Medicare**

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*The views expressed in this testimony are those of the author alone and do not necessarily represent those of the American Enterprise Institute.*

Thank you, Chairman Brady, Ranking Member McDermott, and members of the Committee for the opportunity to discuss the importance of competition to Medicare and the need to eliminate restrictions on competition if we are to maintain the proper balance between cost, quality, and access to care.

I am Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute (AEI), a non-profit, non-partisan public policy research organization based in Washington, D.C. I was formerly the Assistant Director for Health and Human Resources at the Congressional Budget Office (CBO), and I was a member of CBO's Panel of Health Advisers for 7 years. My comments today are my own and do not necessarily reflect the views of AEI, CBO, or other organizations with which I am affiliated.

Competition is central to obtaining good value for the dollars spent by beneficiaries and taxpayers in the Medicare program. The two best-known examples of competition in Medicare are Medicare Advantage (MA) for a comprehensive package of benefits and Part D for prescription drug benefits. Under both MA and Part D, Medicare beneficiaries do not have to be satisfied with "one size fits all." Instead, they can choose the plans they prefer at prices that are based on market bids.

Congress must avoid the temptation to smother competitive markets in Medicare through over-regulation. Private plans must follow rules designed to protect consumers and ensure access to all necessary health services covered by the program. But the regulations should not be drawn so narrowly that health care delivery innovations cannot be adopted or, once adopted, cannot be altered or dropped. The rules should neither prevent the entry of new competing firms nor protect firms already in the market from competition. A competitive Medicare program must welcome change while ensuring that beneficiaries and taxpayers are well served.<sup>1</sup>

### **Choice and Competition in Medicare Advantage**

Medicare Advantage is the private plan alternative to traditional Medicare. In 2015, 16.2 million people enrolled in MA, or about 30 percent of the Medicare population.<sup>2</sup> Two-thirds of the 1,945 MA plans available nationwide are health maintenance organizations (HMOs).<sup>3</sup> Preferred provider organizations account for about a quarter of the plans, and the remainder consists of private fee-for-service and other types of plans. Beneficiaries have an average of 18 MA plans to choose from.

Despite payment reductions instituted by the Affordable Care Act, enrollment in MA has risen in recent years, partly reflecting the greater familiarity of younger Medicare beneficiaries to managed care plans. For many, MA is a better deal compared to traditional Medicare combined with separate Medigap and prescription drug plans. MA plans offer the full Medicare benefit, and may offer additional coverage as well. MA plans expose beneficiaries to a less confusing and less risky benefit structure than traditional Medicare, which requires separate deductibles and varying copayments and coinsurance depending on the type of service that is provided.

Critics of MA argue that private plans are overpaid compared to traditional Medicare. The way MA capitation rates are determined is flawed, typically leading to MA payments that

exceed fee-for-service costs. That defect of the payment system does not tell us whether MA plans can deliver the same level of benefits more efficiently than traditional fee-for-service Medicare.<sup>4</sup>

**MA bidding process.** MA plans bid against a benchmark payment for the cost of providing traditional Medicare benefits in each geographic region. The benchmark is the maximum amount Medicare can pay a plan. The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, which renamed and modified what was then called Medicare+Choice, set the benchmarks to ensure that even the most remote geographic areas would have access to an MA plan.<sup>5</sup> Benchmarks were generally set above fee-for-service cost.

The Affordable Care Act (ACA) revised the MA payment method and reduced the benchmarks. By 2017, they will range from 95% of traditional Medicare costs in the top quartile of counties with relatively high per capita Medicare costs (e.g., Miami-Dade), to 115% of traditional Medicare costs in the bottom quartile of counties with relatively low Medicare costs (e.g., Boise).

Because it sets an upper limit on payment, plan bids tend to cluster around the benchmark. If an MA plan bids higher than the benchmark, enrollees must pay the difference in the form of a higher premium. If the bid is lower than the benchmark, the plan must rebate most of the difference to enrollees in the form of additional benefits or lower premiums. Under the MMA, that rebate was 75% of the difference between the bid and the benchmark. The ACA now requires that the rebate vary between 50 percent and 70 percent of the difference, with high-performing plans under the “star” performance rating system receiving the higher rebates.

**MA plan efficiency.** Can MA plans operate more efficiently than traditional Medicare? The Medicare Payment Advisory Commission (MedPAC) reports that the average benchmark for 2014 was 112% of fee-for-service cost.<sup>6</sup> The average MA plan bid for 2014 was 98% of fee-for-service costs. In other words, the average MA plan could deliver the standard benefits 2 percentage points cheaper than traditional Medicare. HMOs could deliver the standard benefits for 95% of fee-for-service costs.

Because of flawed methodology, the average plan payment was 106% of fee-for-service costs; for HMOs, the payment averaged 105%. In other words, plans received on average between 8% and 10% of fee-for-service costs more than they asked for.

Much of that additional payment covers services that seniors want but cannot get from traditional Medicare. HealthPocket found that 97% of MA plans offered at least one vision, dental, or hearing benefit in 2014.<sup>7</sup> All three benefits were offered by 49% of HMOs in MA.

Recent analyses of premium support proposals suggest that private plans could become even more efficient relative to fee-for-service, reducing costs for Medicare and cutting premiums paid by beneficiaries. CBO projects that the average bid from MA plans will be 6 percent lower than average fee-for-service spending even with no change in law.<sup>8</sup> If Medicare shifted to a premium support model, which sets the government's contribution toward coverage based on

bids from MA and fee-for-service Medicare, CBO expects that MA plan bids will fall by an additional 4% relative to fee-for-service.<sup>9</sup>

**Spillover effects and improved quality.** Several studies find that greater enrollment in MA plans has a positive spillover on the rest of the local health sector, reducing costs for traditional Medicare and commercial health insurance. Chernew, DeCicca, and Town found that a 1% increase in MA enrollment in a market was associated with a 0.9% reduction in Medicare fee-for-service spending per enrollee.<sup>10</sup> Baicker, Chernew, and Robbins found that greater MA enrollment led to reductions in hospital costs for both seniors and commercially insured younger populations.<sup>11</sup> This suggests that more efficient practice styles of private plans become adopted as a kind of community standard of performance.

Enrollees in MA plans also receive higher quality care than their counterparts in fee-for-service Medicare. Ayanian and colleagues found that beneficiaries in Medicare HMOs were consistently more likely than those in traditional Medicare to receive appropriate breast cancer screening, diabetes care, and cholesterol testing for cardiovascular disease.<sup>12</sup> For example, women were about 20 percent more likely to receive a screening mammogram if they were enrolled in a Medicare HMO instead of fee-for-service.

**Risk selection.** There has long been a concern that MA plans attract a younger, healthier population which is not adequately accounted for in determining capitation payments. Studies conducted by Newhouse and McGuire and by Newhouse and colleagues conclude that policies adopted by Medicare have largely resolved this problem of risk adjustment.<sup>13,14</sup>

Until 2000, MA payments were only adjusted based on age, sex, and eligibility category of the beneficiaries, not their underlying health conditions. Beginning in that year, the Centers for Medicare and Medicaid Services (CMS) started to phase in a more accurate risk adjustment system. By 2007, the CMS Hierarchical Condition Categories system based on inpatient and outpatient diagnoses was in place.

In addition, the MMA phased in a “lock-in” that limits the ability of beneficiaries to disenroll outside of annual open enrollment periods. Previously, beneficiaries could disenroll from MA plans on a monthly basis, and could move freely between MA and traditional Medicare. Those changes, combined with a wider array of plan offerings (including MA plans offering a prescription drug benefit), made private plans more attractive to the Medicare population and has greatly reduced favorable selection.

Newhouse and colleagues find some evidence that beneficiaries who switched to MA were expected to cost less than the average fee-for-service enrollee.<sup>15</sup> In 2004, those who switched cost about 10 percent less. By 2008, favorable selection remained but dropped by a factor of 3. The researchers argue that this does not translate into a measure of federal overpayment to MA. Risk selection is only one factor affecting federal cost. Newhouse and McGuire point out that other factors, including higher quality care and positive spillovers, argue for maintaining the level of MA payment at or above the level for traditional Medicare.<sup>16</sup>

**Improving competition.** Actions should be taken to take better advantage of the efficiencies and better performance of a more competitive Medicare program.<sup>17</sup> Options include changing the default enrollment, which under current policy presumes that beneficiaries prefer traditional Medicare unless they specify MA. Once in a plan, Medicare beneficiaries tend to stay there. Consequently, the current rules are biased toward greater enrollment in fee-for-service Medicare. Random assignment among MA plans (possibly limited to low-cost plans) rather than automatically placing a new enrollee in fee-for-service is one possible solution.

Flaws in the current bidding system also should be addressed. Bids should reflect the actual cost of providing benefits. MA plans bid on the basis of the cost in their specific markets for their specific enrollees. Fee-for-service Medicare has a single national premium despite the variation in actual costs from market to market. That gives fee-for-service an advantage in high-cost markets that have the most to gain from fair competition and efficient private plans. Moving to a system of regional fee-for-service bids based on actual cost experience would reduce this bias.

The payment benchmark could be changed to reflect actual cost conditions in competitive markets rather than remaining tied to fee-for-service costs. Basing the benchmark on the second-lowest bid in the region would likely place greater downward pressure on MA bids and provide greater incentive for plans to seek efficiencies in delivering care.

Even without such changes, there is a growing body of evidence that MA plans provide higher value services at less cost to society than the traditional Medicare program.

### **Choice and Competition in Medicare Part D**

Medicare Part D provides prescription drug coverage to about 38 million beneficiaries this year through competing private plans. About 61 percent (23.2 million) are in prescription drug plans (PDPs); the others are enrolled in Medicare Advantage drug plans.<sup>18</sup> The program has been consistently popular with seniors. A recent survey shows that 86 percent of seniors who have Part D are satisfied with their plans.<sup>19</sup>

Although there is a minimum benefit requirement, PDPs are able to modify the cost-sharing requirements, additional benefits, and pricing structure. Because of this flexibility, beneficiaries have numerous plans to choose from. In 2015, there are 1,001 stand-alone PDPs available nationally. Medicare beneficiaries have a choice of 30 stand-alone PDPs, on average.<sup>20</sup>

Premiums and subsidies are based on the national average of plan bids, which reflect each plan's expected benefit payments and administrative costs. Medicare provides plans with a subsidy that averages 74.5 percent of standard coverage for all types of beneficiaries, with higher subsidies for those with low incomes or who are at risk for higher costs.<sup>21</sup> Enrollees in a Part D plan pay the difference, if any, between the plan bid and the federal subsidy.

There is no cap that limits the allowable growth in federal subsidy amounts from year to year. Instead, the cost of Part D depends solely on the strength of plan competition and the responsiveness of consumers to changes in their costs.

**Competition yields savings.** Part D’s cost experience has been far better than initially anticipated.<sup>22</sup> At the start of the program, the CBO estimated that the prescription drug program in full operation would cost \$768 billion between 2006 and 2013.<sup>23</sup> In contrast, the Medicare trustees report that federal outlays for Part D totaled \$473 billion through 2013—38 percent less than the CBO estimate.<sup>24</sup>

Part of this difference is undoubtedly the result of faulty assumptions in the original estimate. Enrollment in Part D has been lower than expected, and the slower introduction of new drugs, coupled with the movement of branded drugs to off-patent status, contributed to the slower cost growth.<sup>25</sup> But we also saw seniors exhibit considerable price sensitivity and pharmaceutical manufacturers discount aggressively as plans fine-tuned their formularies and steered patients toward lower-cost drugs.

This conclusion might surprise some skeptics. Behavioral economists have pointed out that individuals often make poor consumer decisions due to inertia, confusion, limited attention, and confusion associated with age or illness. Some argue that “health insurance is too complicated a product for most consumers to purchase intelligently...[It] is unlikely that most individuals will make sensible decisions when confronted with these choices.”<sup>26</sup> This thinking has led to calls for stronger consumer protection rules and simplification rules, including limiting the number of options available to seniors.

A recent study of more than 71,000 Medicare beneficiaries who enrolled in stand-alone PDPs in both 2006 and 2007 concluded that seniors found ways to reduce their costs over time as they gained experience with Part D.<sup>27</sup> Overspending—measured as the difference between the beneficiary’s actual out-of-pocket costs (including the insurance premium) and the cost of the cheapest alternative—declined an average of \$298. These savings were achieved primarily by switching to a lower-cost plan. For some beneficiaries, that could mean switching to a plan that charges a higher premium but offers their prescriptions on more favorable terms.

These results demonstrate what one would expect: Once seniors understand their plan options, they are apt to enroll in a prescription drug plan that offers what they need at a lower total cost. Not surprisingly, those who had overspent the most in 2006 experienced the greatest savings. This helped keep the cost of prescription drugs in check for Medicare beneficiaries and taxpayers alike.

The competitive design of Part D also enables prescription drug plans to adapt flexibly to changing conditions. CBO’s analysis of program data from 2006 to 2010 found that spending and premiums were lower when more plan sponsors competed for beneficiaries.<sup>28</sup>

The impact could be substantial. For example, the drop in the average number of competing drug plans fell from 22 per region in 2007 to 18 in 2008, and remained at that level through 2010. CBO estimates that had that decline not occurred, the program would have saved between \$30 million and \$70 million in 2010 alone.<sup>29</sup>

**Impact of price controls.** Would the imposition of price controls in Part D reduce the cost of the program? CBO also considered the impact of implementing Medicaid’s statutory rebates for

Part D beneficiaries with low income. Those rebates are a minimum 23.1 percent rebate off the average manufacturer's price and an additional rebate if the brand-name drug price rises faster than general inflation.

According to CBO, applying those rebates would initially cause the prices of drugs purchased by low-income Medicare beneficiaries to drop to levels close to Medicaid prices.<sup>30</sup> However, manufacturers would raise the launch prices of new brand-name drugs, in time largely offsetting the statutory rebates in Part D. Those higher prices will affect all purchasers, including Medicaid and private payers. Moreover, the statutory rebates would reduce prospective returns from drug development and discourage the scientific research necessary to find the next generation of cures.

## Conclusion

Medicare spending has slowed dramatically in the last few years. That is good news, but we cannot relax. If we expect Medicare to meet the needs of 76 million baby boomers—and eventually their children—we must modernize the program and put consumers in charge. Medicare Advantage and the Part D prescription drug program have proven the value of competition in providing essential benefits in a cost-effective way. Future reforms will build on that performance, allowing beneficiaries to choose the kind of coverage that best meets their needs at a price that is affordable to them and to the country.

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<sup>1</sup> Much of what follows is based on Joseph Antos, "Plan Competition and Consumer Choice in Medicare: The Case for Premium Support," American Enterprise Institute and Robert Wood Johnson Foundation, April 15, 2013, <https://www.aei.org/publication/plan-competition-and-consumer-choice-in-medicare-the-case-for-premium-support/>.

<sup>2</sup> Boards of Trustees, 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, July 28, 2014, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2014.pdf>.

<sup>3</sup> Gretchen Jacobson, Anthony Damico, Tricia Neuman, and Marsha Gold, "Medicare Advantage 2015 Data Spotlight: Overview of Plan Changes," Kaiser Family Foundation, December 10, 2014, <http://kff.org/medicare/issue-brief/medicare-advantage-2015-data-spotlight-overview-of-plan-changes/>.

<sup>4</sup> Thomas Miller and James Capretta, "An Emerging Consensus: Medicare Advantage Is Working And Can Deliver Meaningful Reform," Health Affairs Blog, November 6, 2014, <http://healthaffairs.org/blog/2014/11/06/an-emerging-consensus-medicare-advantage-is-working-and-can-deliver-meaningful-reform/>.

<sup>5</sup> Kaiser Family Foundation, Medicare Advantage Fact Sheet, May 1, 2014, <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/>.

<sup>6</sup> Medicare Payment Advisory Commission, Report to Congress: Medicare Payment Policy, March 2014, p. 332, [http://www.medpac.gov/documents/mar14\\_entirereport.pdf](http://www.medpac.gov/documents/mar14_entirereport.pdf).

<sup>7</sup> Jesse Geneson and Kev Coleman, "97% of Medicare Advantage Plans Provide More Medical Benefits Than Original Medicare," HealthPocket, April 16, 2014, <http://www.healthpocket.com/healthcare-research/infostat/medicare-advantage-extra-benefits-supplemental-benefits#..>

<sup>8</sup> Congressional Budget Office, *A Premium Support System for Medicare: Analysis of Illustrative Options*, September 2013, p. 36, <http://www.cbo.gov/publication/44581>.

<sup>9</sup> CBO, op. cit., p. 37.

<sup>10</sup> Michael Chernew, Philip DeCicca, and Robert Town, "Managed Care and Medical Expenditures of Medicare Beneficiaries," National Bureau of Economic Research, Working Paper 13747, January 2008, <http://cid.bcrp.gov.pe/biblio/Papers/NBER/2008/enero/w13747.pdf>.

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- <sup>15</sup> Newhouse et al., p. 2622.
- <sup>16</sup> Newhouse and McGuire, op. cit.
- <sup>17</sup> Miller and Capretta, op. cit.
- <sup>18</sup> Jack Hoadley, Juliette Cubanski, Elizabeth Hargrave, and Laura Summer, "Medicare Part D: A First Look at Plan Offerings in 2015," Kaiser Family Foundation, October 10, 2014, <http://kff.org/medicare/issue-brief/medicare-part-d-a-first-look-at-plan-offerings-in-2015/>.
- <sup>19</sup> KRC Research and Medicare Today, "Seniors' Opinions About Medicare Prescription Drug Coverage," July 2014, [www.medicaretoday.org/MT2014/KRC%202014%20SURVEY/KRC%20Survey%20of%20Seniors%20for%20%20Medicare%20Today%2007-25-2014%20FINAL.pdf](http://www.medicaretoday.org/MT2014/KRC%202014%20SURVEY/KRC%20Survey%20of%20Seniors%20for%20%20Medicare%20Today%2007-25-2014%20FINAL.pdf).
- <sup>20</sup> Hoadley et al., op. cit.
- <sup>21</sup> Medicare Payment Advisory Commission, Part D Payment System, October 2014, <http://www.medpac.gov/documents/payment-basics/part-d-payment-system-14.pdf?sfvrsn=0>.
- <sup>22</sup> Douglas Holtz-Eakin, *Estimating the Cost of the Medicare Modernization Act*, Testimony before the House Committee on Ways and Means, 108th Cong., 2nd sess. (March 24, 2004), [www.cbo.gov/sites/default/files/cbofiles/ftpdocs/52xx/doc5252/03-24-medicare.pdf](http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/52xx/doc5252/03-24-medicare.pdf).
- <sup>23</sup> Douglas Holtz-Eakin (Congressional Budget Office), Letter to Hon. Don Nickles providing additional information about the CBO's cost estimate for the conference agreement on H.R. 1, November 20, 2003, [www.cbo.gov/sites/default/files/cbofiles/ftpdocs/48xx/doc4814/11-20-medicareletter2.pdf](http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/48xx/doc4814/11-20-medicareletter2.pdf). Estimate includes outlays for benefits and insurance load, alternative subsidy to employers and unions, and low-income subsidy.
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- <sup>28</sup> Congressional Budget Office, *Competition and the Cost of Medicare's Prescription Drug Program* (Washington, DC: Congressional Budget Office, July 2014), <http://www.cbo.gov/publication/45552>.
- <sup>29</sup> Congressional Budget Office, op. cit., pp. 17-18.
- <sup>30</sup> Congressional Budget Office, op. cit., pp. 35-36.