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A Premium Support System for Medicare: Analysis of Illustrative Options

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Summary

Over the past two decades, numerous proposals have been advanced for the establishment of a premium support system for Medicare. Under such a program, beneficiaries would purchase health insurance from one of a number of competing plans, and the federal government would pay part of the cost of the coverage. The various proposals have differed in many respects, including the way in which the federal contribution would be set and how that contribution might change over time.

This Congressional Budget Office (CBO) report presents a preliminary analysis of the ways two illustrative options for a premium support system would affect federal spending and beneficiaries' choices and payments. The agency has developed significant new tools to analyze such a system in greater depth than in the past; the specifications of the options examined here also differ from those CBO analyzed previously. As the agency refines its modeling approach and considers alternative options for a premium support system, its findings could change. CBO's analysis to date indicates the following:

- Both options for premium support considered here would reduce federal spending for Medicare net of beneficiaries' premiums and other offsetting receipts.
- Under the *second-lowest-bid option,* the option with the greater reduction in net federal spending, beneficiaries' premiums and total payments for Medicare's Part A

Notes: Unless otherwise indicated, the years referred to in this report are calendar years. The estimates for the next 10 years were generated using the Congressional Budget Office's March 2012 baseline projections of Medicare spending, and the analysis of longer-term effects was based on the agency's June 2012 long-term projections of Medicare spending. (Those were the most recent projections available when much of the analysis was performed.)

Numbers in the text, figures, and tables may not add up to totals because of rounding.

and Part B benefits would each be higher on average than they would be under current law. (Total payments consist of premiums and out-of-pocket costs for deductibles, copayments, and coinsurance.) Under the *average-bid option,* the option with the smaller reduction in net federal spending, those amounts would each be lower on average than they would be under current law.

- Under both options, combined spending by the federal government and by beneficiaries (that is, premiums and out-of-pocket costs) would be less than that if current law remained in place.

- Under both options, effects on premiums and total payments for some beneficiaries would differ greatly from the national averages. In particular, in most regions, the premiums and total payments of beneficiaries enrolled in the fee-for-service (FFS) program would be higher than they would be under current law.

- Alternative specifications for key features of a premium support system would yield different results.

What Premium Support Options Did CBO Analyze?

The two premium support options analyzed in this report differ in terms of the formula by which the federal contribution would be determined. Otherwise, they are very similar. The nation would be divided into regions within which competing private insurers would submit bids indicating the amounts they would accept to provide Medicare benefits to a beneficiary of average health. The FFS program would be part of the system as a competing plan, and its "bid" would be based on the projected FFS spending for an enrollee of average health in a given region. Insurers would bid to provide a benefit package that would encompass the same services covered by Part A (Hospital Insurance) and Part B (Medical Insurance) of Medicare under current law and that would have the same actuarial value as Parts A and B combined (that is, each package would cover the same percentage of total expenses for a given population that Medicare's FFS program would cover under current law). Beneficiaries who were eligible for the premium support system would not be permitted to enroll in Part C (the current Medicare Advantage system, offered by private insurers that contract with Medicare to provide Part A and Part B benefits). Part D (Medicare's prescription drug benefit program), which is now delivered through a competitive system, would continue as it is under current law and would be administered separately from the new program.

The federal government would pay insurers for each enrollee who was in average health an amount that was equal to a "benchmark" set for that region minus the standard premium paid by enrollees; insurers would receive larger or smaller government payments for beneficiaries whose health was worse or better than average. Beneficiaries who enrolled in a plan with a bid that equaled the benchmark would pay the plan a standard premium, which would equal one-quarter of the estimated cost of providing the Part B portion of benefits and would be the same across the nation (set by

the same formula as that used under current law for the Part B premium). Beneficiaries who chose a plan with a bid less than the benchmark would pay a premium that was lower by the full amount of the difference between the bid and the benchmark, and those who chose a more expensive plan would pay a premium that was correspondingly higher.

The benchmarks that would be used to set the federal contribution are the defining features of the two options CBO examined:

- Under the second-lowest-bid option, the benchmark in a region would be the lower of a pair of bids—the region's second-lowest bid submitted by a private insurer and Medicare's FFS bid.

- Under the average-bid option, the benchmark in a region would be the weighted average of all bids, including the FFS bid. Each bid would be weighted by the proportion of beneficiaries enrolled in that plan in the year immediately preceding.

CBO assumed that no cap would be imposed on the amount or the rate of growth of the federal contribution and that insurers would be required to provide coverage to all beneficiaries who selected a particular plan.

The agency made detailed assumptions about many other specifications of the premium support system. Some were chosen to illustrate the potential for savings from a highly competitive system; others were chosen for feasibility of implementation or to simplify the analytical process. The specifications adopted for this analysis are not recommendations, and many alternative specifications are possible.

For this analysis, CBO assumed that dual-eligible beneficiaries—people who are simultaneously enrolled in Medicare and Medicaid—would be excluded from the premium support system and that federal spending for their health care would continue as it would under current law. Anyone else who was enrolled in Medicare when the premium support system was implemented (assumed to be 2018 for this report) would enter the system immediately, and anyone other than dual-eligible beneficiaries who became eligible subsequently would enroll in the new system. (See below for a brief discussion of policy alternatives that would exclude certain other Medicare beneficiaries from a premium support system.) The starting date of 2018 was chosen to allow for a period during which the federal government could develop the necessary administrative structures and beneficiaries and insurers could learn about and prepare for the new system.

How Would the Premium Support Options Affect Federal Spending?

CBO estimates that the second-lowest-bid option would reduce net federal spending for Medicare by about $45 billion in 2020 and that the average-bid option would reduce such spending in that year by about $15 billion (see Table 1). For this analysis, CBO reports those effects as a percentage of two different measures of spending

projected under current law: net federal spending on Medicare as a whole and net federal spending on Medicare's Part A and B benefits for beneficiaries who would be affected by the options (that is, everyone other than dual-eligible beneficiaries who would have enrolled in Medicare under current law).

- Net federal spending for Medicare is total Medicare spending, including spending on dual-eligible beneficiaries and prescription drugs covered by Part D, minus beneficiaries' premiums and other offsetting receipts. The second-lowest-bid option would reduce that spending in 2020 by 6 percent and the average-bid option would reduce that spending by 2 percent, CBO estimates.

- Net federal spending on Medicare Part A and B benefits for affected beneficiaries includes amounts that would be paid for hospital and medical benefits provided by the FFS program and private plans under current law and the premium support options, but excludes net spending for dual-eligible beneficiaries, Part D benefits, and certain items and services that are not covered by the bids of Medicare Advantage plans under current law. Beneficiaries' premiums and other offsetting receipts are subtracted from that amount to arrive at net spending. The second-lowest-bid option would reduce such spending in 2020 by 11 percent and the average-bid option would reduce such spending by 4 percent, CBO estimates. Those percentages are larger than the percentages for total Medicare spending because the savings are measured relative to the portion of Medicare spending that would be for the beneficiaries who are directly affected by the premium support system rather than to total Medicare spending.

Federal savings under either option would be substantially lower over an extended period if all current beneficiaries stayed in the existing Medicare system and only new enrollees participated in the premium support system.

The savings to the federal government would stem, in part, from greater price competition. Because all plans would offer a basic benefit package covering the same services and having the same actuarial value and because the government's contribution within a region would not vary from plan to plan (except to adjust for differences in the health status of enrollees), the full difference between plans' bids would be reflected in the premiums that enrollees would pay. Thus, the two options would generate more price competition among private insurers than would be the case under current law, which would induce insurers to offer plans with lower premiums as a way to attract more enrollees. To reduce premiums, private insurers could, for example, strengthen utilization management (which insurers use to control costs by influencing the quantity and type of services provided) or tighten provider networks (that is, limit the number of providers to be covered by a plan). In most regions, the benchmark would be lower under the second-lowest-bid option than under the average-bid option, so the federal contribution for a plan with a given bid would be lower, and the premium would be higher under the second-lowest-bid option.

Heightened price competition would probably restrain the growth of Medicare spending over the long term by curtailing demand for costly new technologies and treatments and by boosting demand for technologies that reduced costs—although the magnitude of any such changes is highly uncertain. Those effects on the growth of spending would be larger under the second-lowest-bid option than under the average-bid option, CBO anticipates, because the higher premiums under the second-lowest-bid option would cause a larger fraction of beneficiaries to choose private plans with lower bids.

Under current law, the growth of Medicare spending will be restrained in other ways during the next two decades, thus limiting the potential for the government to realize further savings from a premium support system. For example, updates to Medicare's payment rates for most providers in the FFS program are generally scheduled to be smaller than the increases in the costs of their inputs (such as labor and equipment), and the federal government has broad authority under current law to make regulatory changes to expand demonstration projects that successfully reduce spending for Medicare. How effective the various incentives and possible administrative actions under current law ultimately will be at restraining growth in spending, however, is not known.

CBO estimates that the rate of growth in Medicare spending in the 2020s under the two premium support options would be similar overall to the rate under current law. Thus, the estimated savings relative to current law would be roughly the same in percentage terms throughout that period as in 2020, although the dollar amount of the savings would increase. That estimate is subject to considerable uncertainty but, in CBO's judgment, lies in the middle of the distribution of possible outcomes. Beyond the next two decades, the federal savings from the premium support system would probably increase slightly in percentage terms, but CBO has not quantified the amounts because the uncertainties are even greater for that longer period.

How Would the Premium Support Options Affect Beneficiaries' Premiums?

CBO estimates that the premiums that affected beneficiaries would pay for Medicare Part A and B benefits under the second-lowest-bid option in 2020 would be about 30 percent higher, on average, than the current-law Part B premium projected for that year. CBO expects that much of the increase would occur because many beneficiaries would remain in the FFS program and pay much higher premiums than would be the case under current law. Two-fifths of the beneficiaries who chose the FFS program would spend at least 6 percent of their household income on premiums for each beneficiary, CBO estimates. (For comparison, CBO estimates that under current law about one-fifth of FFS enrollees would do so.)

In contrast, under the average-bid option, affected beneficiaries would pay premiums that were 6 percent *lower,* on average, than the current-law Part B premium in 2020. Because of the higher federal contribution, premiums would be substantially lower

under the average-bid option than they would be under the second-lowest-bid option. The impact of either option on premiums would vary geographically, depending on regional differences in plans' bids.

Because CBO estimates that total Medicare spending would be reduced under either option, and the standard premium would equal the same share of spending that the Part B premium equals under current law, the standard premium under either premium support option would be lower than the current-law Part B premium. In each region, beneficiaries would be offered at least one plan at or below the standard premium (given the manner in which the regional benchmarks would be calculated), and in most cases, at least one plan with a premium that is below (not just at) the standard premium would be offered, CBO anticipates. Beneficiaries who chose such a low-cost plan would pay a lower premium than they would under current law. (Beneficiaries subject to the income-related premium under current law—that is, the additional Part B premium required of beneficiaries whose income exceeds specified thresholds—would still be required to pay that additional amount.)

Under both options, most beneficiaries who wanted to remain in the FFS program would face higher premiums than they would for private plans. In addition, in many regions, the bid for the FFS program would exceed the benchmark, so beneficiaries who chose to remain in the FFS program would pay higher premiums than they would under current law. Although many beneficiaries would switch to lower-bidding private plans, CBO estimates, a substantial proportion of beneficiaries would still prefer to remain in the FFS program.

How Would the Premium Support Options Affect Beneficiaries' Total Payments for Medicare Services?

CBO's analysis of beneficiaries' total payments focuses on premiums and out-of-pocket costs for deductibles, copayments, and coinsurance for Medicare's Part A and B benefits for affected beneficiaries. The analysis accounts for the loss of the federally subsidized supplemental benefits that enrollees in Medicare Advantage plans would receive under current law (projected to average about $400 per enrollee annually in 2020), which would not be available under the options analyzed here. In 2020, beneficiaries' total payments would be about 11 percent higher, on average, under the second-lowest-bid option and about 6 percent lower, on average, under the average-bid option than they would be under current law (see Table 2).

Under the second-lowest-bid option, the premiums that beneficiaries would pay generally would be higher than current-law premiums, but out-of-pocket costs generally would be lower than under current law because more beneficiaries would enroll in lower-bidding private plans, which would tend to reduce the total costs of care while maintaining the required actuarial value. The lower out-of-pocket costs would offset part, but not all, of the increase in premiums. (On average, according to CBO's estimates, out-of-pocket costs would account for a higher share of beneficiaries' total

payments than premiums would, but under the second-lowest-bid option, they would decline by a smaller percentage than premiums would increase relative to amounts under current law.)

Under the average-bid option, the estimated reduction in beneficiaries' total payments results from the combination of lower average premiums and lower out-of-pocket costs. As with the second-lowest-bid option, the difference in out-of-pocket costs would be attributable primarily to increased enrollment in lower-bidding private plans.

Under both options, the change in total payments for particular beneficiaries could differ markedly from the national average. For example, those who chose to remain in the FFS program would generally face higher premiums and would not see a reduction in out-of-pocket costs.

How Would the Premium Support System Affect Combined Spending by the Government and by Beneficiaries?

The sum of net federal spending for Medicare and beneficiaries' total payments as discussed above would be about 5 percent lower in 2020 under the second-lowest-bid option than under current law, CBO estimates. Under the average-bid option, combined payments would be about 4 percent lower than under current law. The estimated effects under both options are measured as a percentage of projected net federal spending and beneficiaries' total payments for benefits covered by Parts A and B, in each case focusing on the beneficiaries who would be affected by the premium support system. The second-lowest-bid option would yield slightly more savings overall than would accrue from the average-bid option because the smaller federal contribution under the second-lowest-bid option would increase competitive pressure. The federal savings under the second-lowest-bid option would be much larger than those under the average-bid option, but beneficiaries' payments would be higher.

What Are the Implications of a "Grandfathering" Provision in a Premium Support System?

Under some premium support proposals, all beneficiaries who became eligible for Medicare before the system took effect would remain in the current-law Medicare program and only those who became eligible after that time would enroll in the premium support system. Such an arrangement would substantially reduce federal savings relative to a system without a grandfathering provision—for an extended period—because, in the early years, only a small portion of the Medicare population would be covered under the new system. Moreover, because newly eligible beneficiaries entering the system would have health care costs that were lower than the average for Medicare beneficiaries as a group, the potential savings would be limited even more.

CBO estimates that if a premium support system began in 2018 and existing Medicare beneficiaries remained in the current system, only about 25 percent of the Medicare

population would be covered under the new system after five years (assuming dual-eligible beneficiaries were excluded), and those beneficiaries would account for only about 15 percent of net Medicare spending in total for that year under current law (including spending for dual-eligible beneficiaries and for Part D). After 10 years, about 45 percent of the Medicare population would be covered, accounting for about 30 percent of net Medicare spending in total.

Although in order to simplify the modeling, CBO decided for this analysis not to consider grandfathering provisions, the agency expects to complete such a study soon. A very rough approximation (made on the basis of the estimated share of Medicare spending that would be covered each year) suggests that federal savings after five years of operation under a system with grandfathering would be about 15 percent of the savings achieved if all beneficiaries other than those with dual eligibility entered the new system in 2018; after a decade, about 30 percent of those savings would be realized.

Thus, the cumulative savings would be substantially less than would be possible if all beneficiaries entered a premium support system immediately. Grandfathering also would reduce, for an extended period, the incentives to modify the development and adoption of new technologies, so the restraint in the growth of Medicare spending that would probably occur under a premium support system would be substantially smaller for many years.

What Key Specifications of a Premium Support System Would Affect Federal Spending and Beneficiaries' Payments?

On the basis of its preliminary analysis, CBO identified several important features of premium support proposals that would significantly affect federal spending and beneficiaries' payments:

- A smaller federal contribution would yield greater federal budgetary savings; on average, beneficiaries' premiums would be higher, however.

- Including the FFS program as a competing plan would boost federal savings, both because the rates the program pays providers (which generally are below rates paid by commercial plans) would serve to hold down the rates paid by competing private insurers and because in some regions the FFS program would be the lowest-bidding plan and therefore could lower the benchmark relative to what it would be otherwise.

- Excluding some groups of beneficiaries from the premium support system—say, people born before a particular year or dual-eligible beneficiaries—would reduce federal savings; however, including certain groups could pose additional challenges for administering the system and could have unintended consequences for members of those groups. (Dual-eligible beneficiaries, for example, might face limited provider networks and complex issues of care coordination.)

- Features that make beneficiaries more responsive to differences in premiums would boost enrollment in plans with lower bids and thus increase the incentive for plans to submit lower bids.

Many other aspects of a premium support system also would significantly affect federal spending and enrollees' payments. CBO will continue to develop its capacity to estimate the effects of varying those features.

Two Illustrative Options for a Premium Support System for Medicare

In designing a premium support system for Medicare, lawmakers would confront many choices affecting federal costs, beneficiaries' payments, and, perhaps, beneficiaries' access to care and the quality and nature of the care that they would receive—both in the short term and over the longer term. To project the potential effects of such a system, CBO developed detailed illustrative specifications regarding eligibility for the program and the timing of its implementation, the structure of the market for Medicare benefits, and the determination of federal contributions and beneficiaries' payments.

CBO analyzed two illustrative options, both of which would require insurers to submit bids specifying the payment they would accept to provide a basic package of Medicare benefits for an enrollee of average health. Under each option, the federal contribution toward beneficiaries' health care costs would be determined on the basis of a benchmark set for each region of the country. The two options differ in that under the first, determination of the benchmark would involve the second-lowest bid in each region; under the second, the benchmark would be set on the basis of a weighted average of bids in the region. For this analysis, CBO adopted a variant of the second-lowest-bid approach that is similar to those included in several recent proposals.[1] Under such an approach, the benchmark would equal the lower of two bids: the second-lowest bid from a private insurer and Medicare's FFS bid. Thus, in any region, the benchmark could be no higher than the bid of the FFS program. (For a summary of the program's operations under the second-lowest-bid option, see Figure 1. The operations under the average-bid option would be the same except for the determination of the benchmark.)

Medicare would continue to be divided into Parts A, B, and D under both options, and financing for federal outlays would come mostly from the same sources as under current law (see Box 1).

1. See House Committee on the Budget, *The Path to Prosperity: A Responsible Balanced Budget: Fiscal Year 2014 Budget Resolution* (March 2013), http://go.usa.gov/bAAV (PDF, 7 MB); Pete Domenici and Alice Rivlin, *Domenici–Rivlin Protect Medicare Act* (Bipartisan Policy Center, June 2012), http://tinyurl.com/nherwb4; and Ron Wyden and Paul Ryan, *Guaranteed Choices to Strengthen Medicare and Health Security for All: Bipartisan Options for the Future* (House Committee on the Budget, December 15, 2011), http://go.usa.gov/bAsz.

The specifications outlined in this report are not recommendations. Some were chosen to illustrate the potential for savings from a premium support framework; others were chosen for feasibility of implementation or to simplify the modeling approach. Many other variants of these options are possible. (For additional discussion, see the section "Implications of Key Specifications and Alternatives.")

Eligibility and Timing

CBO assumed that dual-eligible beneficiaries would be excluded from the premium support system and that gross federal spending for their health care would continue as it would if current law remained in place. (In 2009, those beneficiaries made up 19 percent of the Medicare population and accounted for 29 percent of total spending for Medicare's Part A and Part B benefits.)[2] CBO made that assumption because of the additional complexity of specifying how the system would work if such beneficiaries were included, although alternative systems could be designed to include them. CBO did not make any explicit assumptions about the system of care that would be in place for dual-eligible beneficiaries, and it assumed that their exclusion from the premium support system would not affect the number of Medicare beneficiaries who enrolled simultaneously in Medicaid.

Everyone else who was enrolled in Medicare when the premium support program took effect in 2018 would enter the new system at once, and people who reached eligibility after 2018 (other than dual-eligible beneficiaries) would enter the new system when they became eligible. The Medicare Advantage program would not be available as an option after 2017 for beneficiaries in the premium support system.

The Structure of the Market for Medicare Benefits

CBO made several assumptions about the structure of the market for Medicare coverage, including the required scope of benefits, the bidding process, and the process by which beneficiaries would choose a plan.

Scope of Benefits. Under each premium support option, insurers would offer a basic package of benefits with services and an actuarial value that matched those provided by Medicare's FFS program under Parts A and B. CBO assumed that hospice services and certain services provided to beneficiaries with end-stage renal disease would not be included in the basic benefit package and that spending for those services would continue as it would under current law. Those services were excluded so that the plans' benefits would be identical to those that are included in the bids of Medicare Advantage plans under current law. That assumption simplified CBO's modeling.

2. See Congressional Budget Office, *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies* (June 2013), www.cbo.gov/publication/44308.

Insurers would be permitted to offer an additional package with enhanced benefits, however, and would submit separate bids for providing prescription drug benefits through Medicare's Part D, as under current law. Enrollment in Part D would remain voluntary.

Bids. To simplify the choices for beneficiaries (and thereby heighten competition based on differences in premiums), private insurers would be allowed to submit bids for just one or two plans for the basic Medicare package in each region. (The two plans could have different features—offering a larger or smaller provider network, for example—but both would need to have the same actuarial value.) Insurers would submit bids reflecting their costs for a combined package of Part A and Part B benefits (as insurers do for Medicare Advantage) and not separate bids for Parts A and B. Bids would be the amount that insurers would charge to provide care for a beneficiary of average health. Insurers also could offer one package of enhanced benefits (with a single, fixed higher actuarial value that would be the same for all insurers) to go along with each basic package offered. Enrollees would pay the full additional cost of the enhanced packages through higher premiums. Under such rules regarding packages with enhanced benefits, beneficiaries would find it easier to compare plans, and thus competition would be heightened.

Bidding Regions. Regional boundaries would be determined by the government and designed to coincide with health care markets within states. Regions would be the same for all prospective bidders, and insurers would be required to serve the entire regions for which they submitted bids.

Fee-for-Service Medicare. Medicare's FFS program would act as a competing plan. Its bid in each region would be based on the amount it would cost the program in that region to provide care for a beneficiary with average health as projected by the Medicare program. Support for disproportionate-share hospitals (whose share of low-income patients exceeds a specified threshold) and spending for medical education, hospice benefits, and certain benefits for patients with end-stage renal disease would be excluded from that projection. CBO assumed that such spending would continue outside the premium support system at the amounts projected under current law. The government's administrative costs for the FFS program, however, would be included in the bid. The FFS program would be required to maintain a contingency reserve fund equal to a specified percentage of projected expenses, and if the program's actual expenses differed from its projected expenses, future bids would be adjusted to maintain adequate reserves. CBO assumed that there would be no changes to current law concerning either the mechanisms for setting the rates paid to providers or the tools available to the FFS program to help it contain costs. As under current law, enrollees in the program could purchase supplemental (medigap) coverage from private insurers. CBO assumed that the same standard medigap plans that are currently available would be available under the two premium support options.

Coverage for Retirees. CBO assumed that employers and unions that provide coverage for retirees who are Medicare beneficiaries would make cash payments to their retirees to be applied toward the purchase of a basic package offered in the bidding region, an enhanced-benefit package (on top of a basic package) from any of the private plans in that region, or supplemental coverage for the FFS program. In that way, the choices of beneficiaries with retiree coverage would be the same as those of other beneficiaries, and they would have no additional incentives to select a particular plan (as typically occurs now when employers pay part of the premium if retirees enroll in a plan offered by the employer). CBO assumed that the premium support system would be implemented so as to not affect the percentage of beneficiaries with retiree coverage. Those assumptions simplified CBO's modeling.

Requirement Regarding Issuance. Insurers would be required to issue insurance to all Medicare beneficiaries who applied and to charge the same premium for all enrollees in a particular plan within a bidding region.

Plan Selection. Beneficiaries would receive information about premiums, cost sharing, and other plan attributes to help them compare plans. Enrollees would choose a plan during an annual enrollment period and would be required to remain in that plan for a year. Once beneficiaries chose a plan, they would automatically remain in that plan in subsequent years unless they chose a different one.

Initial Choice. Beneficiaries would not automatically remain in their current plan when the premium support system began in 2018. In 2018 and later years, beneficiaries who entered the premium support system and did not make an affirmative choice for enrollment would be assigned (with equal probability) to plans that presented bids at or below the benchmark, including the FFS program if it met that criterion. (If more than four plans in a region did so, beneficiaries would be assigned to one of the four lowest-bidding plans.) After their first year in the system, beneficiaries who were initially assigned to a plan would remain in that plan unless they chose a different plan during a future enrollment period or the plan to which they were assigned was no longer one of the lowest-bidding plans in their region (in that case, the beneficiaries would be assigned to one of the new low-bidding plans in their region). Beneficiaries who had been assigned to a plan and then subsequently chose another plan, as well as beneficiaries who affirmatively chose a plan when they entered the premium support system, would remain in that plan in subsequent years unless they chose a different one.

Enrollment in Part A and Part B. For this analysis, CBO assumed that enrollment in Part B would remain voluntary and that beneficiaries with coverage under Part A or Part B (or both) could enroll in any plan within a bidding region. Federal payments to plans for enrollees with Part A coverage only would be reduced proportionately on the basis of

the share of total Medicare spending nationally for Part A services, and federal payments to plans for people covered under Part B only would be reduced in a similar manner.[3]

Federal Contributions and Beneficiaries' Payments

CBO also made assumptions about the determination of the amounts the federal government would pay insurers for providing Medicare coverage and the amounts beneficiaries would pay for that coverage under the illustrative premium support options.

Federal Contributions and Risk Adjustment. The benchmarks for setting the federal contribution would be based on the bids for the basic package of benefits. A benchmark would be calculated in each bidding region for a beneficiary of average expected health. For each enrollee of average health, the federal government would pay insurers an amount that was equal to the regional benchmark minus the standard premium. To compensate for a higher or lower cost implied by an individual beneficiary's "risk score," insurers would receive a larger or smaller payment for a beneficiary whose health was worse or better than average—as is the case under current law for Medicare Advantage and Part D.[4] Neither the amount nor the rate of growth in federal payments would be capped.

Beneficiaries' Payments. Medicare beneficiaries who joined plans with bids that equaled the regional benchmark and were enrolled in Parts A and B would pay the insurer a standard premium, which would be set at 25 percent of total costs for covered services in Part B (physicians' services, hospital outpatient care, durable medical equipment, and other services, including some home health care)—using the same formula as that for the standard Part B premium under current law. The premium for beneficiaries with Part A coverage only would be proportionately smaller than the standard premium based on the share of total Medicare spending nationally for Part A services (about half); a similar calculation would be used to set the premium for enrollees in Part B only.

3. That approach to enrollment of beneficiaries who are not enrolled in both Parts A and B of Medicare was adopted to simplify the modeling for this analysis. In fact, including such beneficiaries in a premium support system would raise complex issues that are not addressed in this report.

4. CBO assumed that a risk adjustment mechanism comparable to that used for the Medicare Advantage program would be used for a premium support system. That mechanism assigns each beneficiary a risk score, based on the person's medical conditions and demographic characteristics, that represents the expected spending in the FFS program relative to the national average for the Medicare population. A beneficiary with a risk score of 1.0 has average expected spending. To simplify the discussion, this report refers to beneficiaries with risk scores that are less than or greater than 1 as being in better or worse than average health—although personal characteristics other than health also influence spending for Medicare services.

Beneficiaries who joined plans with bids that were higher than the benchmark would pay the insurers the standard premium *plus* the difference between the bid and the benchmark. Those who selected plans below the benchmark would pay the insurers the standard premium *minus* the difference between the benchmark and the bid. In contrast to the rules for the current Medicare Advantage program, insurers with bids below the benchmark could not use such differences to enhance benefits or reduce premiums for Part D prescription drug insurance and the result would be heightened competition based on differences in premiums for the basic benefit package.

For the most part, premiums would be paid directly to insurers, as is generally the case for Part D, rather than withheld from Social Security benefits, as is generally the case under current law for Parts A and B. Income-related premiums for Part B specified in current law would continue and would be withheld from Social Security benefits.

Hypothetical Examples of Determining Premiums

Several examples show how premiums would be determined under the illustrative premium support options considered here. The hypothetical bids for regions with high and low levels of FFS spending per beneficiary are roughly consistent with the bids CBO has projected for such regions under the two options. In regions where FFS spending is high, premiums under the second-lowest-bid option would generally be higher than those under the average-bid option because the benchmark would be set at a low bid rather than at the average bid, and low bids would be much lower than the average bid. In regions where FFS spending is low, the low bids and the average bid would be closer and premiums under the two options would be more similar.

The Second-Lowest-Bid Option. Consider a region with high FFS spending in which the FFS program's bid in 2020 was $14,000 and the bids from the region's five private plans were in the range of $11,000 to $11,800 (see Table 3). Under the second-lowest-bid option, the regional benchmark would be $11,200, equal to the bid of the second-lowest-bidding private plan. The annual premium for enrollees in that plan would be $1,500, the standard premium nationwide. Premiums for the other plans would differ from that amount depending on how the bids compared with the benchmark. Because the FFS bid would be $2,800 more than the benchmark, the premium for FFS enrollees would be $4,300 ($1,500 plus $2,800). The annual premium for the lowest-bidding private plan would be $1,300.

Next, consider a low-spending region in which the FFS program's bid was $9,900 and the bids of the five private plans ranged from $9,300 to $10,100. The regional benchmark would equal that of the second-lowest-bidding private plan ($9,500), and enrollees in that plan would pay the standard premium of $1,500. Because the bid of the FFS program would be $400 more than the benchmark, FFS enrollees would pay an annual premium of $1,900.

The Average-Bid Option. Consider again the high-spending region in which the FFS bid was $14,000. The private plans' bids would be slightly higher in this region—ranging from $11,200 to $12,000—because the share of income that beneficiaries would spend on premiums would be lower, on average, thus reducing the sensitivity of beneficiaries' choice to differences in premiums and reducing competition among plans to lower bids. As a simple example, assume that, in the previous year, 25 percent of the people in the region enrolled in the FFS program and 75 percent enrolled in private plans, with an equal number enrolled in each private plan. Then the benchmark (the enrollment-weighted average bid) would be $12,200. Under this option, the standard premium would be $1,500 nationwide. Because the FFS program's bid would be $1,800 more than the benchmark, the FFS premium would be $3,300. The annual premium for the lowest-bidding private plan would be $500 because that plan's bid would be $1,000 less than the benchmark.

Finally, consider the low-spending region in which the FFS program's bid would be $9,900. The bids of private plans would be about the same as that for the second-lowest-bid option in this region, ranging from $9,500 to $10,300. Assume that, because FFS spending is low, in the previous year 75 percent of the region's beneficiaries enrolled in the FFS program and 25 percent enrolled in private plans, with an equal number enrolled in each private plan. The benchmark would be the enrollment-weighted average bid of $9,900. Because the FFS bid would be the same as the benchmark, the FFS premium would be the standard premium of $1,500. The annual premium for the lowest-bidding private plan would be $1,100.

Comparison With the Current Medicare Program

Although some aspects of a premium support system would make it similar to the current Medicare program, there also would be significant differences. Under both illustrative options analyzed here, insurers would be required to provide a benefit package that encompassed the same services that were covered under Parts A and B of Medicare (with the few exceptions noted above) and that had the same actuarial value as Parts A and B combined. However, under both options, the federal contribution per beneficiary in each bidding region would be determined prospectively each year on the basis of the bids submitted by participating insurers. In contrast, except for Part D, federal spending for Medicare under current law is either on a fee-for-service basis or, in the case of Medicare Advantage enrollees, is tied to spending in the FFS program.

Under current law, the premium paid by enrollees in the FFS program is the same regardless of where a beneficiary lives. That premium has two components, both for enrollment in Part B: the standard amount (referred to in this report as the Part B premium), and the income-related amount. Under either illustrative option, by contrast, the FFS program would be one of the bidders, and its premium would vary by region depending on how its bid compared with the benchmark.

Although the current Medicare Advantage program is similar in some ways to a premium support system, several features limit the extent of price competition among private insurers, and the FFS program is not a bidder in Medicare Advantage. For example, benchmarks for Medicare Advantage (which determine the maximum federal payment for an enrollee) are set by law as a specified percentage of the average FFS spending in a given county and are announced before insurers submit bids (see Box 1).[5] In contrast, benchmarks for the premium support options would be determined from plans' bids. Another difference concerns the incentives offered to beneficiaries to enroll in plans with lower bids. Under Medicare Advantage, beneficiaries who enroll in a plan with a bid below the benchmark receive some of the difference between the two, generally in the form of additional benefits. Under the two premium support options, by contrast, beneficiaries who enrolled in a plan with a bid below the benchmark would receive the entire difference between the two in the form of a lower premium.

Effects on Federal Spending

Projecting the effects of a premium support system in the first several years after implementation is difficult, given the substantial changes to the Medicare program that such a system would entail, the lack of historical experience with similar systems, the rapid evolution of health care and health insurance, and the significant changes in the Medicare program occurring under current law. (For additional details about the methods used in the analysis, see Appendix A.) Projections are even more uncertain for the period following the first several years of implementation. One reason is that growth in Medicare spending—and for health care more generally—has slowed markedly over the past several years, although it is not clear how much of the slowdown is attributable to persistent changes in the health care system.[6] Moreover, spending for Medicare is projected to be restrained by provisions of the Affordable Care Act that will change the ways and amounts that health care providers and insurers are paid.[7] The implications of those changes for long-term growth in Medicare spending are difficult to assess, thus adding to the uncertainty concerning the difference in spending that might occur as a result of policy changes—including the adoption of a premium support system.

5. This description reflects the method of determining Medicare Advantage benchmarks that will be fully phased in by 2017. The benchmark for each county will be set at a specified share (ranging from 95 percent to 115 percent) of local FFS costs.

6. See Michael Levine and Melinda Buntin, *Why Has Growth in Spending for Fee-for-Service Medicare Slowed?* Working Paper 2013-06 (Congressional Budget Office, August 2013), www.cbo.gov/publication/44513.

7. The Affordable Care Act comprises the Patient Protection and Affordable Care Act and the health care provisions of the Health Care and Education Reconciliation Act of 2010.

Effects in the First Several Years

CBO assumed that the premium support system would be implemented in 2018. This analysis reflects the assumption that dual-eligible beneficiaries would be excluded from the premium support system and that federal spending for their health care would continue as projected under current law. Everyone else enrolled in Medicare in 2018 would enter the new system in that year, and people who became eligible for Medicare subsequently (other than dual-eligible beneficiaries) would enter the new system. For this analysis, CBO chose 2020 as an illustrative year shortly after implementation for which to report results about federal spending. Additional information—both about the bids of private plans and about the uncertainty in the estimates—provides context for understanding those results.

In 2020, the second-lowest-bid option would reduce net federal spending for Medicare by about $45 billion, or 6 percent, from the approximately $700 billion projected under current law, CBO estimates (see Figure 2). The average-bid option would reduce net spending in that year by about $15 billion, or 2 percent, the agency estimates.[8] Those percentage savings were estimated relative to net federal spending on all services covered by Parts A, B, and D, including spending on benefits for dual-eligible beneficiaries. (The estimated savings in percentage terms were generated using CBO's March 2012 baseline projections of Medicare spending—because the agency's work on the estimates in this report began in earnest in early 2012—and the estimated savings in dollar terms were obtained by applying the percentages to the agency's latest baseline projections of Medicare spending, which were released in May 2013.)[9]

The second-lowest-bid option would reduce net federal spending on Parts A and B of Medicare in 2020 by about 11 percent for beneficiaries who would be affected and the average-bid option would reduce such spending by about 4 percent, CBO estimates. Those savings are larger than the savings for net federal spending on all of Medicare because the amount of spending to which the savings are compared is restricted here to include only the beneficiaries and the portions of Medicare that would be covered by

8. This analysis presents estimated changes in net federal spending because the allocation of financial flows to the budget categories of gross outlays and offsetting receipts would differ from those under current law in complicated ways. The two options would eliminate withholding of basic premiums from Social Security benefits; instead, beneficiaries would pay the basic premium directly to a plan. The reduction in gross spending attributable to that change in the way premiums were collected would be accompanied by a corresponding reduction in the government's collections of offsetting receipts. However, the proposals also would establish a new source of offsetting receipts consisting of the premiums paid by beneficiaries who enrolled in the FFS program—that is, the basic premiums plus the amount by which the FFS program's bid exceeded the benchmark (or minus the amount by which the benchmark exceeded the FFS program's bid).

9. See Congressional Budget Office, "Medicare—March 2012 Baseline" (March 13, 2012), www.cbo.gov/publication/43060, and "Medicare—May 2013 Baseline" (May 14, 2013), www.cbo.gov/publication/44205.

the new system. (The ratios of the two estimates for each premium support option are nearly identical, and the difference reported here is attributable primarily to rounding.)[10]

For either option, during the first several years of a premium support system, Medicare savings would be similar in percentage terms to the savings estimated for 2020, with one main exception. Under the average-bid option, the federal savings estimated for 2018 would be much smaller than the amount estimated for 2020 in percentage terms because the FFS bid would receive a greater weight in constructing benchmarks in the first year of the new system than it would in later years. (CBO assumed that the weight would equal the proportion of enrollment in the FFS program under current law in 2017.) Thus, under the average-bid option, most regions would have higher benchmarks in 2018 than they would later.

Federal savings would be greater under the second-lowest-bid option than under the average-bid option because the benchmarks that determine the federal contribution would be lower. Under either option, CBO projects, the benchmarks in most regions would be lower than the FFS program's bid.

Although federal costs would decrease if more people declined Medicare coverage under either option than did so under current law, CBO projects that few people would do so. Beneficiaries would have plans available that cost less than, or about the same as, Medicare under current law. Also, beneficiaries who did not actively choose a plan would be assigned to one, and CBO expects that few would choose to drop out of the Medicare program rather than remain in an assigned plan for the required one-year period.

Effects on Private Plans' Bids. The options' effects on federal spending would be determined in part by how they influenced the bids of private plans. Various factors, such as competition and the reduced importance of the administratively determined payment rates of the FFS program, would affect the bids that determined the benchmarks. CBO used its projection of the bids that Medicare Advantage plans would submit under current law as a starting point in estimating the bids of private insurers under premium support. On net, CBO's analysis indicates that private insurers' bids in 2020 under the two options would be below the current-law bids for Medicare Advantage by about 4 percent, on average, and that the differences between those types of bids would vary regionally. That outcome would be the net result of different types of downward and upward pressures on bids.

10. The ratios also differ because of small effects on net spending for dual-eligible beneficiaries. Although CBO assumed that gross federal spending for dual-eligible beneficiaries would not change, net spending would increase by a small amount relative to that under current law because premiums for dual-eligible beneficiaries would decrease. Those premiums would be linked to total Part B spending in Medicare, which would decline under the premium support options.

On the one hand, CBO expects, both options would create more competitive pressure than the Medicare Advantage program, encouraging insurers to reduce their costs (primarily by constraining the volume and intensity of health care services provided and to a lesser extent by reducing administrative costs and profits) and thus to be able to lower their bids. The greater competition relative to the current Medicare program would arise because insurers with lower bids would expect to achieve larger increases in enrollment, because more Medicare beneficiaries would choose plans affirmatively and those beneficiaries would face larger differences in premiums among different plans. The specification adopted for this report that insurers could submit no more than two bids for the basic benefit package per bidding region also would increase competitive pressure to submit lower bids, in CBO's view. (Under the Medicare Advantage program, insurers often submit more than two bids in their service areas.) Given the competitive structure of the two premium support options, CBO expects that restricting insurers to a maximum of two bids would cause insurers to eliminate some of the higher-bidding plans that would exist under the current-law Medicare Advantage program. Another smaller but notable force also would tend to lower private plans' bids: The enrollees in private plans would be healthier (on average, after accounting for characteristics included in the risk adjustment mechanism) than enrollees in the FFS program, and such "favorable selection" would occur to a greater extent in a premium support system than under current law, CBO expects. That relatively greater favorable selection would occur because private plans would face greater pressure under premium support to contain costs (for example, by narrowing provider networks), and as a result, they would be less attractive to beneficiaries who use more health care services than do other beneficiaries with the same risk score.

On the other hand, reductions in the share of Medicare beneficiaries enrolled in the FFS program would cause private insurers participating in a premium support system to pay higher rates to health care providers. Two main mechanisms would be at work. First, although the rates private insurers pay now under the Medicare Advantage program are similar to those for Medicare's FFS program, CBO expects that a lower FFS market share would reduce the importance of the FFS program's rates in determining how much private insurers would pay providers for treating Medicare enrollees. Second, to accommodate an influx of enrollees, some private plans might need to expand their networks to include health care providers who would be more costly, on average. (CBO assumed in this preliminary analysis that all plans would be required to serve all beneficiaries who wished to enroll.) The resulting payment rates negotiated between insurers and health care providers would probably rise toward commercial rates for people under age 65 (which, adjusted for differences in average health status by age, are generally higher than Medicare's rates), especially where the market share of the FFS program declined substantially. However, even in areas where the FFS market share would be very low, CBO expects, the rates private insurers paid providers for their premium support enrollees would be somewhat lower than the rates they would pay for commercial enrollees under current law for several reasons: The FFS

provider payment rates would serve as a reference point for negotiations, the competitive structure of a premium support system would tend to constrain rates, and the commercial rates existing alongside a premium support system would be lower because the extent to which relatively low Medicare FFS rates led providers to charge more to treat privately insured enrollees would abate as the FFS market share declined.

Although CBO projects that bids would be similar under the two premium support options, the agency expects that they would be just slightly lower under the second-lowest-bid option than under the average-bid option because private insurers would have a stronger incentive to bid low under the former. However, factors that would tend to increase private plans' bids—the reduced importance of the provider payment rates in the FFS program and the broadening of provider networks—also would be stronger under the second-lowest-bid option than under the average-bid option and would partially offset the stronger incentive to bid low.

Uncertainty in the Estimates. CBO's estimates of the effects on Medicare spending of the two illustrative premium support options depend on numerous parameters and other factors used in predicting the responses of insurers, health care providers, and beneficiaries—all of which are subject to considerable uncertainty. To characterize that uncertainty, the agency specified ranges of values for five key parameters in its analysis and determined the effects of varying those parameters, focusing on estimates for 2020.[11] The ranges for the parameters' values were chosen to represent CBO's judgment that, accounting not only for uncertainty about those parameters but for many other sources of uncertainty, there would be about a two-thirds chance that the effect on federal spending would be within the range reported (under an assumption that the premium support system was implemented as specified here).

The results indicate that for the second-lowest-bid option, net federal spending in 2020 on Parts A and B for beneficiaries who would be covered under the premium support system analyzed would probably be reduced by between 9 percent and 14 percent (CBO's central estimate is 11 percent), and for the average-bid option, federal spending would probably be reduced by some amount between 1 percent and 7 percent (the central estimate is 4 percent). (See Table 2.)[12] The range is smaller for the

11. CBO varied the following parameters to construct the ranges: bids of Medicare Advantage plans relative to FFS spending as projected under current law, the amount by which private insurers would reduce their bids relative to Medicare Advantage bids under current law in response to the increased competitive pressure created by the premium support system, the higher rates that private insurers would need to pay providers (with corresponding increases in bids) that CBO projects would result if the market share of the FFS program fell significantly, the responsiveness of beneficiaries to differences in premiums when choosing among plans, and the percentage of beneficiaries who would not actively choose a plan in the first year of premium support and that therefore would be assigned to a plan with a bid at or below the benchmark.

12. For the second-lowest-bid option, the reported range is not symmetric about the central estimate because of rounding.

second-lowest-bid option mainly because a higher or lower proportion of beneficiaries enrolled in lower-bidding plans under that option would not directly affect the benchmarks that determined the federal contribution. By contrast, spending under the average-bid option would be directly sensitive to the fraction enrolled in lower-bidding plans, and the range of estimates incorporates the greater uncertainty from that additional factor. (For additional discussion of factors affecting the ranges, see Appendix B.)

Effects After the First Several Years

After the initial years of a premium support system, the percentage savings from either illustrative option would remain roughly constant for about a decade, CBO estimates. At that point, heightened price competition would probably reduce the growth of Medicare spending over the long term relative to that under current law, and that effect would probably be larger under the second-lowest-bid option than under the average-bid option. However, the longer-term effects are even more uncertain than are the short-term effects of a premium support system on Medicare spending. And if other health care or health insurance policies changed as well, the effects of such a system on spending could differ significantly from those presented here.

Effects of the Two Illustrative Options. During the decade following the first several years of implementation, CBO expects that the growth in bids of private plans under either option would be close to the growth in per capita costs in the FFS program under current law, contributing to the roughly constant percentage savings over that period. Over the longer term, CBO expects that the growth in Medicare spending under the options would probably be somewhat less than the growth of Medicare spending under current law.

The increased competition created by either option would tend to restrain growth in Medicare spending by reducing demand for costly new technologies and treatments and by increasing demand for cost-reducing technologies. A crucial factor underlying the rise in spending for health care in recent decades has been the emergence, adoption, and widespread diffusion of new medical technologies and services.[13] Although such advances can sometimes reduce costs, in medicine they and the accompanying changes in clinical practice have generally had the opposite effect. By strengthening price-based competition in Medicare, a premium support system could change that dynamic within the program and perhaps in the broader health care system. Moreover, relative to outcomes under current law, the potential for cost savings from managing utilization and limiting provider networks would be greater under a premium support system with a larger share of Medicare beneficiaries enrolled in private plans that have the flexibility to manage care. The magnitude of that effect is highly uncertain, however, and it would take a number of years before it became fully

13. See Congressional Budget Office, *Technological Change and the Growth of Health Care Spending* (January 2008), www.cbo.gov/publication/41665.

apparent. CBO anticipates that the effect on spending would be larger under the second-lowest-bid option—because of greater competitive pressure—than under the average-bid option.

However, the provisions of current law that will restrain growth in Medicare spending limit the potential for *additional* savings to result from a premium support system. In particular, CBO anticipates, private insurers would not be able to hold down payments to health care providers to the extent required in the FFS program under the sustainable growth rate mechanism for physicians or under the provisions of the Affordable Care Act that apply to other providers (the consequences of those provisions are discussed below). More generally, current law offers incentives to providers and beneficiaries to help reduce growth in federal spending, and it allows some flexibility for the Centers for Medicare & Medicaid Services in managing the program. Beneficiaries' demand for Medicare services will be constrained as the program's premiums and cost sharing consume a larger portion of their income. For providers, whose updates to Medicare's payment rates are generally scheduled to be smaller than the increases in the costs of inputs, the pressure to adopt cost-reducing procedures and technologies will be significant. Other changes in the structure of Medicare payments to providers—such as financial incentives to reduce hospital-acquired infections and readmissions—also might help to constrain federal spending.[14] The Centers for Medicare & Medicaid Innovation, like many state Medicaid agencies and private insurance companies and providers, is hoping to achieve cost savings by testing promising ideas for modifying rules and payment methods and by expanding the use of ideas that prove effective.[15] Whether any of the several demonstrations currently in process will succeed and be applied more widely is still uncertain.

Another factor limiting the potential for cost savings under a premium support system is that the Medicare program is required by law to cover items and services that are judged to be medically necessary and reasonable. Private insurers participating in the premium support options analyzed for this report would be required to cover the same services as those covered by the FFS program. The options would cause less restraint on the development of costly new technologies than would be the case if private insurers (or the Medicare program as a whole) had the authority to refuse coverage for certain services if, for example, less costly alternatives were available that were at least as effective. Under the options analyzed in this report, however, private insurers would have some flexibility to reduce beneficiaries' use of costly services through tools such as utilization management, higher cost sharing, and exclusion of providers from an

14. For example, see Sarah L. Krein and others, "Preventing Hospital-Acquired Infections: A National Survey of Practices Reported by U.S. Hospitals in 2005 and 2009," *Journal of General Internal Medicine*, vol. 27, no. 7 (July 2012), pp. 773–779, http://go.usa.gov/DbQC; and Centers for Medicare & Medicaid Services, "Readmissions Reduction Program," http://go.usa.gov/DbQW.

15. A list of ongoing demonstration projects is available at Centers for Medicare & Medicaid Services, "Innovation Models," http://go.usa.gov/DbQd.

insurer's network on the basis of practice style. By contrast, the FFS program does not have the authority to apply such methods to influence beneficiaries' use of services but, rather, must pay for any services that are used as long as they meet Medicare's criteria for coverage. That feature of the FFS program would remain in place under the two premium support options and might limit the extent to which either option could reduce the growth in Medicare spending. (Removing the FFS program as a competitor in the premium support system would tend to push up Medicare spending in other ways, as discussed earlier.)

In quantifying the effects of the illustrative premium support options relative to outcomes under current law, CBO recognized that current law provides for three approaches to restraining cost growth in Medicare that could be difficult to sustain over the long term: the ongoing reductions in payment updates for most providers in the FFS program, the sustainable growth rate mechanism for payment rates for physicians, and the process associated with the Independent Payment Advisory Board.[16] It is unclear whether the long-term restraint of Medicare spending envisioned to occur through those provisions can be accomplished through greater efficiency in the delivery of health care or whether it would lead to reductions in beneficiaries' access to care or the quality of care they received. Accordingly, CBO's extended baseline reflects the assumption that the growth rate of Medicare spending after 2029 will not be affected by those provisions but that the percentage reduction in Medicare spending in 2029 achieved through those provisions will continue in later years.[17] In the analysis in this report, CBO anticipates that beneficiaries will respond to concerns regarding access and quality in the FFS program by showing some additional preference for private plans relative to the FFS program when payment rates for providers in private plans increase relative to those paid by the FFS system.

Under the assumptions of its extended baseline, CBO anticipates that growth in Medicare spending per beneficiary (after removing the effects of demographic changes on health care spending—in particular, changes in the population's age distribution) would exceed growth in spending per beneficiary for all forms of private health insurance combined because the private sector has more flexibility to respond to the

16. Before the enactment of the Affordable Care Act, payment updates for most providers (except for physicians, whose payments have been controlled by the sustainable growth rate mechanism since 1998) generally were set to equal the estimated percentage change in the average cost of providers' inputs. Under current law, however, the updates will equal those percentage changes in costs minus the 10-year moving average of growth in productivity in the economy overall—a measure that seeks to capture, for the economy as a whole, how much more output is produced from a given amount of inputs. Under current law, payment rates for physicians' services in Medicare will be reduced by about 25 percent in January 2014 and, CBO projects, will be increased by small amounts in most subsequent years. The Independent Payment Advisory Board will be required to submit a proposal to reduce Medicare spending in certain years if the rate of growth in spending per enrollee is projected to exceed specified targets.

17. For more discussion, see Congressional Budget Office, *The 2012 Long-Term Budget Outlook* (June 2012), pp. 56–57, www.cbo.gov/publication/43288.

pressures created by rising health care spending than administrators of Medicare have under current law. The growth rate of federal spending for Medicare under the two illustrative premium support options—which involve a mixture of features of Medicare and private health insurance—would probably be lower than that for the existing Medicare program but above that for private health insurance.

Uncertainty in the Estimates. Estimates of the longer-term effects of the premium support options on Medicare spending are subject to the same sources of uncertainty that are described above for the shorter-term effects, but the magnitude of the uncertainty is increased by the longer time horizon. Uncertainty in projecting federal spending for Medicare over the long term under current law adds to the uncertainty of such estimates.

In particular, CBO's assessment—that the growth rate of federal spending for Medicare under the two options would probably be lower than that for the existing Medicare program but above that for private health insurance—is highly uncertain. It is possible, for instance, that over the long term, the bargaining power of health care providers relative to private insurers could increase to such an extent that spending growth under the options would exceed that for the existing Medicare program. Alternatively, private health insurers could be more successful than CBO projects in developing processes for delivering care in ways that would reduce costs, in which case spending growth under the options could be further below that for the existing Medicare program than CBO anticipates.

Effects of Modifying the Illustrative Premium Support Options or of Combining a Premium Support System With Other Changes to Medicare. The longer-term effects of the two illustrative options on Medicare spending could differ significantly from the estimates presented here if either option was modified or if policies for setting payment rates in the FFS program were revised. For example, imposing a cap on federal contributions under a premium support system could have an important effect on federal savings, and changes in the way provider payment rates in the FFS program were set could have complex interactions with a premium support system. Although CBO has not estimated the consequences of such policies, the following observations provide some relevant information.

Effects of a Cap on Federal Contributions. The effects of a cap on federal contributions under a premium support system would depend in part on how the cap was specified. CBO expects that if a premium support system limited the growth rate of federal contributions per beneficiary to match the growth of gross domestic product (GDP) per capita plus, say, 1.5 percentage points per year, in most years such a cap probably would not be binding. Under last year's extended baseline, which largely follows current law and which CBO used for the analysis in this report, the agency projected that the growth rate of Medicare spending per beneficiary between 2020 and 2032 (after adjusting for demographic changes) would be, on average, 0.8 percentage

points greater than the growth rate of GDP per capita.[18] As a result of the offsetting factors just described, CBO estimates that the growth rate for Medicare spending during those years under both premium support options would be similar to that under current law.

A cap of per capita GDP plus 1.5 percentage points could be binding regularly, however, if CBO's long-term projection underestimates growth in Medicare spending. And that cap could be binding in some years but not in others even if the projection is generally accurate because of volatility in the growth of health care costs and GDP. Moreover, the prospect of a cap's taking effect could alter the behavior of insurers in any year, thus increasing or decreasing the likelihood that such a cap would take effect. The effects of a cap would also depend on the details of how it was specified and enforced. For the current report, CBO has not attempted to estimate the effects of imposing a cap on federal contributions.

Effects of Alternative Policies for Setting Payment Rates for Providers in Fee-for-Service Medicare. Under CBO's extended alternative fiscal scenario (included in *The 2012 Long-Term Budget Outlook*), the reduced payment updates would expire and the Independent Payment Advisory Board process would cease to be effective after 2022, and payments to physicians would be maintained at 2012 rates rather than declining as scheduled. Under that scenario, CBO projected, net Medicare spending in 2030 would be about 0.5 percent of GDP higher than it would be under CBO's extended baseline. CBO has not estimated the effects of combining a premium support system with the changes to current law that are assumed under its extended alternative fiscal scenario.

Instead, if current-law policies restraining cost growth were retained through the 2030s or longer, then spending in the existing Medicare program would be below that projected under CBO's extended baseline. CBO has not estimated the long-term effects of a premium support system under such restraints either.

Effects on Beneficiaries' Premiums

The premiums that beneficiaries would pay under the two premium support options would depend on the premiums charged by the plans in their region and on the beneficiaries' choice of plan. Under each option, at least one plan would be available in every region that charged the standard premium or less, and in most regions other plans would be available that charged premiums that were higher or lower than that amount (depending on whether the bid was above or below the benchmark). For each option, CBO estimated the premiums that would be charged by the array of plans

18. See Congressional Budget Office, *The 2012 Long-Term Budget Outlook* (June 2012), www.cbo.gov/publication/43288.

offered, and the agency summarized that information by estimating the average premiums charged by three plans—the second-lowest-bidding private plan in the region, the median-bidding private plan (that is, the plan with a bid in the middle of the distribution among private plans), and the FFS program. To arrive at the average premium charged by each plan, CBO computed a weighted average of region-specific premiums, with each region weighted by the proportion of affected beneficiaries.

CBO next estimated the premiums that beneficiaries would pay under each option by estimating their choice of plan, based on the differences in the premiums charged and on beneficiaries' sensitivity to those differences. For that analysis, CBO computed a weighted average of the premiums charged, weighting plans by the number of beneficiaries each one enrolled. CBO compared average premiums charged by plans and average premiums paid by beneficiaries with the Part B premium under current law.

Background on Premium Determination

Under either premium support option analyzed in this report, beneficiaries would pay the standard premium if they chose a plan with a bid that was equal to the regional benchmark. That premium would be the same everywhere in the country and would be determined by the same formula used under current law for the Part B premium: The federal government allocates spending under Medicare Advantage to Parts A and B on the basis of the share of total spending in the FFS program for Part B services and then sets the Part B premium equal to 25 percent of all Part B spending, divided by the number of beneficiaries. In this report, the standard premium equals 25 percent of the estimated amount of total Medicare spending attributable to Part B services under a premium support system.

Under current law, the Part B premium will be $1,600 in 2020, CBO projects. Because total Medicare spending would be slightly less than it would be under current law under either premium support option, CBO estimates, the standard premium for each would be slightly lower than the Part B premium under current law—$1,500 per year under either option. (All estimates of annual premiums in this report are rounded to the nearest $100; although CBO projects that the standard premium under the average-bid option would be higher than that under the second-lowest-bid option, those amounts round to the same number.)

If a beneficiary chose a plan with a bid that differed from the regional benchmark, the premium would depend on the plan chosen. Someone who enrolled in a plan with a bid above the benchmark would pay the standard premium plus the amount by which the plan's bid exceeded the benchmark, and someone who enrolled in a plan with a bid below the benchmark would pay a correspondingly lower premium. CBO expects that, depending on how bidding regions were defined, there might be some sparsely populated regions in which no private plans would participate under either option. In

those regions, the FFS program would be the only plan available, and beneficiaries who enrolled in the program would pay the standard premium.

CBO focused on standard premium amounts that did not include income-related adjustments. In addition, the agency analyzed premiums only for the basic package of Medicare benefits, excluding additional amounts that enrollees in private plans might pay for enhanced benefits or that enrollees in the FFS program might pay for supplemental coverage.

Enrollees in private plans under the options would forgo the federal subsidies for supplemental benefits that would be provided by many Medicare Advantage plans under current law. CBO estimates that the annual value of those supplemental benefits (under current law) will be about $400, on average, per Medicare Advantage enrollee in 2020. The loss of those subsidies would make private plans less attractive under the options, all else being equal. For this analysis, CBO compared premiums for both options with the $1,600 current-law premium projected for Part B. The agency did not make any adjustment in that analysis for the loss of supplemental benefits under the Medicare Advantage program. Those forgone benefits are included in the analysis presented below concerning the effects of the two options on beneficiaries' total payments.

Premiums by Region. The range of premiums around the standard premium would vary geographically. CBO's analysis focused on four groups of regions—ranked from highest to lowest average FFS spending—with equal numbers of beneficiaries in each group. In regions with high FFS spending, CBO estimates, the bid for the FFS program would be higher than the private plans' bids and higher than the benchmark under either option. Medicare beneficiaries enrolled in the FFS program in such regions tend to use certain health care services at a higher-than-average rate, so private plans would have greater potential to achieve savings relative to the FFS program by reducing that use. In contrast, CBO estimates, the FFS program's bid would be similar to or lower than the bids of private plans in many regions with low FFS spending. People enrolled in the FFS program in those regions tend to use less care, so private plans would have less potential to achieve savings by reducing the quantity of care; savings from reducing the price of care also would be difficult to achieve because of the restraints in provider payment rates that are scheduled for the FFS system under current law. Thus, the range of premiums would be narrower in regions with low FFS spending.

Premiums for Beneficiaries Who Do Not Actively Choose a Plan. CBO projects that many beneficiaries would not actively choose a plan in the first year of a premium support system—perhaps because they were unaware of the new system, did not understand

how to enroll, were hampered by a health problem, or for some other reason. Under the options considered for this report, beneficiaries who did not choose a plan would be assigned to a plan with a bid at or below the benchmark. CBO projects that about 15 percent of beneficiaries would not choose a plan in the first year of premium support under the second-lowest-bid option and about 20 percent would not choose a plan in the first year under the average-bid option.[19] Those beneficiaries would pay premiums less than or equal to the standard premium, but there would be no guarantee that the assigned plan would include all of their current providers.

Under an alternative approach, which CBO has not yet analyzed, beneficiaries who did not make a choice would remain in the plan most similar to their current plan (or be transferred to the FFS program if a similar plan was no longer available). In particular, beneficiaries who had been in the FFS program when the premium support system began would remain in that program unless they chose a private plan. In that sort of system, FFS beneficiaries would retain access to their current providers but, depending on the region, their premiums could be substantially higher. In addition, insurers would have less incentive to reduce their bids because they would anticipate that being a lower-bidding plan would result in a smaller gain in enrollment than they would achieve if all beneficiaries were required to affirmatively choose a plan.

Premiums Charged by Plans in 2020

Under either illustrative premium support option, CBO anticipates, beneficiaries would be offered at least one plan at or below the standard premium and most people would have access to at least one other plan with a premium below that amount. In most regions, the plans with premiums at or below the standard amount would be private. Overall, CBO estimates, the premiums charged by plans would generally be lower under the average-bid option than under the second-lowest-bid option because the benchmarks would be higher under the average-bid option, so the federal government would contribute more for each plan.

The Second-Lowest-Bid Option. Under this option, CBO estimates, the average premium for the second-lowest-bidding private plan across all regions would be about $1,500 per year in 2020, or 6 percent below the Part B premium projected under current law for that year (see Table 4). In regions with low FFS spending, however, the premium for the second-lowest-bidding private plan would tend to be higher than in other regions because of the role of FFS spending in determining the benchmark. Specifically, in some regions with low FFS spending, the bid for the FFS program would be lower than

19. CBO expects that some beneficiaries who were assigned to a low-bidding plan in the first year would later switch to the FFS program or to another plan that would have, on average, a higher premium.

that of the second-lowest-bidding private plan, so the FFS program's bid would become the benchmark, and the premium for the second-lowest-bidding private plan would be above the standard amount. CBO estimates that the average premium for the second-lowest-bidding private plan would be $1,600 in regions with the lowest FFS spending (see Figure 3).

The average premium for the median-bidding private plan available would be $1,800 in 2020 under the second-lowest-bid option, CBO estimates. That amount would be 13 percent above the current-law Part B premium.

The average premium for the FFS program under the second-lowest-bid option would be about $3,100, or almost twice the projected Part B premium under current law, CBO estimates. That increase would occur because, in most regions, the FFS program's bid would be substantially above that of the second-lowest-bidding private plan, and thus the bid for the latter would become the benchmark. The premium for the FFS program would be highest in regions with the highest average FFS spending. CBO estimates that in those regions, the average premium for the FFS program would be $4,600, or almost triple the projected current-law Part B premium. Even in regions with the lowest FFS spending, the average FFS premium would be $1,900, or almost 20 percent above the projected current-law Part B premium. (In some regions, the FFS program's bid would be lower than that of the second-lowest-bidding private plan, and the premium would equal the standard premium.)

The Average-Bid Option. Premiums would generally be lower under the average-bid option than under the second-lowest-bid option. For the second-lowest-bidding private plan, the national average premium in 2020 would be $900 under the average-bid option, CBO estimates—more than 40 percent below the projected current-law Part B premium for that year. That amount would be less than the premium for that plan under the second-lowest-bid option because, in most areas, the benchmark would be higher and the plan's bid would be below the benchmark, which determines the government's contribution. Under the average-bid option, the average premium of the second-lowest-bidding private plan would be the smallest (at $600) in regions with the highest FFS spending because that plan's bid would be lower relative to the benchmark (which would be influenced by the bids of the FFS program and the higher-bidding private plans). The average premium of the second-lowest-bidding private plan would be substantially greater (at $1,400) in regions where FFS spending is lowest because, in most of those areas, that plan's bid would be close to the bid of the FFS program.

For the median-bidding private plan, CBO estimates that the average premium would be $1,200. That amount would be 25 percent below the current-law Part B premium in 2020.

The FFS program's bid under the average-bid option would be above the benchmark in most areas. CBO estimates that the national average premium for the FFS program would be $2,400, 50 percent higher than the projected current-law Part B premium.

Premiums Paid in 2020

The average premiums that beneficiaries would pay under a premium support system would depend not only on the premiums charged by plans as just discussed, but also on the plans beneficiaries chose to enroll in. Under the second-lowest-bid option, CBO estimates, the average annual premium paid by beneficiaries in 2020 would be $2,100—about 30 percent higher than the current-law Part B premium for that year (see Figure 4). Under the average-bid option, CBO estimates, the average premium paid by beneficiaries in 2020 would be $1,500, or 6 percent below the current-law Part B premium.

The Second-Lowest-Bid Option. CBO estimates that about half of the beneficiaries included in the premium support system would enroll in private plans under the second-lowest-bid option and about half would enroll in the FFS program. The average premium paid by beneficiaries for private plans across all regions would be $1,800 and the average premium paid for the FFS program would be $2,500. The percentage of household income that beneficiaries would spend on the premium for the FFS program would vary substantially. The premium for the FFS program would amount to less than 2 percent of household income for about one-fourth of enrollees in that plan and to 6 percent or more for about two-fifths of the plan's enrollees. In comparison, under current law that premium would amount to less than 2 percent of household income for about two-fifths of beneficiaries in the FFS program and to 6 percent or more of household income for about one-fifth of beneficiaries in that program. (Those estimates focus on the standard premium and, in the case of premium support, on any reduction or increase in that premium that would result when a beneficiary enrolled in a plan with a bid below or above the benchmark. The estimates do not include amounts paid for the income-related premium.)

Under the second-lowest-bid option, average premiums would vary regionally. Beneficiaries in regions with the highest FFS spending would pay an average of $2,300 (compared with the nationwide average of $2,100). The higher average premium estimated for the regions with highest FFS spending is largely a reflection of CBO's estimate that about one-fifth of the beneficiaries would enroll in the FFS program. In those regions, roughly half of all beneficiaries enrolled in the FFS program would spend at least 6 percent of their household income on the FFS premium. Beneficiaries in regions with the lowest FFS spending would pay an average premium of $1,800, according to CBO's estimates. About 80 percent of beneficiaries in regions with the lowest FFS spending would enroll in the FFS program.

The Average-Bid Option. CBO estimates that slightly fewer than half of all beneficiaries would enroll in private plans under the average-bid option in 2020 and slightly more than half would enroll in the FFS program—proportions that are similar to those CBO

projects for the second-lowest-bid option.[20] For all regions combined, the average premium paid by beneficiaries in the FFS program would be $2,000 and the average premium paid by enrollees in private plans would be $1,000, compared with $2,500 and $1,800, respectively, under the second-lowest-bid option.

Under the average-bid option, the average premium would be approximately equal for beneficiaries in all four groups of regions classified by FFS spending, CBO estimates. Where FFS spending is highest, the estimated $1,500 average premium reflects the anticipated choice of some beneficiaries to enroll in private plans with bids below the benchmark (about three-fourths of that group; their average premium would be less than $1,500) and of others to enroll in the higher-bidding FFS program (about one-fourth; their average premium would be more than $1,500). In areas with the lowest FFS spending, the $1,500 average premium reflects much smaller differences between the bids of private plans and the FFS program. In those regions, about three-fourths of beneficiaries would enroll in the FFS program, by CBO's estimate.

Effects on Beneficiaries' Total Payments

CBO has estimated the effects of the two illustrative premium support options on beneficiaries' total payments for covered services. The total consists of premiums and out-of-pocket payments for deductibles, coinsurance, and copayments. In this analysis, out-of-pocket payments include all such obligations for beneficiaries, whether paid directly by beneficiaries or covered by supplemental insurance.[21] The premiums included in CBO's estimates are the average premiums that beneficiaries would pay as presented above and are based on CBO's projections of the distribution of beneficiaries among plans. Income-related premiums for Part B also were included in the total payments the agency estimates under current law and for both options. In addition, the estimates account for the value of the forgone federally subsidized supplemental benefits that would have been available to enrollees in Medicare

20. Two opposing considerations led CBO to project similar—but not identical—enrollment patterns for the two options. In most regions, the FFS premium would be higher relative to private plans' premiums under the second-lowest-bid option than under the average-bid option. That difference would arise because the second-lowest bid would be lower than the average bid, resulting in a larger gap between the federal contribution and FFS costs under the second-lowest-bid option. As a result, enrollment would tend to be higher in private plans under the second-lowest-bid option. CBO expects, however, that the prospect of paying higher premiums under the second-lowest-bid option would prompt more beneficiaries to choose a plan in the first year of the program. Thus, a smaller proportion of beneficiaries would be assigned to a plan at or below the benchmark, and that would tend to decrease enrollment in private plans under the second-lowest-bid option.

21. This report does not provide estimates of the *total* effects of the premium support options on beneficiaries' payments for Medicare services because the analysis did not include premiums that beneficiaries would pay for supplemental coverage. (CBO has not yet modeled such coverage as part of a premium support system.) However, by including total out-of-pocket costs for Medicare services, whether paid by the beneficiary or by supplemental insurance, the analysis captures, in the aggregate, most of the costs beneficiaries would incur for premiums for supplemental insurance.

Advantage plans under current law but that would not be available under the two options. As discussed below, the estimated effects of the two premium support options on beneficiaries' total payments are subject to considerably greater uncertainty than are the estimated effects on federal spending and the premiums charged by plans.

Effects in 2020

CBO estimates that beneficiaries' total payments in 2020 would be about 11 percent higher, on average, under the second-lowest-bid option than they would be under current law. The premiums paid by beneficiaries would be higher, on average, than under current law, but beneficiaries' out-of-pocket costs would be lower—even though the actuarial value of the Medicare benefit would be unchanged—because of a decline in the total cost of covered services, which would be a result primarily of greater enrollment in lower-bidding private plans.[22] (On average, a larger share of beneficiaries' total payments is in out-of-pocket costs than in premiums, so, in the calculations of the change in total payments, the percentage change in out-of-pocket costs receives a greater weight than the corresponding change in premiums.) The projected savings in out-of-pocket costs would offset part, but not all, of the increase in premiums.

CBO's analysis implies that beneficiaries' total payments would be about 6 percent lower, on average, under the average-bid option than under current law. That reduction results from the combination of the lower average premiums paid discussed above and a reduction in average out-of-pocket costs, which would result primarily from higher enrollment in lower-bidding private plans.

Under both options, the effect on total payments for particular beneficiaries could differ greatly from the nationwide average and would depend partly on the region and the choice of plan. In particular, beneficiaries who chose to remain in the FFS program would generally face higher premiums and would not experience a reduction in out-of-pocket costs.

Uncertainty in the Estimates

To characterize the uncertainty of the estimated effects of the options on beneficiaries' total payments, CBO applied the same type of analysis reported above for the effects of the premium support options on federal spending. Specifically, it varied the same five parameters, with ranges chosen to generate lower and higher estimates of the effects on beneficiaries' payments for each option. In CBO's judgment, there is a two-thirds

22. CBO expects that lower-bidding plans would generally have lower rates of health care utilization. As a result, enrollees would pay less out of pocket than they would with higher-bidding plans. Under the options in this report, the actuarial value of all plans would match the value of current-law Medicare; that is, every plan would cover the same percentage of the total expenses of a given population that is covered by the current Medicare benefit package. For general information on the actuarial value of health plans, see Chris L. Peterson, *Setting and Valuing Health Insurance Benefits*, Report for Congress R40491 (Congressional Research Service, April 6, 2009).

chance under the second-lowest-bid option that beneficiaries' total payments in 2020 would, on average, be within a range extending from a reduction of 2 percent to an increase of 24 percent relative to payments under current law (CBO's central estimate is that total payments would increase by 11 percent). For the average-bid option, the corresponding range of likely average effects on beneficiaries' total payments extends from no effect to a reduction of 12 percent (the central estimate is a reduction of 6 percent.) (See Table 2.) The range under the average-bid option is narrower than that under the second-lowest-bid option mainly because the changes in beneficiaries' premiums from varying those parameters are smaller under the average-bid option and because the variation in responsiveness to smaller changes in premiums results in a smaller range of effects on total payments. (For additional discussion of factors affecting the ranges, see Appendix B.)

Beneficiaries' total payments would be unlikely to rise, on average, under the average-bid option relative to those under current law, for two main reasons. First, because use of health care services tends to be higher for enrollees in the FFS program than for those in private plans, out-of-pocket costs would probably be lower under the average-bid option than they would be under current law as long as the percentage of beneficiaries in the FFS program did not increase. According to CBO's central estimates, the share of beneficiaries in private plans would be about 20 percentage points greater than under current law, and a reduction in that share would be unlikely. Second, average premiums paid under the option would be closely tied to the standard premium, which would be set using the same formula as the Part B premium under current law, so those average premiums would not differ greatly from the Part B premium. And even if premiums were slightly higher under the average-bid option than under current law, the effect probably would not offset the decline in out-of-pocket costs.

Effects on Combined Federal Spending and Beneficiaries' Total Payments

The combined payments of the federal government and beneficiaries constitute the total amount paid for health care services covered by Medicare. They consist of the federal government's payments to plans, beneficiaries' premiums, and beneficiaries' out-of-pocket payments. CBO estimates that those payments would be about 5 percent lower under the second-lowest-bid option and about 4 percent lower under the average-bid option than they would be under current law. Those percentages are a combination of the effects on net Medicare spending and on beneficiaries' total payments discussed above.

CBO expects that the decrease in combined payments would probably be slightly larger under the second-lowest-bid option than under the average-bid option mainly because the former would result in lower bids by private plans and a larger share of beneficiaries enrolled in those plans. CBO did not quantify the uncertainty of those

estimates but it did reach two conclusions about ranges that would cover two-thirds of the possible outcomes for the two options: First, such ranges would clearly overlap; that is, CBO is not confident that combined payments under the second-lowest-bid option would be lower than combined payments under the average-bid option. Second, based on the separate ranges for federal spending and for beneficiaries' total spending, ranges for combined payments would extend only over reductions in payments; that is, it is likely that either option would result in reductions in combined federal spending and beneficiaries' total payments.

The sum of federal spending and beneficiaries' payments examined here is a significant component of total national spending on health care, and this analysis suggests that total national spending would probably decline under either of the two illustrative premium support options. However, a premium support system would interact with other parts of the health care system in complex ways that CBO has not quantified.

Comparison With CBO's Previous Analyses of a Premium Support System

CBO has previously estimated the budgetary effects of revamping Medicare as a premium support system.[23] But those earlier analyses were limited in at least two key respects: They did not include detailed modeling of beneficiaries' choices among alternative insurance plans, and they did not include detailed modeling of insurers' behavior regarding bids or payments to health care providers. Thus, none of those analyses captured the full effects of a competitive system on federal spending or payments by beneficiaries. The analysis in this report incorporates such modeling. In addition, this report differs from some previous analyses by CBO in considering different illustrative options for a premium support system instead of a specific proposal.

The treatment in this report is substantially different from the rough analysis of a specific premium support proposal published by CBO in April 2011. Not only have there been substantial improvements in CBO's modeling of the behavior of beneficiaries and insurers, but the options examined in this report differ in important ways from that earlier proposal. For example, the earlier proposal included a grandfathering provision, and CBO estimated that only 4 percent of Medicare spending in 2022 would be accounted for by premium support payments under that proposal. The proposal also specified a federal contribution that was initially fixed (rather than determined through bidding) and that would keep pace with the consumer price index

23. For example, see Congressional Budget Office, *The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan* (March 2012), www.cbo.gov/publication/43023; *Long-Term Analysis of a Budget Proposal by Chairman Ryan* (attachment to a letter to the Honorable Paul Ryan, April 5, 2011), www.cbo.gov/publication/22085; *Budget Options, Volume 1: Health Care* (December 2008), pp. 120–121, www.cbo.gov/publication/41747; and *Designing a Premium Support System for Medicare* (December 2006), www.cbo.gov/publication/18258.

for all urban consumers (at a rate that CBO estimated would be substantially slower than the rate of growth in Medicare spending under current law). Moreover, because of the simple formula for determining federal spending in that proposal, CBO projected such spending over a longer period than it does in this report.

CBO's estimates of the total payments by beneficiaries and of combined federal spending and beneficiaries' payments for the 2011 proposal were much higher than the estimates for the two options in this report primarily because CBO projected for that earlier report that health care spending covered by private plans would be much higher initially and would grow faster than the agency currently estimates. The difference arose from two main factors: First, the earlier proposal did not include the Medicare FFS program as a bidding plan in the premium support system. Because that program was not present to put downward pressure on the rates paid to providers by private insurers, CBO projected, the premiums of private plans would be substantially higher than they would be under the premium support options discussed in this report. Second, more recent information has led CBO to make a downward revision in its projections of the future growth rate of private health insurance premiums.[24]

Implications of Key Specifications and Alternatives

Although policymakers would need to determine many specific characteristics of a premium support system, several choices would be particularly important from a federal budgetary perspective: setting the formula for the government's contributions, determining whether the traditional FFS program would be included as a competing plan, setting rules of eligibility for the system, delineating bidding regions, and designing the program features that would influence beneficiaries' choice of a plan. Policymakers would also need to address many other design and operational issues to implement such a system.

Note again that the illustrative premium support options analyzed here are anchored in basic features of the current Medicare system: Both would guarantee insurance for all beneficiaries; adjust payments to private insurers to account for the health of their enrollees (that is, use risk adjustment); and, under what is called community rating, require that insurers charge everyone in a region the same premium for the same coverage. Changes to those features also could have important consequences for a premium support system.

In addition, changes in the broader health care and health financing systems would affect a premium support system and change the way it affected federal spending and beneficiaries' payments. For example, if more people outside of the Medicare market purchased health insurance plans with narrower networks of providers and lower

24. See Congressional Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act* (March 2012), www.cbo.gov/publication/43076.

premiums than CBO expects under current law, the willingness of Medicare beneficiaries to purchase similar plans in a premium support system would probably increase—although the opposite could occur if people's experiences with those plans left them dissatisfied. Legislative changes affecting the broader health care market also could have consequences for the effects of a premium support system in Medicare. For instance, repealing the tax exclusion for employment-based health insurance would heighten pressure to restrain the growth of health care costs outside of Medicare. The resulting changes in practice patterns of health care providers would probably decrease private plans' bids under a premium support system, although CBO has no basis for estimating the magnitude of such an effect.

Federal Contributions

In this analysis, CBO focused on two possible approaches to determining federal contributions, but many other methods could be used. For example, capping the growth rate of federal contributions could generate additional federal savings relative to an uncapped proposal, although CBO has not yet estimated the effects of such a cap. In general, federal budgetary savings would increase as federal contributions declined, but beneficiaries' premiums would be higher.

The Fee-for-Service Program

CBO assumed that Medicare's FFS program would continue to be offered within the premium support options analyzed here. If, instead, the FFS program was eliminated, the savings produced for the government under a premium support system would be less (or federal spending could be even more than under current law) because the rates that private insurers would pay health care providers for treating Medicare enrollees would probably be higher than CBO estimates for either premium support option. In general, the rates that private insurers now pay providers for Medicare Advantage enrollees are similar to those Medicare pays under the FFS program but substantially below the rates paid for enrollees who are in commercial plans and are not Medicare beneficiaries.

CBO anticipates that competition from the FFS program within a premium support system would constrain the rates that private insurers paid for premium support enrollees in the same way that the FFS program now appears to constrain the rates that insurers pay for Medicare Advantage enrollees. If a system did not offer the FFS program as a choice, the result probably would be higher payment rates, higher bids, and higher costs for the government. CBO also expects that, under the options analyzed here, in some regions the FFS program would submit the lowest bid, so eliminating the program would directly reduce federal savings by raising the benchmark in those regions.

Eligibility

If fewer people were included in a premium support system, federal savings generally would be lower, all else being equal. For this analysis, CBO assumed that the premium support systems would not include a grandfathering provision (thus including more beneficiaries than if such a provision were part of the system) and would exclude dual-eligible beneficiaries.

A Grandfathering Provision. Under some premium support proposals, all beneficiaries who became eligible for Medicare before the system took effect would remain in the current-law Medicare program and only those who became eligible after that time would enroll in the premium support system. Several important questions would arise about the structure of such a program (see Box 2). Clearly, however, grandfathering some beneficiaries would limit the savings that could be achieved over an extended period because only a subset of the Medicare population would enroll in the new system and (because the grandfathered beneficiaries would be older) the cost of health care for the eligible population would tend to be lower than average.

CBO estimates that if a premium support system implemented in 2018 excluded beneficiaries who entered the program before 2018 and dual-eligible beneficiaries, only about 25 percent of the Medicare population would be covered under the new system after five years, and spending for those beneficiaries would represent only about 15 percent of net Medicare spending in total in that year under current law (where such spending includes that for dual-eligible beneficiaries and for Part D). After a decade, approximately 45 percent of the Medicare population would be covered, and spending for that group would represent about 30 percent of net Medicare spending in total under current law.

Because the share of the Medicare population and the share of Medicare spending covered would rise gradually under a grandfathering provision, federal savings would be substantially smaller over an extended period than would be the case if all beneficiaries entered the new system immediately. A very rough approximation (made on the basis of the estimated share of Medicare spending covered each year) for a system that also excluded dual-eligible beneficiaries suggests that of the total savings achieved if all eligible beneficiaries entered in 2018, federal savings would be about 15 percent as much after 5 years and about 30 percent as much after 10 years.

Moreover, the savings under a grandfathering provision could be slightly smaller than the rough estimates would suggest, for two reasons. First, CBO anticipates that the gradual rise in the proportion of Medicare beneficiaries and Medicare spending covered under such a system would give private insurers less incentive to reduce their bids, over an extended period, than would be the case if all eligible beneficiaries entered the system immediately. Second, the reduction in the growth of Medicare spending likely to occur under a premium support system as a result of changes in the

demand for new technologies would be substantially smaller for many years if that system included a grandfathering provision.

Dual-Eligible Beneficiaries. Medicare covers some services for dual-eligible beneficiaries and Medicaid covers others, thus creating conflicting financial incentives for the federal and state governments and for health care providers.[25] Recent federal and state efforts have focused on integrating the Medicare and Medicaid funding streams and coordinating the often-complex care of many of those beneficiaries—and including that group in a premium support system would pose substantial additional challenges. For instance, it would be difficult to give dual-eligible beneficiaries incentives to choose low-bidding plans in a premium support system while also minimizing their total payments for medical services. Despite that, excluding such beneficiaries would reduce the potential savings that could be achieved from a premium support system. In addition, that exclusion might create incentives for private plans to encourage lower-income beneficiaries with higher health care costs than predicted by their risk scores to seek Medicaid eligibility and thereby leave the plan.[26]

Bidding Regions

CBO assumed that bidding regions for both options would reflect health care markets within states. The precise definition of those markets would involve trade-offs. For example, defining regions to include large numbers of beneficiaries would make insurers' projections of average spending within the region more reliable. However, regions that included areas that varied greatly in their spending would make it more difficult for insurers to project spending for their enrollees because those enrollees could be concentrated in certain areas within the region. As another example, because CBO assumed that a premium support system would require any insurer that submitted a bid for a region to serve the entire region, some local and regional insurers might decline to participate if a region included areas they could not serve effectively, thus reducing competition. And in some regions, those firms could be among the insurers offering the lowest-cost health care, the highest-quality health care, or both. However, if regions were small, some insurers might decline to participate even though they would have served those same areas if they had been included in larger regions. That result could occur, say, if the costs to carriers of developing networks of providers in those areas were higher than in nearby areas and if those costs would have been worth incurring to serve a larger region.

25. See Congressional Budget Office, *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies* (June 2013), www.cbo.gov/publication/44308.

26. Such effects are not included in CBO's estimates in this report.

Features of a System That Could Influence Enrollment

Features of a premium support system that made beneficiaries more sensitive to differences in plans' premiums would tend to reward plans that bid low with higher enrollment and thus encourage more plans to submit lower bids.

In the illustrative premium support options analyzed here, CBO assumed that differences in bids would be translated dollar for dollar into differences in premiums. If, instead, the government retained some of the difference between the benchmark and bids below that amount, two effects would occur: First, the government would reduce its spending by the amount retained, all else being equal. Second, however, by retaining some of the difference between the benchmark and the bids, the government would reduce the incentive for beneficiaries to enroll in low-bidding plans and thus reduce the incentive for plans to submit low bids—which would increase the benchmark and federal spending. The net effect of those two factors on government spending would depend partly on beneficiaries' responsiveness to premiums and partly on the extent to which private insurers raised their bids. Moreover, if the difference between the benchmark and bids below that amount was provided as additional benefits rather than as cash, beneficiaries would tend to have more difficulty comparing plans.

CBO assumed that beneficiaries who did not choose a plan when they entered the premium support system would be assigned to a plan that submitted a bid that was at or below the benchmark (or assigned to one of the four lowest-bidding plans if more than four were at or below the benchmark). If, instead, beneficiaries were automatically placed into their original plan (if they had already been enrolled in Medicare) or into the FFS program, insurers would probably have less incentive to submit low bids, and beneficiaries' total payments would be higher because low-bidding plans would have lower enrollment. Conversely, if those beneficiaries were assigned to plans that had especially low bids (rather than being assigned equally to all plans bidding at or below the benchmark), insurers would probably have a greater incentive to submit low bids, and beneficiaries' total payments would be lower. Alternatively, if beneficiaries were required to choose a plan if they wished to enroll in the premium support system and thus to maintain or obtain Medicare coverage, some would not do so and the fraction of the eligible population not covered by Medicare would increase—particularly in the first few years after implementation.

In this analysis, CBO assumed that the basic packages that plans would be required to offer would consist of health care services and an actuarial value that matched those provided by Medicare's FFS program under Parts A and B—although the plans could vary in other dimensions, such as the breadth of provider networks or the structure of coinsurance. If that basic package was only a minimum requirement and plans could supplement a package in unrestricted ways without offering the basic package itself, comparisons would be more difficult for beneficiaries, enrollment in low-bidding plans would be reduced, and plans' bids would rise. Conversely, if the deductibles and

copayments of the basic package were made standard, comparisons would be simpler. The drawback of standardization, however, is that it could dampen the ability of insurers and providers to develop more cost-effective approaches to providing health care and for beneficiaries to choose those approaches rather than more expensive ones.

Appendix A: Basis for CBO's Findings

The preliminary findings presented in this report regarding the effects of two illustrative options for a premium support system for Medicare (one called the second-lowest-bid option and the other called the average-bid option) are based on detailed modeling of the behavior of buyers and sellers of health insurance policies. In its analysis, the Congressional Budget Office (CBO) focused particular effort on estimating private insurers' bids under those options.

CBO reviewed the research literature and consulted a variety of experts who represented a broad span of views about premium support systems. In addition, some insights about the potential responses of beneficiaries and insurers are possible from observing current experience with the Medicare Advantage program (which provides benefits through private insurance), Medicare Part D (the prescription drug program), the Federal Employees Health Benefits program, and various employment-based insurance plans. The usefulness of those systems to inform the analysis of a premium support system is limited, however, because the competitive structure of a premium support system would be quite different from that of Medicare Advantage or the federal employees' program, and the array of health care services covered would be broader than that under Part D. Moreover, information about the small number of employers whose experiences with similar systems have been studied in depth may not be broadly generalizable—particularly to the Medicare population, which is likely to be less responsive than the nonelderly population to differences in health insurance premiums. Finally, the changes that are occurring in private health care and in health insurance could affect federal spending on Medicare in complicated and unpredictable ways—either under current law or under a premium support system. And the adoption of a premium support system for Medicare could have spillover effects on private health care and health insurance systems.

The current analysis incorporates a range of significant improvements in the modeling of a premium support system for Medicare compared with CBO's earlier analyses of such systems.[27] The agency has devoted considerable time and effort to strengthening its analytical capabilities in this area. Nonetheless, it is extremely difficult to know how beneficiaries or insurers would respond to a premium support system for Medicare, and the actual outcomes would surely differ from the estimates presented in this report—which, according to CBO's current judgment, represent the middle of the distribution of possible outcomes. The agency's modeling effort is not complete; further analysis and

27. For examples of earlier analyses, see Congressional Budget Office, *Long-Term Analysis of a Budget Proposal by Chairman Ryan* (attachment to a letter to the Honorable Paul Ryan, April 5, 2011), www.cbo.gov/publication/22085, and *Designing a Premium Support System for Medicare* (December 2006), www.cbo.gov/publication/18258.

additional consultation with outside experts may alter the findings, perhaps in significant ways. One potential area of inquiry that CBO has not analyzed concerns the ways a premium support system might affect the coordination of care or the quality of care that beneficiaries receive; the agency does not currently have the tools necessary to study such effects, nor does it anticipate having them in the near future.

Estimating Private Insurers' Bids

To estimate the bids that private insurers would submit in 2020 under the two illustrative premium support options considered in this report, CBO analyzed insurers' 2012 bids for Medicare Advantage, projected those bids to 2020, and adjusted them to account for the differences in competition that CBO anticipates private insurers would face under the two options as compared with the current Medicare Advantage program.

In adjusting the projected Medicare Advantage bids to develop estimates of what private insurers would bid under a premium support system, CBO concluded that some factors would tend to lower bids and others would tend to raise them (see Figure A-1). The net effect is that the projected bids under the two premium support options considered in this report are lower, by an average of about 4 percent under each option, than those projected for the current-law Medicare Advantage program. (Bids would be slightly lower under the second-lowest-bid option than under the average-bid option, but the differences relative to bids under the Medicare Advantage program are rounded to the nearest percentage point.) The difference between private insurers' bids under the two options and average spending in Medicare's fee-for-service (FFS) program would remain fairly constant in the decade after the first few years of implementation, CBO anticipates.

Projecting Medicare Advantage Bids

Under current law, each Medicare Advantage plan generally can define its service area as consisting of one or more counties.[28] CBO based its estimates on the bids submitted by insurers for their service areas, using the county as the unit of analysis. The agency developed simulated distributions of bids for counties based on the view that insurers would participate in a premium support system and would offer insurance plans with a range of prices, just as is the case for the current Medicare Advantage program.

CBO estimated benchmarks for counties under the two premium support options on the basis of the agency's projected distributions of private insurers' bids, which were combined with projected per capita Medicare FFS spending for each county. The use of the county as the unit of analysis simplified the modeling and provides a foundation for

28. This discussion applies to local Medicare Advantage plans, which account for the bulk of enrollment in the Medicare Advantage program. By contrast, the federal government defines service areas for regional preferred provider organizations—or PPOs—as consisting of one or more states; each PPO must serve one or more of those designated service areas.

subsequent analyses of a system with other types of bidding regions. The results of the analysis could change if different types of regions were specified.

Under current law, Medicare Advantage insurers submit a bid for a beneficiary in average health (defined as a beneficiary with a risk score of 1.0). CBO projects that the average bid from current-law Medicare Advantage plans in 2020 will be 6 percent below the average FFS spending for a beneficiary with the same reported risk score. For the one-quarter of the nation's counties with the highest average FFS spending, CBO estimates, the average Medicare Advantage bid will be 12 percent below that amount.[29] For the one-quarter of counties with the lowest average FFS spending, CBO projects that the average Medicare Advantage bid will be 6 percent above that amount.[30]

CBO expects that Medicare Advantage bids will be higher relative to average FFS spending in the same areas in 2020 than in 2012 because Medicare Advantage plans will be able to achieve some—but not all—of the restraint in provider payment rates that is scheduled for the FFS system under current law. As a result, the agency projects higher growth in the bids of Medicare Advantage plans than it does for growth in per capita spending under the FFS system.

Factors That Would Tend to Reduce Bids

CBO anticipates that two main mechanisms would tend to lower bids under either option relative to Medicare Advantage bids under current law: increased competition that would result from stronger incentives for beneficiaries and insurers to focus on reducing health care costs and the slightly greater favorable selection for private plans than exists under the Medicare Advantage program.

Increased Competition. Differences in the plans' bids under either option would translate directly into differences in beneficiaries' premiums. Under current law, a Medicare Advantage plan with a bid below the benchmark receives a federal payment that

29. For this analysis, CBO divided counties into quartiles on the basis of average FFS spending in the county, with the same number of counties in each quartile. This differs from the approach elsewhere in the report for the analysis of beneficiaries' premiums, which divides groups of regions into quartiles constructed such that the same number of beneficiaries is in each quartile.

30. Those estimates incorporate factors affecting bids that are related to the risk adjustment mechanism, discussed below. For this analysis, CBO excluded three types of Medicare Advantage plans that differ substantially from plans that would probably be offered under a premium support system: private FFS plans, special needs plans, and employment-based group plans. The FFS program's costs used for the comparisons in this report exclude certain types of spending because it is not covered by the bids that Medicare Advantage plans submit under current law—namely, the additional payments to disproportionate-share hospitals (whose share of low-income patients exceeds a specified threshold) and spending for medical education, hospice benefits, and certain benefits for patients with end-stage renal disease. CBO included in its calculations the government's cost of administering the FFS program. The analysis was based on CBO's projections of Medicare expenditures and Medicare Advantage enrollments in March 2012. See Congressional Budget Office, "Medicare—March 2012 Baseline" (March 13, 2012), www.cbo.gov/publication/43060.

equals the bid plus a rebate that is a percentage of the difference between the bid and the benchmark. (Beginning in 2014, the rebate will range from 50 percent to 70 percent, depending on the plan's performance on certain measures of quality.) Plans now return most of that difference in the form of supplemental benefits (rather than as reduced premiums), which consumers generally find harder to evaluate than a cash amount. Under the illustrative premium support options, plans with bids below the benchmark would return the entire difference between the two in the form of lower premiums. Beneficiaries would therefore be more sensitive to differences in plans' bids in deciding on a plan than they would be under the Medicare Advantage program, so the insurers would have more incentive to lower their bids under the two premium support options.

Insurers also would face more competition under both options because of changes in market structure. Under the Medicare Advantage program, the benchmarks are announced before insurers submit their bids. Under the two premium support options, the benchmarks would be determined from the bids themselves. Some evidence suggesting that competition among Medicare Advantage plans is limited under the current approach comes from a study that concluded that a $1.00 increase in a benchmark, with all other factors (including health care costs) held constant, results in a $0.49 increase in the average bid.[31] In a highly competitive system (for example, one in which each dollar that a bid was below the bid of another plan within a region would correspond to a dollar's difference in the premiums between the two plans), the insurers' bids would primarily reflect their costs rather than the benchmarks.

Insurers would be expected to respond to increased competition by reducing their costs and lowering their bids.[32] The reductions might occur partly as a result of reduced administrative costs or smaller profit margins. But they also could result from cuts in spending for services, perhaps made possible by insurers' combining improvements in management of care with development of more restrictive provider networks, slower adoption of expensive technological advances, faster adoption of methods to compensate providers that demonstrated cost-effective care, or changes in benefit design (for example, tying cost-sharing requirements to evidence of the cost-effectiveness of specific services).

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31. Zirui Song, Mary Beth Landrum, and Michael E. Chernew, "Competitive Bidding in Medicare: Who Benefits From Competition?" *American Journal of Managed Care*, vol. 18, no. 9 (September 2012), pp. 546–552, http://tinyurl.com/odtwf87.

32. For related research, see Thomas C. Buchmueller, "Consumer-Oriented Health Care Reform Strategies: A Review of the Evidence on Managed Competition and Consumer-Directed Health Insurance," *Milbank Quarterly*, vol. 87, no. 4 (December 2009), pp. 820–841, http://tinyurl.com/nsaff32, and "Does a Fixed-Dollar Premium Contribution Lower Spending?" *Health Affairs*, vol. 17, no. 6 (November 1998), pp. 228–235, http://tinyurl.com/puwqjaz; David M. Cutler and Sarah J. Reber, "Paying for Health Insurance: The Trade-Off Between Competition and Adverse Selection," *Quarterly Journal of Economics*, vol. 113, no. 2 (May 1998), pp. 433–466, http://tinyurl.com/mycqvem; and Steven C. Hill and Barbara L. Wolfe, "Testing the HMO Competitive Strategy: An Analysis of Its Impact on Medical Care Resources," *Journal of Health Economics*, vol. 16, no. 3 (June 1997), pp. 261–286, http://tinyurl.com/nvvz76c.

Under the specification of the two options that restricts insurers to submitting a maximum of two bids for the basic benefit package in any bidding region, CBO also expects that insurers would eliminate some of the higher-bidding plans that would exist under the Medicare Advantage program—reducing average bids. (Under the Medicare Advantage program, insurers often submit more than two bids in their service areas.)

Increased Favorable Selection. Under both premium support options, all private insurers in a region would submit bids indicating the payment they would accept to provide Medicare benefits for a beneficiary of average health, and those standardized bids would be used to establish regional benchmarks. Payments to insurers would be adjusted to reflect the health status of their enrollees, using a risk adjustment mechanism that CBO assumed would be comparable to that of the Medicare Advantage program.

It is difficult to adjust payments to reflect health status, and the system used for Medicare Advantage is unavoidably imperfect. Medicare beneficiaries in poor health tend to prefer to enroll in the FFS program because it generally places fewer restrictions on the use of health care services. That tendency is in evidence even among beneficiaries with the same risk scores because risk scores incorporate only limited information about health status. When a beneficiary who enrolls in a private plan is healthier than someone with the same risk score enrolled in the FFS program, the private plan experiences "favorable selection" beyond that captured by risk scores. Some research indicates that current Medicare Advantage enrollees who have a given risk score would have had lower costs, on average, under the FFS program than people enrolled in the FFS program with that same score.[33]

CBO expects that, under either premium support option, private plans would experience greater favorable selection (beyond that captured by risk scores) than they will experience under the Medicare Advantage program. That is, people who enrolled in private plans—under either option—would use fewer health care services, on average, than people with the same risk score enrolled in Medicare Advantage. CBO anticipates that outcome because increased competition would prompt insurers to take more aggressive steps to control costs (by enhancing utilization management or using tighter provider networks, for example), thus rendering private insurers less attractive to

33. Estimates of the difference vary considerably, however. For example, see Joseph P. Newhouse and others, "Steps to Reduce Favorable Risk Selection in Medicare Advantage Largely Succeeded, Boding Well for Health Insurance Exchanges," *Health Affairs*, vol. 31, no. 12 (December 2012), pp. 2618–2628, http://tinyurl.com/naps2jl; Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System* (June 2012), pp. 100–101, http://go.usa.gov/DXbF; Gerald F. Riley, "Impact of Continued Biased Disenrollment From the Medicare Advantage Program to Fee-for-Service," *Medicare and Medicaid Research Review*, vol. 2, no. 4 (2012), pp. E1–E17, http://go.usa.gov/DXbd; and Jason Brown and others, *How Does Risk Selection Respond to Risk Adjustment? Evidence From the Medicare Advantage Program*, Working Paper 16977 (National Bureau of Economic Research, April 2011), www.nber.org/papers/w16977.

beneficiaries who would, on average, use more health care services than would other beneficiaries with the same risk score.

Because of the increased favorable selection, costs per enrollee would be lower for private plans under a premium support system than for Medicare Advantage plans under current law if the average risk scores in the two sets of plans were the same. Reflecting those lower costs, private plans competing for additional enrollees under either option would tend to reduce their bids for a beneficiary of average health relative to those of Medicare Advantage plans, CBO anticipates.

Factors That Would Tend to Raise Bids

CBO estimates that in most counties the percentage of beneficiaries enrolled in the FFS program would decline once either premium support option took effect. In CBO's assessment, the reduced market share of the FFS program would tend to boost the rates that private insurers paid to health care providers and thereby lead them to raise their bids. That reduction in market share, and thus the effect on private insurers' bids, would be greater in areas where average FFS spending was high. (CBO's methodology for estimating the proportion of beneficiaries who would select the FFS program is discussed below.)

Declines in the FFS program's market share would affect payment rates for private insurers through two main mechanisms. First, the importance of payment rates from the FFS program would diminish as a determinant of the amounts private insurers would pay health care providers for treating Medicare enrollees (those FFS payment rates are generally a good deal lower than the rates private insurers pay to providers of health care for people with commercial insurance—that is, employment-based coverage). Second, some private insurers would need to broaden their provider networks to accommodate additional enrollees. Both mechanisms would cause insurers to raise their bids to cover additional costs, CBO projects.

The Reduced Importance of FFS Provider Payment Rates. CBO's assessment of the importance to private plans of FFS payment rates is based on the observation that, on balance, the rates paid for Medicare Advantage enrollees are similar to or slightly above those that Medicare pays for FFS patients' care—even though providers receive substantially higher amounts when they offer the same services to patients in commercial plans focused on the under-65 population.[34] The exact cause of the difference is not known, but it appears to arise in part because private insurers that offer Medicare Advantage plans can exclude from their networks any providers who are unwilling to accept Medicare's rates, thus reducing those providers' volume of

34. Information about those rates is based on interviews conducted by CBO staff with industry sources and is consistent with reports in the research literature. See Robert A. Berenson and others, "The Growing Power of Some Providers to Win Steep Payment Increases From Insurers Suggests Policy Remedies May Be Needed," *Health Affairs*, vol. 31, no. 5 (May 2012), pp. 973–981, http://tinyurl.com/ntyyudv.

Medicare patients; those same providers would generally end up being paid the lower rates for treating Medicare patients in the FFS system. Moreover, when Medicare Advantage enrollees go outside their plan's provider network to obtain care that the plan either must cover by law (emergency care, for example) or that it covers as a matter of choice (such as certain highly specialized services), federal law requires providers to accept Medicare's FFS rates as payment in full.[35] Thus, a hospital that might anticipate providing a certain amount of emergency care to enrollees in a Medicare Advantage plan would not receive higher commercial rates for treating those patients simply because it refused to join the plan's network.

The relationship between private insurers and providers is much different for plans that serve commercial enrollees. Although there are dominant insurers in many commercial markets, they appear to have less leverage than the Medicare FFS program has with providers—in part, at least, because FFS payment rates are established by law and are not subject to negotiation. If providers are unwilling to accept rates for their commercial enrollees that are similar to Medicare's rates, they can be reasonably confident that other insurers will pay them more—particularly because private insurers typically try to satisfy consumers' desire for broad provider networks. In addition, when enrollees in commercial plans go outside the plan's network to receive care, the providers who treat them generally charge more than they would have charged had they been in the plan's network. Insurers often limit their payments for such care to predetermined amounts, but patients are often responsible for some or all of the differences between those payments and the provider's charges.

In regions where the role of the FFS program diminished under a premium support system, CBO expects, the relationship between private insurers and health care providers would become less similar to the relationship in Medicare Advantage under current law and more similar to the relationship in the commercial market for people under age 65.

Broadening of Provider Networks. Another reason bids would increase as the share of beneficiaries in the FFS program fell is that private insurers, on average, would need to expand their networks to accommodate increased enrollment. As a result, private insurers would probably need either to pay higher rates or to contract with providers with higher-cost practice styles. Bids would rise as a result of including higher-cost health care providers that private insurers would tend to have excluded when their networks could be narrower. The expansion would be greater for lower-bidding plans, CBO projects, because those plans would experience greater increases in enrollment.

The Magnitude of the Resulting Adjustments to Bids. CBO did not adjust its projections of private insurers' bids in counties in which it expects that the FFS program would

35. Sections 1866(a)(1)(O) and 1876(i)(1) of the Social Security Act contain the relevant provisions for hospitals and physicians, respectively.

maintain the share that it currently holds (or its nationwide market share, if that is lower). The agency anticipates that, in those counties, the forces that now allow private insurers to obtain payment rates for their Medicare Advantage plans that are similar to those for Medicare's FFS program would continue to prevail under a premium support system.[36] However, where the market share of the FFS program is projected to fall below its current level—and where that share would be below the current national market share—CBO expects that private insurers would pay higher rates to providers for their premium support enrollees than they would pay under current law for Medicare Advantage enrollees. CBO adjusted its projections for insurers in those counties, and the adjustment was greater for counties where larger reductions are anticipated in the FFS program's market share. CBO also adjusted the bids upward slightly for plans at or near the bottom of the bid distribution to account for the expected broadening of provider networks.

The size of the adjustment for private plans' bids was made partly on the basis of the agency's assessment of the average difference between the rates paid by Medicare and the rates paid by private insurers to hospitals, physicians, and other providers for enrollees in commercial plans. However, the adjustment was smaller than that average difference as a way to account for four main factors:

- The observed difference in payment rates now is more informative about the rise in rates that might occur under a premium support system in which the FFS program was eliminated; rates would generally rise much less under a system in which the FFS program was a competing plan—particularly in regions where the FFS program retained a significant market share.

- Medicare's FFS payment rates would be used as a reference point in negotiations between private plans and providers for their premium support enrollees, which would tend to keep those rates below commercial rates even in regions where the FFS program had a very low market share.

- The competitive structure of a premium support system would tend to push rates below commercial rates. In particular, current tax-based subsidies to health insurance for commercial enrollees result in less competitive pressure on provider payment rates than would occur under the premium support options analyzed here.

- A reduction in the FFS market share would lower commercial rates, reducing the difference between FFS rates and commercial rates. Because of the reduction in the

36. CBO expects that the rates private insurers will pay providers under Medicare Advantage plans will rise over time relative to Medicare's FFS rates because private insurers are not likely to obtain all of the reductions in payment updates that are scheduled for the FFS program under current law. The adjustments to bids discussed in this section were applied to projected Medicare Advantage bids, developed under the expectation that private insurers' payment rates would be higher relative to Medicare FFS rates than they are now.

FFS market share, fewer health care services would be paid for at relatively low Medicare FFS rates. As a result, fewer costs associated with Medicare beneficiaries would probably be shifted to private insurers through higher rates for hospital services, thus reducing commercial rates.

After considering all of those factors, CBO made separate adjustments to its estimates of the bids in each county, depending on the projected changes in the FFS program's market share. The relationship between the FFS market share and private plans' bids is subject to considerable uncertainty, but CBO regards its estimates as being in the middle of the distribution of possible outcomes.

Differences Between the Options' Effects on Bids

The combined effects of the factors that would tend to lower bids would be slightly larger under the second-lowest-bid option than under the average-bid option. In 2020, those effects would reduce bids by about 7 percent, on average, under the second-lowest-bid option and by about 6 percent under the average-bid option. In either case, the amount by which bids were reduced would vary considerably from one region to another.

The effects of the factors that tended to increase bids also would be slightly larger under the second-lowest-bid option than under the average-bid option because the increased competition, and the resulting changes in enrollment among the plans, would be greater. In 2020, that effect would boost bids by about 3 percent, on average, under the second-lowest-bid option and by about 2 percent under the average-bid option.

The largest difference in the effects of the two options on bids by private insurers would result from a difference in the degree of competition. That difference would occur for two main reasons.

First, and more important, the benchmark would be lower under the second-lowest-bid option than under the average-bid option in most regions, so the premiums for a plan with a given bid would be higher. In CBO's judgment, insurers would expect those higher premiums to increase beneficiaries' sensitivity to differences in costs because premiums would consume a greater share of enrollees' discretionary income.

Second, bids for plans that wanted to attract automatically assigned beneficiaries would tend to be lower under the second-lowest-bid option than under the average-bid option. Under either option, according to specifications outlined in this report, beneficiaries who made no affirmative choice would be assigned with equal probability to an available plan that had submitted a bid that was at or below the regional benchmark (or to one of the four lowest-bidding plans if more than four met that criterion). Although such beneficiaries would be comparatively less attractive to plans than those who made an active enrollment choice, some plans would nevertheless seek

to obtain them through assignment. Because no more than two plans would receive automatically assigned beneficiaries under the second-lowest-bid option in most instances, compared with as many as four under the average-bid option, the plans that wanted to enroll such beneficiaries would have greater incentives to submit lower bids under the second-lowest-bid option.

Changes Over Time in Effects on Bids

Under either option, the combined effects of the factors that tended to reduce bids would increase over time, as would the combined effects of the factors that tended to increase bids. On balance, CBO anticipates, the difference between private insurers' bids under the two options and average FFS costs would remain fairly constant for the decade following the first few years of implementation.

CBO expects that the increased competition in particular would lead insurers to reduce costs even more after 2020 so they could keep their bids as low as possible in subsequent years. However, for three reasons, the incremental reductions would probably be smaller than the initial drop: First, one assumption of this analysis is that the legislation that created a new premium support system would provide private insurers with several years to determine how to reduce their costs before the system was implemented with the result that many changes would probably be undertaken in the first few years. Second, because many beneficiaries would probably remain in the first plan they chose without thoroughly evaluating their options in subsequent years, insurers would have an especially strong incentive to submit low bids in the first year of the new system. Third, insurers would tend to undertake the easier reductions first, and additional reductions would probably involve more difficult actions.

However, CBO also projects that Medicare Advantage bids under current law will rise more rapidly than average spending in the FFS program. As a result, greater cost reduction under the premium support options would be necessary in future years to maintain the percentage savings relative to FFS spending projected for 2020. By CBO's estimate, the additional cost reductions would roughly offset the trends in Medicare Advantage bids projected under current law through the 2020s.

Estimating Federal Spending for Medicare and Beneficiaries' Total Payments

The methods for estimating combined federal spending and beneficiaries' total payments were similar for both options CBO analyzed. CBO projected bids for a given year as described in the previous section. The agency used those bids (and, for the average-bid option, past enrollment) to estimate benchmarks in each county and premiums for each plan in each county. It then simulated the enrollment of a large sample of beneficiaries in different plans on the basis of premiums and previous patterns of enrollment, calculated federal spending as the sum of the risk-adjusted federal contribution for each beneficiary, and compared total federal spending with the

baseline projection. To project beneficiaries' total payments, CBO used claims data to estimate cost-sharing payments by each beneficiary for the services covered by Medicare and combined those estimates with the plans' premiums.

The estimates incorporated data from administrative records for a sample of about 600,000 Medicare beneficiaries, along with county-level projections of the FFS program's bid and the bids of private plans. CBO adjusted the estimates of out-of-pocket spending to match the actuarial value of the plans and current distributions of health spending by age, health risk, and other factors.

The enrollment simulations were based in part on estimates of two especially important aspects of beneficiaries' choices of plans: their sensitivity to premiums and the likelihood that they would actively choose to enroll in a plan. The analysis also incorporated the effects of CBO's expectation that patients who enrolled in private plans would have their diagnoses coded more intensively than would patients in the FFS program. Possible spillover effects on Medicare FFS spending from increased enrollment in private plans were not considered in the estimates.

Sensitivity to Premiums

To develop its projections of the plans that Medicare beneficiaries would choose under different premium support proposals, CBO conducted its own analysis and it examined findings from the research literature concerning beneficiaries' sensitivity to premiums in selecting health plans.[37] In the agency's judgment, there are two main reasons that beneficiaries' sensitivity under either option would be greater than is generally reported in the literature for the Medicare population. First, they would face larger differences in premiums under the options than those that have been studied previously. Second,

37. See, for example, Thomas C. Buchmueller and others, "The Price Sensitivity of Medicare Beneficiaries: A Regression Discontinuity Approach," *Health Economics*, vol. 22, no. 1 (January 2013), pp. 35–51, http://tinyurl.com/oo2rrk4; Steven D. Pizer, Austin B. Frakt, and Roger Feldman, "Nothing for Something? Estimating Cost and Value for Beneficiaries From Recent Medicare Spending Increases on HMO Payments and Drug Benefits," *International Journal of Health Care Finance and Economics*, vol. 9, no. 1 (March 2009), pp. 59–81, http://tinyurl.com/p7xjtvh; Thomas C. Buchmueller, "Price and the Health Plan Choices of Retirees," *Journal of Health Economics*, vol. 25, no. 1 (January 2006), pp. 81–101, http://tinyurl.com/m6p93dz; Adam Atherly, Bryan E. Dowd, and Roger Feldman, "The Effect of Benefits, Premiums, and Health Risk on Health Plan Choice in the Medicare Program," *Health Services Research*, vol. 39, no. 4 (August 2004), pp. 847–864, http://tinyurl.com/o4wl339; Bryan E. Dowd, Roger Feldman, and Robert Coulam, ''The Effect of Health Plan Characteristics on Medicare+Choice Enrollment,'' *Health Services Research*, vol. 38, no. 1, part 1 (February 2003), pp. 113–135, http://tinyurl.com/p34m69r; Anne Beeson Royalty and Neil Solomon, "Health Plan Choice: Price Elasticities in a Managed Competition Setting," *Journal of Human Resources*, vol. 34, no. 1 (Winter 1999), pp. 1–41, http://tinyurl.com/o2m3br7; David M. Cutler and Sarah J. Reber, "Paying for Health Insurance: The Trade-Off Between Competition and Adverse Selection," *Quarterly Journal of Economics*, vol. 113, no. 2 (May 1998), pp. 433–466, http://tinyurl.com/mycqvem; and Thomas C. Buchmueller, "The Health Plan Choices of Retirees Under Managed Competition," *Health Services Research*, vol. 35, no. 5, part 1 (December 2000), pp. 949–976, http://tinyurl.com/lajxa4w.

beneficiaries would receive information on the features of available plans—including premiums—in ways that would make comparison among plans simpler than is generally the case under current law. Moreover, CBO anticipates, beneficiaries who are new Medicare enrollees in the future will be more sensitive, on average, than current beneficiaries are to differences in premiums. CBO expects those beneficiaries to be healthier generally (and thus less likely to have strong ties to providers who might not be in some plans' networks) and, because of their experience in the health insurance marketplace, to be more conversant than many current enrollees are with the process of choosing among plans that offer different premiums and packages of benefits.

In most regions, under either option, beneficiaries would be able to choose from several private plans that are likely to be more similar to one another than to the FFS program in terms of the size of provider networks and approaches to utilization management. Therefore, CBO anticipates, beneficiaries would be more sensitive to premiums when choosing among private plans than they would be when choosing between any private plan and the FFS program. Additionally, CBO expects, beneficiaries would become somewhat less sensitive to the cost of premiums after the first few years; once beneficiaries are in a plan, they generally do not seem to switch readily.[38] Nevertheless, the possibilities of attracting new enrollees each year and of losing existing enrollees to competitors would provide incentives for private plans to continue to keep bids low.

The constraints on Medicare payment rates for providers embodied in current law may result in diminished access to care and in reduced quality of care for beneficiaries in the FFS program, although the timing and extent of such changes are very difficult to predict. In this analysis, CBO anticipates that beneficiaries would respond to the possibility of reduced access or quality by being somewhat more inclined to choose a private plan than to choose the FFS program when the FFS rates for health care providers fell relative to those of private plans.

Active Choice of a Plan

In CBO's assessment, a significant proportion of beneficiaries would not actively choose a plan in the first year that a premium support system was implemented. Under

38. For related discussion, see Benjamin R. Handel, "Adverse Selection and Inertia in Health Insurance Markets: When Nudging Hurts," working paper (University of California at Berkeley, March 2013, http://emlab.berkeley.edu/~bhandel/index.shtml; Peter J. Cunningham, *Few Americans Switch Employer Health Plans for Better Quality, Lower Costs,* Research Brief 12 (National Institute for Health Care Reform, January 2013), www.nihcr.org/Health-Plan-Switching; Jonathan D. Ketcham and others, "Sinking, Swimming, or Learning to Swim in Medicare Part D," *American Economic Review*, vol. 102, no. 6 (October 2012), pp. 2639–2673, http://tinyurl.com/ow8luxd; Keith M. Marzilli Ericson, *Consumer Inertia and Firm Pricing in the Medicare Part D Prescription Drug Insurance Exchange,* Working Paper 18359 (National Bureau of Economic Research, September 2012), www.nber.org/papers/w18359; and Kathleen Nosal, "Estimating Switching Costs for Medicare Advantage Plans," working paper (University of Arizona, June 2012), www.u.arizona.edu/~nosal/research.html.

the specifications adopted for this report, beneficiaries who did not make a choice would be assigned randomly to a plan with a bid at or below the benchmark (or to one among the four lowest-bidding plans, if more than four bid at or below the benchmark). To project that share of beneficiaries, CBO analyzed the behavior of Medicare Advantage enrollees whose plans had left the market, and it reviewed research on enrollment in the Part D program.

CBO expects that a higher percentage of beneficiaries would choose a plan under the second-lowest-bid option than under the average-bid option because the higher average premiums would be more likely to impel beneficiaries to learn about the new program and choose a plan. CBO projects that, on average, about 15 percent of beneficiaries would not choose a plan in the first year of premium support under the second-lowest-bid option and about 20 percent would not choose a plan in the first year under the average-bid option. The percentages would be expected to vary according to certain demographic characteristics and health status identified in CBO's analyses and in its review of related research. The agency also projects that most beneficiaries who were assigned to a plan in 2018 would still be in that plan by 2020 (the reference year for the analysis of beneficiaries' premiums) but that some beneficiaries who did not choose a plan in the first year would switch from the low-bidding plan to which they were assigned to a higher-bidding plan later.

More Intensive Diagnostic Coding by Private Insurers

Evidence suggests that private insurers in the Medicare Advantage program record a larger number of diagnoses than FFS providers do, so a given beneficiary would be expected to have a higher risk score in a Medicare Advantage plan than in the FFS program. Because higher risk scores result in larger payments, private insurers have a financial incentive to ensure that every appropriate diagnosis is coded for each enrollee; such an incentive does not generally exist in the FFS sector. Although the Medicare program adjusts the risk scores of Medicare Advantage enrollees downward to attempt to account for the difference—and that adjustment was incorporated in the risk scores used in this analysis—there is recent evidence that the adjustment is probably insufficient.[39] CBO expects that under the two options private insurers would code diagnoses more intensively than providers treating FFS patients to the same extent that they would do so in the Medicare Advantage program under current law and that

39. The Centers for Medicare & Medicaid Services has estimated that reported risk scores for Medicare Advantage enrollees are 3.4 percent higher than they would have been in the FFS sector, and the agency adjusts the reported risk scores downward by 3.4 percent when it calculates payments to the plans. Under current law, beginning in 2014 and continuing until 2018, the agency must increase the adjustment until the downward adjustment reaches at least 5.9 percent. The Government Accountability Office has estimated that the difference in coding boosts risk scores for Medicare Advantage enrollees by between 5 percent and 6 percent relative to likely scores in the FFS system and that the difference has widened over time. See Government Accountability Office, *Substantial Excess Payments Underscore Need for CMS to Improve Accuracy of Risk Score Adjustments*, GAO-13-206 (January 2013), www.gao.gov/products/GAO-13-206.

the Medicare program would adjust the risk scores of enrollees in private plans to the same extent that is projected for Medicare Advantage under current law. Thus, no adjustments to plans' projected bids in Medicare Advantage were needed to account for those practices.

However, CBO expects that the more intensive coding of diagnoses would affect federal spending under a premium support system even though it would not affect the bids of private plans relative to those under current law. In particular, under both options, a larger fraction of the Medicare population would be covered by private plans, and thus more of the population would be subject to more intensive coding, on average, than is the case under current law. Therefore, CBO accounted for differences in coding in its projections of payments to insurers. CBO expects that beneficiaries who switched from the FFS program to a private plan would end up with higher risk scores and that the Medicare program would adjust for only part of that difference in calculating payment amounts for the insurers. As a result, the federal government would pay more for such beneficiaries under a premium support system, all else being equal, than it would if there was no difference in coding or if the Medicare program adjusted the risk scores of private plans to completely remove the effects of coding differences.

Possible Spillover Effects on Medicare FFS Spending

There is evidence that increases in the proportion of beneficiaries enrolled in Medicare Advantage plans lead to lower federal spending for beneficiaries in the FFS program and in a lower intensity of their treatment.[40] Such spillover effects could occur through at least two pathways: Increased managed care penetration could change the way physicians treat *all* of their patients, not just those enrolled in managed care plans, and it could influence investment decisions and the adoption of new technology in local markets. For this report, CBO did not incorporate such spillover effects on the FFS program.

In CBO's estimation, such effects would be very small or even negligible in 2020, although the agency will explore the issue more in future analyses. The sustainable growth rate mechanism for physicians and the provisions of the Affordable Care Act

40. See Katherine Baicker, Michael Chernew, and Jacob Robbins, *The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization,* Working Paper 19070 (National Bureau of Economic Research, May 2013), www.nber.org/papers/w19070; Michael Chernew, Philip DeCicca, and Robert Town, "Managed Care and Medical Expenditures of Medicare Beneficiaries," *Journal of Health Economics*, vol. 27, no. 6 (December 2008), pp. 1451–1461, http://tinyurl.com/qxfh4h9; and Laurence C. Baker, "The Effect of HMOs on Fee-for-Service Health Care Expenditures: Evidence From Medicare," *Journal of Health Economics,* vol. 16, no. 4 (July 1997), pp. 453–481, http://tinyurl.com/kf28hus. The study of Baicker and others presented estimates of the effects of Medicare Advantage plans' market share on hospitals' resource costs of treating Medicare beneficiaries, which do not directly determine Medicare's payments for FFS beneficiaries under the prospective payment system. The two other studies estimated the effects of Medicare Advantage plans' market share on Medicare spending for FFS beneficiaries.

that restrain payment updates for most other FFS providers also will restrain federal spending in Medicare's FFS program, suggesting that any additional reductions in Medicare spending on the FFS program that might result from a spillover effect would be smaller than has been estimated in the past.[41]

Over the longer term, the size of spillover effects would depend in part on whether the restraints on payment updates in the FFS program specified under current law are maintained. However, as discussed in the section of the text on "Effects After the First Several Years," stronger price-based competition under a premium support system would probably affect the emergence and diffusion of new technology and services in ways that might reduce FFS spending (for a beneficiary of average health, relative to that under current law) in the longer term.

41. The Affordable Care Act comprises the Patient Protection and Affordable Care Act and the health care provisions of the Health Care and Education Reconciliation Act of 2010.

Appendix B: Analysis of Uncertainty in the Estimates

To characterize uncertainty in the estimated effects of the two illustrative options for a premium support system (one called the second-lowest-bid option and the other called the average-bid option) on federal spending for Medicare and on beneficiaries' total payments, the Congressional Budget Office (CBO) determined ranges of values for five key parameters and estimated the effects of varying those parameters. Those estimates focused on results for 2020, which CBO used as a reference year in the analysis. The ranges for the parameters' values were chosen to represent CBO's judgment that, accounting not only for uncertainty about those parameters but also about most of the sources of uncertainty in the analysis (assuming that a premium support system was implemented as specified here), there would be about a two-thirds chance that CBO's central estimate for the effect on federal spending would be within the range reported.

CBO varied the following parameters to construct the ranges:

- Bids of Medicare Advantage plans relative to Medicare fee-for-service (FFS) spending as projected under current law,
- The amount by which private insurers would reduce their bids relative to Medicare Advantage bids under current law in response to the increased competitive pressure created by the premium support system and other factors,
- The higher rates that private insurers would need to pay providers (with corresponding increases in bids) that CBO projects would result if the market share of the FFS program fell significantly,
- The responsiveness of beneficiaries to differences in premiums when choosing among plans, and
- The percentage of beneficiaries who would not actively choose a plan in the first year of premium support and who therefore would be assigned to a plan with a bid at or below the benchmark.

Effects on Federal Spending

CBO estimated a range of effects on federal spending by simultaneously varying all five key parameters in ways that would result in higher or lower spending under the premium support options. To do so, the agency examined how varying each parameter would affect spending.

Bids by Medicare Advantage Plans Relative to Fee-for-Service Spending

If Medicare Advantage bids under current law were lower than those in CBO's projections and FFS spending was as CBO projects, then federal savings under both options would be greater, according to CBO's estimates, because the benchmarks under the options would be lower than projected. Conversely, if Medicare Advantage bids under current law were higher than those in CBO's projections and FFS spending was as CBO projects, federal savings would be smaller than projected. Although CBO's estimates of the effects of a premium support system are sensitive to changes in the bids of Medicare Advantage plans *relative* to FFS spending, those estimates are not directly sensitive to *equal* percentage changes in Medicare Advantage bids and FFS spending—that is, to an across-the-board increase or decrease in Medicare spending relative to the amounts that CBO projects—because the difference between the benchmarks under the options and federal spending for Medicare under current law would not be affected. However, if such an across-the-board change occurred, it could affect the amount by which private insurers under a premium support system reduced their bids relative to Medicare Advantage bids (as discussed below).

Reduction of Bids of Private Plans in Response to Increased Competitive Pressure and Other Factors

If private insurers responded to increased competitive pressure by reducing their bids by more than the amounts in CBO's central estimates, federal savings would be correspondingly greater under both options because the benchmarks would be lower than estimated. But federal savings would be lower if private insurers reduced their bids by less than the central estimates.

In addition, if FFS and Medicare Advantage costs were higher across the board (because of greater systemwide growth in costs), there might be more opportunity for cost savings, depending on the underlying drivers of that growth, and the amounts by which private insurers reduced their bids under the premium support options would probably be greater than they are in the agency's central estimates. Similarly, if costs were lower across the board, the amounts by which private insurers reduced their bids under the premium support options would probably be smaller than they are in the agency's central estimates.

Rates That Private Insurers Would Pay to Providers

If the decline in the market share of the FFS program under a premium support system resulted in higher payment rates for health care providers and therefore in higher bids from private insurers than in CBO's central estimates, federal savings would be correspondingly smaller because both those bids and the benchmarks would be higher, all else being equal. If that effect was smaller than in the central estimates, however, federal savings would be correspondingly greater.

Beneficiaries' Sensitivity to Premiums

Departures from the central estimates in beneficiaries' responsiveness to differences in premiums would influence federal spending both through the effects on plans' bids and through the effects on the share of beneficiaries enrolled in private plans. If beneficiaries were more responsive to differences in premiums than is predicted in CBO's central estimates, private insurers' bids would be lower than they are in those estimates (because insurers would have a stronger incentive to reduce their bids if such reductions led to larger increases in enrollment); those lower bids would result in greater federal savings. Conversely, if beneficiaries were less responsive to differences in premiums than in the central estimates, the private insurers' bids would be higher and federal savings would be lower. Regarding enrollment shares, if beneficiaries were more responsive to differences in premiums than in the central estimates, a larger proportion would switch to lower-bidding plans under premium support, causing several indirect effects on federal savings (as discussed below). If they were less responsive, the opposite would occur.

Active Choice of a Plan

If a larger percentage of beneficiaries did not actively choose a plan in the first year of premium support than is predicted in CBO's central estimates and if those beneficiaries were assigned to plans with bids at or below the benchmark, a larger percentage of beneficiaries would be enrolled in low-bidding plans, all else being equal. Conversely, if a smaller percentage of beneficiaries did not actively choose a plan, a smaller percentage would be enrolled in low-bidding plans. The implications for federal savings under the two premium support options would be similar to the indirect effects (discussed below) that would occur through changes in the shares of enrollment in private plans when beneficiaries were more, or less, sensitive to differences in premiums than is predicted in the central estimates. (Although one might expect that having a higher share of beneficiaries not actively choosing a plan would have effects similar to beneficiaries' being less sensitive to premiums, that is not the case because the beneficiaries who did not choose a plan would be assigned to a low-bidding plan.)

Effects of Changes in the Proportion of Beneficiaries in Lower-Bidding Plans

A greater responsiveness of beneficiaries to differences in premiums when choosing among plans and a larger percentage of beneficiaries not actively choosing a plan in the first year would both lead to a larger proportion of beneficiaries being enrolled in lower-bidding plans. Similarly, less responsiveness to differences in premiums and a smaller percentage of beneficiaries not actively choosing a plan would lead to a smaller proportion of beneficiaries being enrolled in lower-bidding plans. Those differences in enrollment would have indirect effects on federal savings through three main mechanisms:

- Under the average-bid option, having a greater proportion of beneficiaries in lower-bidding plans would result in lower benchmarks (because benchmarks are constructed by weighting each plan's bid by its enrollment in the prior year) and thus would result in greater federal savings. And if a smaller proportion were enrolled in lower-bidding plans, higher benchmarks and lower federal savings would result. Under the second-lowest-bid option, however, having a higher or lower proportion of beneficiaries enrolled in lower-bidding plans would not directly affect benchmarks.

- In most regions, the lower-bidding plans would be private plans, and higher enrollment in those plans would be accompanied by a lower market share for the FFS program, which would increase bids of private plans for reasons discussed above, all else being equal. Lower enrollment in private plans would have the opposite effect.

- For any given set of bids, CBO expects, greater enrollment in private plans would result in smaller federal savings because diagnostic coding by private insurers would be more intensive than that by FFS providers under a premium support system (as is now the case under the Medicare Advantage program) and federal payments to private plans would be adjusted to account for only part of that difference in coding. Again, lower enrollment in private plans would have the opposite effect.

Effects on Beneficiaries' Total Payments

CBO estimated a range of effects on beneficiaries' total payments by simultaneously varying all five key parameters in ways that would result in higher and lower payments under the premium support options. In CBO's assessment, the uncertainty of the estimated effects on beneficiaries' total payments is greater than that concerning the estimated effects on federal spending because there are especially broad ranges of plausible values for the two parameters that would affect beneficiaries' payments the most: their sensitivity to premiums and the percentage who would not initially choose a plan. Varying other parameters also affects the estimates.

If beneficiaries were more sensitive to premiums than CBO's central estimates indicate, more of them would enroll in lower-bidding plans, and their total payments would be lower, on average, than the central estimates indicate (because enrollees in low-bidding plans would pay lower premiums and use fewer medical services and therefore pay less out of pocket for services). The opposite also is true: If beneficiaries are less sensitive to premiums, fewer would enroll in lower-bidding plans, and their total payments would be higher, on average.

By the same logic, if the proportion of beneficiaries who did not choose a plan in the first year of a premium support system was larger than that indicated by the central estimates, their total payments would be lower, on average, than predicted (because

those who did not choose a plan would be assigned to one with a bid at or below the benchmark). And if the proportion of beneficiaries who did not choose a plan was smaller than in the central estimates, their total payments would be higher, on average.

Beneficiaries' payments under the premium support options also would depend on other factors that contribute to the uncertainty of CBO's estimates. Private plans' bids could differ from the agency's central estimates if the current-law bids for Medicare Advantage were higher or lower than they are in CBO's estimates, if private insurers reduced their bids under a premium support system by more or less than the amounts in those estimates, or if the adjustment to plans' provider payment rates (and thus their bids) reflected a decline in the FFS market share that was smaller or larger than that in the estimates. For example, if the bids of private plans were below the central estimates, then payments would be lower for enrollees in those plans (because of lower premiums and reduced cost sharing) and higher for those who enrolled in the FFS program (because the lower cost of private plans would reduce benchmarks and raise FFS premiums). As a result, beneficiaries would have a greater incentive to switch from the FFS program to private plans, and beneficiaries' total payments would be lower than CBO's central estimates would indicate (assuming that the number of beneficiaries enrolled in the FFS program was not so large that the increase in payments for those beneficiaries outweighed the reduction in payments for enrollees in private plans and the reduction in the standard premium for all beneficiaries as a result of the lower benchmarks). If private plans' bids were higher than predicted by the central estimates, beneficiaries' total payments would rise relative to the central estimates.

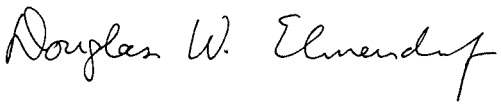
About This Document

This Congressional Budget Office (CBO) report was prepared in response to interest expressed by Members of Congress. In keeping with CBO's mandate to provide objective, impartial analysis, the report makes no recommendations.

Jessica Banthin, James Baumgardner, Tom Bradley, Melinda Buntin (formerly of CBO), Holly Harvey, Paul Jacobs, Jeffrey Kling, Paul Masi, Eamon Molloy, Lyle Nelson, Romain Parsad, and Andrew Stocking contributed to the analysis and prepared the report with guidance from Linda Bilheimer and Peter Fontaine. Additional assistance was provided by numerous analysts in CBO's Budget Analysis Division and in its Health, Retirement, and Long-Term Analysis Division.

Henry Aaron of the Brookings Institution, Joseph Antos of the American Enterprise Institute, Thomas Buchmueller of the University of Michigan, Michael Chernew of Harvard University, Mark Duggan of the University of Pennsylvania, Alain Enthoven of Stanford University, Roger Feldman of the University of Minnesota, Amy Finkelstein of the Massachusetts Institute of Technology, Paul Ginsburg of the Center for Studying Health System Change, Mark McClellan of the Brookings Institution, Mark Miller of the Medicare Payment Advisory Commission, Joseph Newhouse of Harvard University, Patricia Neuman of the Kaiser Family Foundation, and Robert Reischauer of the Urban Institute provided comments about CBO's analytical approach. (The assistance of external experts implies no responsibility for the final product, which rests solely with CBO.)

Kate Kelly edited the report, and Maureen Costantino and Jeanine Rees prepared it for publication. An electronic version is available on CBO's website (www.cbo.gov/publications/44581).



Douglas W. Elmendorf
Director

September 2013

Table 1. Return to Reference

Change in Net Federal Spending for Medicare Under Illustrative Premium Support Options, Relative to That Under Current Law, 2020

	Second-Lowest-Bid Option	Average-Bid Option
In Billions of Dollars[a]	-45	-15
As a Percentage of Net Federal Spending for Medicare	-6	-2
As a Percentage of Net Federal Spending for Parts A and B for Affected Beneficiaries[b]	-11	-4

Source: Congressional Budget Office.

Note: Although estimates of percentage changes are based on CBO's March 2012 baseline projections (which are the projections underlying the analysis in this report), the dollar savings are based on applying those percentages to CBO's most recent projections (see *Updated Budget Projections: Fiscal Years 2013 to 2023*, May 2013, www.cbo.gov/publication/44172).

a. Rounded to the nearest $5 billion.

b. Affected beneficiaries include everyone who would have enrolled in Medicare under current law, except dual-eligible beneficiaries (people who are simultaneously enrolled in Medicare and Medicaid). Spending for affected beneficiaries includes all spending for Part A (Hospital Insurance) and Part B (Medical Insurance) except spending that was excluded because it is not covered by the bids that Medicare Advantage plans submit under current law—namely, the additional payments to disproportionate-share hospitals (whose share of low-income patients exceeds a specified threshold) and spending for medical education, hospice benefits, and certain benefits for patients with end-stage renal disease. Spending for Part D prescription drug insurance is excluded.

Table 2. Return to Reference 1, 2, 3

Change in Net Federal Spending for Medicare and in Beneficiaries' Payments Under Illustrative Premium Support Options, Relative to Amounts Under Current Law, 2020

(Percent)

	Second-Lowest-Bid Option	Average-Bid Option
Net Federal Spending for Parts A and B for Affected Beneficiaries[a]		
Central Estimate	-11	-4
Range	-9 to -14	-1 to -7
Total Payments by Affected Beneficiaries[b]		
Central Estimate	11	-6
Range	-2 to 24	0 to -12
Net Federal Spending for Parts A and B for Affected Beneficiaries Plus Total Payments by Affected Beneficiaries[a,b,c]		
Central Estimate	-5	-4
Memorandum:		
Premiums Paid by Affected Beneficiaries[c,d]		
Central Estimate	31	-6

Source: Congressional Budget Office.

Note: Affected beneficiaries include everyone who would have enrolled in Medicare under current law, except dual-eligible beneficiaries (people who are simultaneously enrolled in Medicare and Medicaid).

a. The reported range for the second-lowest-bid option is not symmetric around the central estimate because of rounding. Spending for affected beneficiaries includes all spending for Part A (Hospital Insurance) and Part B (Medical Insurance) except spending that was excluded because it is not covered by the bids that Medicare Advantage plans submit under current law—namely, the additional payments to disproportionate-share hospitals (whose share of low-income patients exceeds a specified threshold) and spending for medical education, hospice benefits, and certain benefits for patients with end-stage renal disease. Spending for Part D prescription drug insurance is excluded.

b. Payments include premiums and out-of-pocket costs for deductibles, copayments, and coinsurance for services and supplies covered by Part A and Part B. Payments include the standard Part B premium and the income-related premium (applicable for beneficiaries whose income exceeds specified threholds) but exclude any additional amounts paid for enhanced benefits or supplemental (medigap) coverage.

c. Range has not yet been estimated.

d. Under current law and under the options, premiums are for the basic package of Medicare benefits covered under Parts A and B. They exclude any additional amounts paid for enhanced benefits or supplemental (medigap) coverage and any amounts paid for the income-related premium.

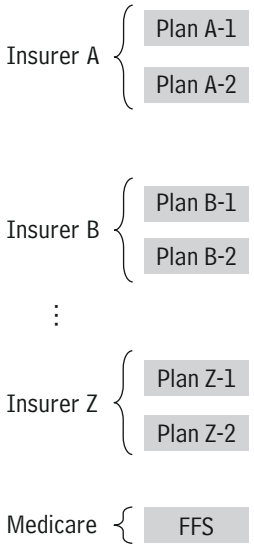
Figure 1. Return to Reference

Key Operations Under the Illustrative Second-Lowest-Bid Option for Premium Support

Operation in each region: The federal government divides the country into regions that reflect health care markets within states. Any insurer that submits a bid for a region would be required to serve the entire region.

Bidding

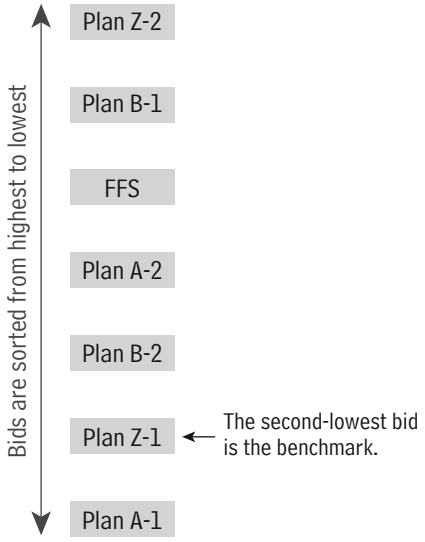
Insurers submit bids for up to two basic plans per region indicating the amount they are willing to accept to provide a package of benefits to a beneficiary in average health. All plans cover the same percentage of total expenses that Medicare's FFS program provides under current law.



The FFS program is a competing plan with a bid equal to the projected cost of care for a beneficiary of average health within the region.

Benchmark

In this option, the benchmark is the lower of the region's second-lowest bid from a private plan and the bid from the FFS program. The other option has the benchmark set as the average bid, weighted by enrollment in the previous year.



Continued

Figure 1. **Continued**

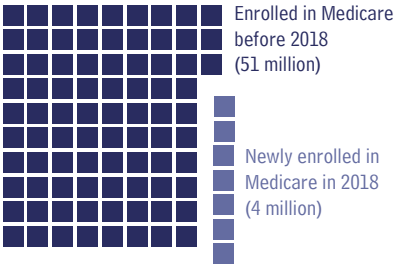
Key Operations Under the Illustrative Second-Lowest-Bid Option for Premium Support

Participation

Dual-eligible beneficiaries (who enroll in Medicare and Medicaid simultaneously) are excluded.

Anyone else enrolled in Medicare when the program takes effect enters the new system.

Number of Eligible Beneficiaries



People who become eligible after 2018 (except dual-eligible beneficiaries) enter the new system when they become eligible.

Plan Selection and Premiums

Beneficiaries either select a plan or are assigned to a plan with a bid at or below the benchmark.

For all beneficiaries:
beneficiary's premium =
standard premium + plan's bid − benchmark

Plan	Premium
Plan Z-2	Standard + $$$
Plan B-1	Standard + $$
FFS	Standard + $$
Plan A-2	Standard + $
Plan B-2	Standard + $
Plan Z-1	Standard ← The second-lowest bid is the benchmark.
Plan A-1	Standard − $

The standard premium is calculated as 25 percent of the national average of the cost per beneficiary for services and supplies covered by Part B.

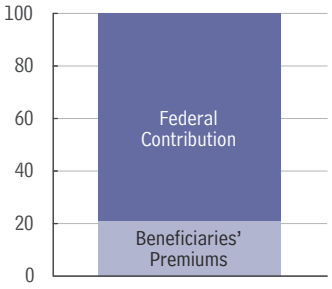
Federal Contribution

The government pays most of the cost of insurance for covered Part A and Part B benefits.

For a beneficiary in average health:
federal contribution =
benchmark − standard premium

The payment to each plan is adjusted up or down for beneficiaries in worse or better health than average.

Share of Contribution to Total Cost of Insurance



For all plans:
total payments received for a beneficiary in average health = bid

Source: Congressional Budget Office.

Note: FFS = fee-for-service.

Box 1. Return to Reference 1, 2

The Medicare Program

In 2013, Medicare will provide federal health insurance for 52 million people who are elderly (age 65 or older) or disabled or who have end-stage renal disease. Of that group, about 85 percent are elderly. Medicare's Part A (Hospital Insurance) primarily covers inpatient hospital, skilled nursing facility, and hospice care. Part B (Medical Insurance) mainly covers services provided by physicians and other practitioners and by hospital outpatient departments. Home health care may be covered by Part A or by Part B. Medicare's Part D is the prescription drug program. Nearly 30 percent of Medicare beneficiaries receive care through the Medicare Advantage program, or Part C, in which private health insurers assume responsibility for, and the financial risk of, providing Medicare benefits. Almost all of the remaining beneficiaries receive care in the traditional fee-for-service (FFS) program. In 2012, gross spending for Medicare was $557 billion. Net of offsetting receipts (mostly premiums paid by beneficiaries), federal spending for the program was $472 billion.

Medicare's Financing

The various parts of Medicare are financed in different ways. Part A is financed primarily by a payroll tax. Beneficiaries' premiums (including income-related adjustments paid by higher-income beneficiaries) cover just over one-quarter of the outlays for Part B, and general funds from the U.S. Treasury cover nearly all of the rest. The government's payments to Medicare Advantage plans are financed by funds from Parts A and B. For Part D, enrollees' premiums cover about one-quarter of the cost of the basic prescription drug benefit, the federal government receives payments from states for dual-eligible beneficiaries (who are enrolled simultaneously in Medicare and Medicaid), and general funds cover most of the remaining cost. In fiscal year 2012, payroll taxes financed about 37 percent of Medicare outlays, beneficiaries' premiums covered about 13 percent, and most of the rest came from general funds of the Treasury.

Medicare's Traditional Fee-for-Service Program

Enrollees in the traditional FFS program are covered for services delivered by any participating provider, and both the package of benefits and the rates paid to providers are set by law. Medicare beneficiaries share those costs through deductibles and coinsurance, but because cost-sharing liabilities can be substantial (in part because traditional Medicare does not include an annual cap on what beneficiaries spend), about 90 percent of beneficiaries in the FFS program have supplemental insurance that covers most or all of their cost sharing, often through retiree plans offered by former employers or through individual insurance policies (known as medigap plans) or Medicaid.

Medicare Advantage

In most places in the United States, Medicare beneficiaries may choose among competing private insurers—through the Medicare Advantage program—instead of the traditional FFS program. Participating insurance companies submit bids indicating the per capita payment they are willing to accept for providing Part A and B benefits to a beneficiary of average health. (A separate bidding process determines payments for Part D.) The federal payment per enrollee then depends on what the insurance company bids and on how that amount compares with a "benchmark" that is announced by the federal government before those bids are submitted. Under a system set to be fully phased in by 2017, benchmarks will be based on per capita spending in the FFS program at the county level, and they will range from 95 percent of FFS spending per capita in the one-quarter of counties where such spending is highest to 115 percent of FFS spending per capita in the one-quarter of counties where such spending is lowest. Plans with quality ratings above a specified threshold will have bonus amounts added to their benchmarks.

Plans that submit a bid below the benchmark for a service area receive federal payments that equal their bid plus a rebate that is a percentage of the difference between the bid and the benchmark. (Beginning in 2014, the rebate will range from 50 percent to 70 percent, depending on the plan's performance on certain quality measures.) Plans must return the rebate to enrollees in the form of reduced cost sharing for benefits, coverage for items not covered by Medicare, or reduced Part B or Part D premiums. Plans with a bid that equals or exceeds the benchmark receive federal payments that equal the benchmark and must charge enrollees a premium for their Medicare coverage equal to the amount by which their bid exceeds the benchmark. Plans' payments from Medicare are larger or smaller, respectively, for enrollees who are in worse- or better-than-average health.

Table 3. Return to Reference

Examples of Determining Premiums Under Illustrative Premium Support Options, Using Hypothetical Bids and Enrollment

	Region With High Fee-for-Service Spending			Region With Low Fee-for-Service Spending		
	Bid	Annual Premium	Proportion Enrolled	Bid	Annual Premium	Proportion Enrolled
			Second-Lowest-Bid Option			
Fee-for-Service Program	14,000	4,300	0.25	9,900	1,900	0.75
Private Plans						
A	11,800	2,100	0.15	10,100	2,100	0.05
B	11,600	1,900	0.15	9,900	1,900	0.05
C	11,400	1,700	0.15	9,700	1,700	0.05
D	11,200	1,500	0.15	9,500	1,500	0.05
E	11,000	1,300	0.15	9,300	1,300	0.05
Benchmark	11,200	n.a.	n.a.	9,500	n.a.	n.a.
Standard Premium	n.a.	1,500	n.a.	n.a.	1,500	n.a.
			Average-Bid Option			
Fee-for-Service Program	14,000	3,300	0.25	9,900	1,500	0.75
Private Plans						
A	12,000	1,300	0.15	10,300	1,900	0.05
B	11,800	1,100	0.15	10,100	1,700	0.05
C	11,600	900	0.15	9,900	1,500	0.05
D	11,400	700	0.15	9,700	1,300	0.05
E	11,200	500	0.15	9,500	1,100	0.05
Benchmark	12,200	n.a.	n.a.	9,900	n.a.	n.a.
Standard Premium	n.a.	1,500	n.a.	n.a.	1,500	n.a.
Enrollment-Weighted Average	12,200	1,500	n.a.	9,900	1,500	n.a.

Source: Congressional Budget Office.

Notes: Under the second-lowest-bid option, the benchmark would equal the lower of the second-lowest bid from a private plan and the bid of the fee-for-service program. Under the average-bid option, the benchmark would equal the enrollment-weighted-average bid among all plans, including the fee-for-service program.

Proportion enrolled is for the previous year. Equal proportions among private plans are used to simplify the example. (According to CBO's estimates, enrollment would be higher in low-bidding plans.)

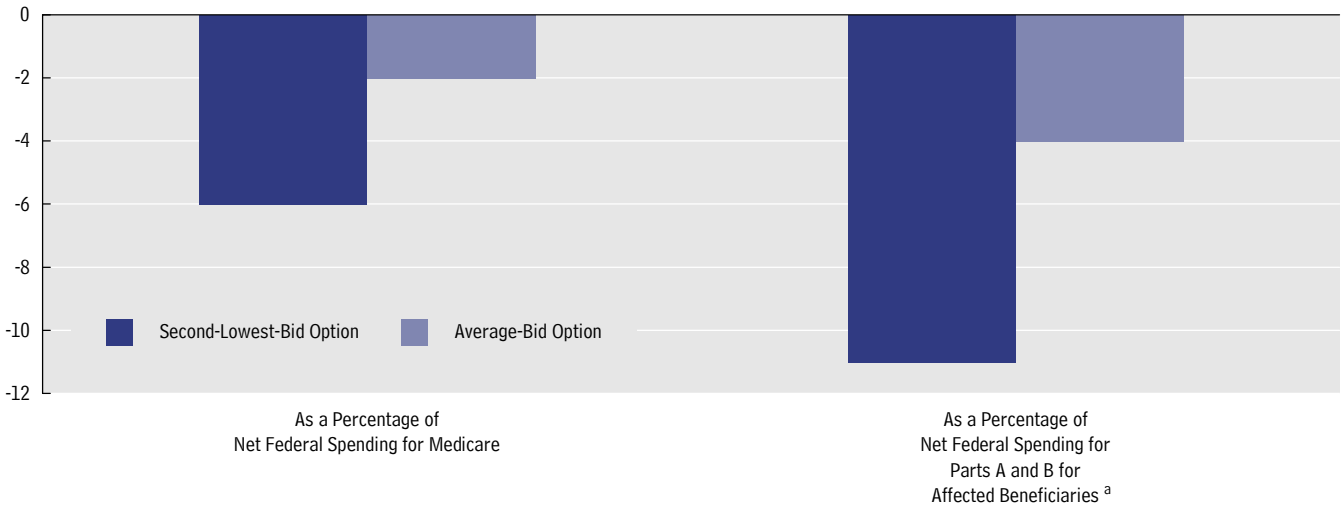
Under both options, premiums would equal the standard premium plus the bid minus the benchmark, and federal contributions for a beneficiary of average health would equal the benchmark minus the standard premium. Those federal contributions would be $9,700 and $8,000 under the second-lowest-bid option in regions with high and low fee-for-service spending, respectively, and $10,700 and $8,400 under the average-bid option in such regions, respectively.

n.a. = not applicable.

Figure 2. Return to Reference

Change in Net Federal Spending for Medicare Under Illustrative Premium Support Options, Relative to That Under Current Law, 2020

(Percent)



Source: Congressional Budget Office.

Note: The second-lowest-bid option would reduce net federal spending for Medicare by about $45 billion in 2020, and the average-bid option would reduce such spending in that year by about $15 billion. Although estimates of percentage changes are based on CBO's March 2012 baseline projections (which are the projections underlying the analysis in this report), the dollar savings are based on applying those percentages to CBO's most recent projections (see *Updated Budget Projections: Fiscal Years 2013 to 2023*, May 2013, www.cbo.gov/publication/44172).

a. Affected beneficiaries include everyone who would have enrolled in Medicare under current law, except dual-eligible beneficiaries (people who are simultaneously enrolled in Medicare and Medicaid). Spending for affected beneficiaries includes all spending for Part A (Hospital Insurance) and Part B (Medical Insurance) except spending that was excluded because it is not covered by the bids that Medicare Advantage plans submit under current law—namely, the additional payments to disproportionate-share hospitals (whose share of low-income patients exceeds a specified threshold) and spending for medical education, hospice benefits, and certain benefits for patients with end-stage renal disease. Spending for Part D prescription drug insurance is excluded.

Table 4. Return to Reference

Average Annual Premiums Charged by Plans for Medicare Part A and B Benefits Under Illustrative Premium Support Options, Weighted by Population, 2020

	Second-Lowest-Bid Option		Average-Bid Option	
	Annual Premium (Dollars)	Change From Part B Premium Under Current Law (Percent)	Annual Premium (Dollars)	Change From Part B Premium Under Current Law (Percent)
Second-Lowest-Bidding Private Plan	1,500	-6	900	-44
Median-Bidding Private Plan	1,800	13	1,200	-25
Fee-for-Service Program	3,100	94	2,400	50

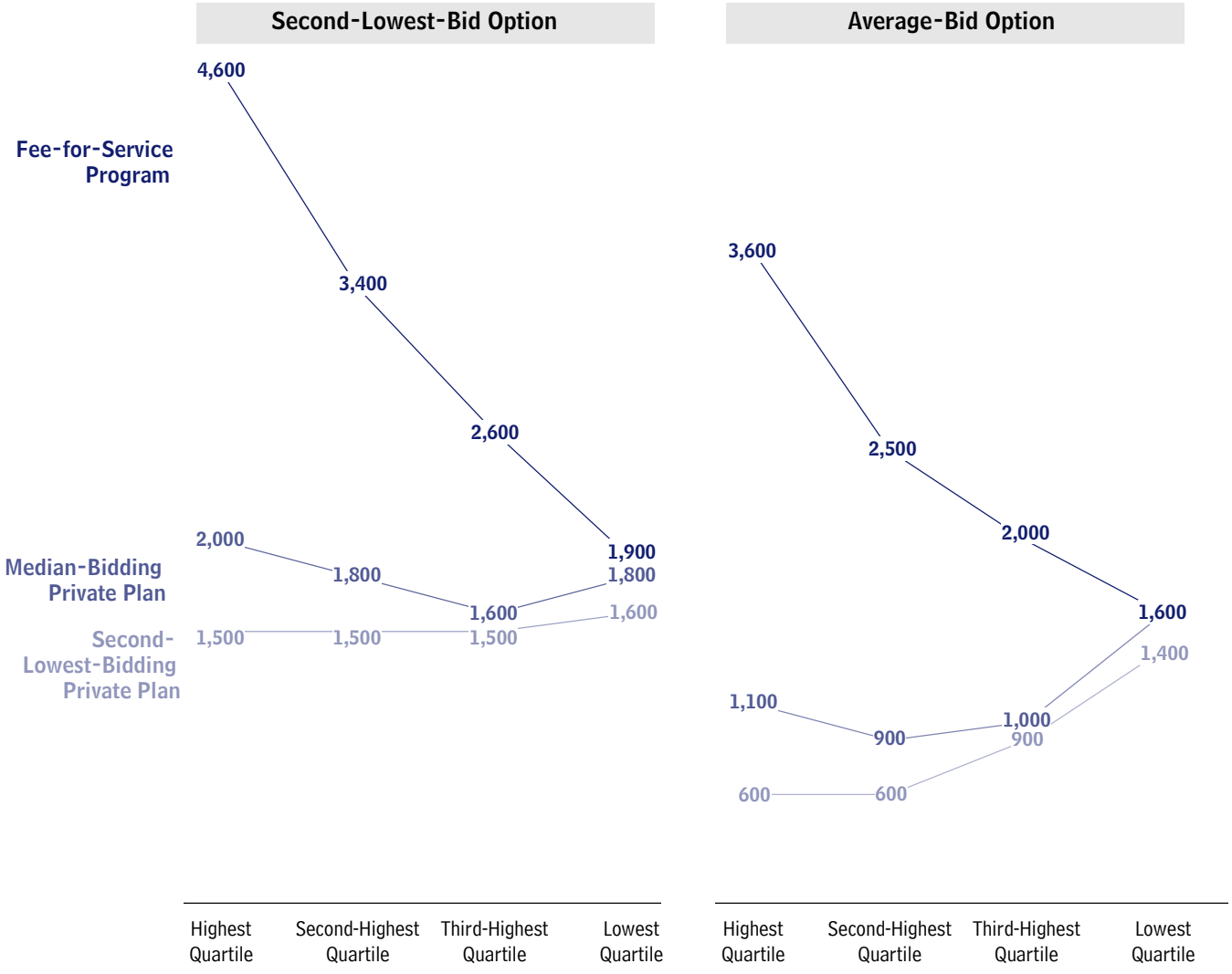
Source: Congressional Budget Office.

Note: Premiums charged by plans are averages weighted by the Medicare population in each region. (Those averages differ from the average premiums paid by beneficiaries, which are based on CBO's projections of enrollment in plans.) Under current law and under the options, premiums are for the basic package of Medicare benefits covered under Part A (Hospital Insurance) and Part B (Medical Insurance). They exclude any additional amounts paid for enhanced benefits or supplemental (medigap) coverage and any amounts paid for the income-related premium (applicable for beneficiaries whose income exceeds specified threholds). Under current law, for most beneficiaries, Part A will have no premium and the premium for Part B (excluding income-related adjustments) will be $1,600 in 2020, CBO projects. Amounts are rounded to the nearest $100.

Figure 3. Return to Reference

Average Annual Premiums Charged by Plans for Medicare Part A and B Benefits Under Illustrative Premium Support Options, by Fee-for-Service Spending in a Region, Weighted by Population, 2020

(Dollars)



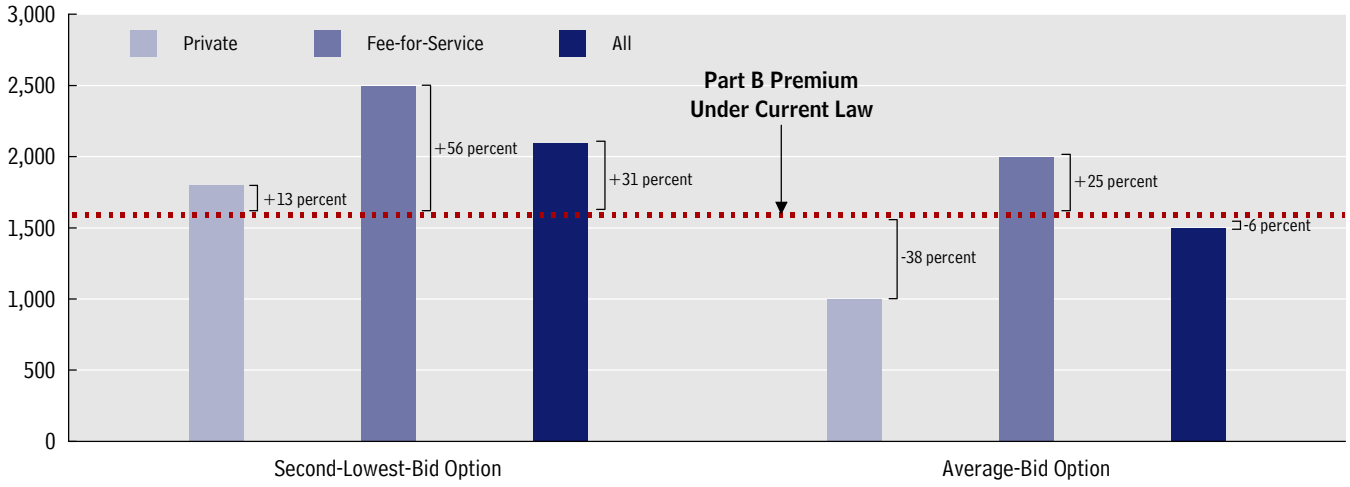
Source: Congressional Budget Office.

Note: Premiums charged by plans are averages weighted by the Medicare population in each region. (Those averages differ from the average premiums paid by beneficiaries, which are based on CBO's projections of enrollment in plans.) Under current law and under the options, premiums are for the basic package of Medicare benefits covered under Part A (Hospital Insurance) and Part B (Medical Insurance). They exclude any additional amounts paid for enhanced benefits or supplemental (medigap) coverage and any amounts paid for the income-related premium (applicable for beneficiaries whose income exceeds specified thresholds). Under current law, for most beneficiaries, Part A will have no premium and the premium for Part B (excluding income-related adjustments) will be $1,600 in 2020, CBO projects. Amounts are rounded to the nearest $100. Quartiles are groups of regions classified by per capita fee-for-service spending; each contains a quarter of the Medicare population.

Figure 4. Return to Reference

Average Annual Premiums Paid by Beneficiaries for Medicare Part A and B Benefits Under Illustrative Premium Support Options, by Type of Plan, Weighted by Enrollment, 2020

(Dollars)



Source: Congressional Budget Office.

Note: Premiums paid are averages weighted by CBO's projections of enrollment in plans. Under current law and under the options, premiums are for the basic package of Medicare benefits covered under Part A (Hospital Insurance) and Part B (Medical Insurance). They exclude any additional amounts paid for enhanced benefits or supplemental (medigap) coverage and any amounts paid for the income-related premium (applicable for beneficiaries whose income exceeds specified thresholds). Under current law, for most beneficiaries, Part A will have no premium and the premium for Part B (excluding income-related adjustments) will be $1,600 in 2020, CBO projects. Amounts are rounded to the nearest $100. Percentage differences are reported relative to the Part B premium under the current law.

Box 2. Return to Reference

Grandfathering of Beneficiaries Under a Premium Support System

Under one type of proposal for a premium support system, current beneficiaries and those who became eligible for Medicare before the new system took effect would continue to receive coverage under the existing Medicare program; only those beneficiaries who became newly eligible on or after a specified date would enroll in the premium support system. Such an arrangement would require the federal government to address several important design questions—some are unique to such a system and others are relevant for any premium support system but have added significance if grandfathering is part of the design. Although policymakers might also consider changing the existing Medicare program if it remained in operation, this discussion focuses on design issues specifically related to a grandfathering provision in a premium support system, and it assumes that beneficiaries who remained in the existing system could choose Medicare's fee-for-service (FFS) program or a Medicare Advantage plan and that private insurers could participate in the premium support system, the Medicare Advantage program, or both.

Enrollment in Part B

An important question for any premium support system is whether enrollment in Medicare's Part B (Medical Insurance) would remain voluntary, and if so, how beneficiaries who declined that coverage would be treated by the system. About 8 percent of Medicare beneficiaries are not enrolled in Part B currently, generally because either they or a spouse are still working and have employment-based coverage as primary insurance with Medicare as a secondary insurer.

Among the Medicare population age 65 or older, younger beneficiaries are more likely to decline Part B coverage, and the percentage that does so has increased as more people have stayed in the workforce past age 65. (The late-enrollment penalty for Part B is waived for active workers in larger companies that offer employment-based coverage. If such workers were to enroll, Medicare would be a secondary payer for their health care costs, which would reduce the value of the coverage.) Some 19 percent of 65-year-old Medicare beneficiaries were not enrolled in Part B in 2011, up from 15 percent in 1999. If a premium support program included grandfathering, the question of whether Part B enrollment would remain voluntary would be especially important because the younger segment of the retirement-age population would constitute a substantial fraction of the beneficiaries covered in the first few years.

Bidding Regions

Depending on how the regions were defined, in many regions the number of beneficiaries in a premium support system with a grandfathering provision could initially be very small. If dual-eligible beneficiaries also were excluded from the new system, the Congressional Budget Office (CBO) projects, just 5 percent of the

Medicare population would be covered by the system after the first year, and only 25 percent would be covered after the fifth year.

Some proposals would have bidding regions correspond to health care markets within states. In that case, grandfathering would result in some regions' enrolling very small numbers of people in the new system in the first few years. Because personal health care expenditures vary widely, the actual costs of enrollees in private plans and the FFS program could differ greatly from those plans' bids for their regions. That uncertainty could make participation less attractive to private insurers, cause them to raise their bids if they chose to participate, and create significant year-to-year variation in the amounts of the bids. In regions with few beneficiaries, private insurers also would have less incentive to modify health care plans to contain costs.

Bids and Risk Adjustment

Under the illustrative premium support options analyzed for this report, insurers would submit a bid for a beneficiary with average expected health care costs (that is, a beneficiary with a risk score of 1.0), and federal payments to insurers would be adjusted to account for differences between their enrollees' expected costs and those of the average beneficiary. CBO assumed that the risk adjustment would be comparable to that for the Medicare Advantage program, in which federal payments to insurers are adjusted on the basis of enrollees' medical conditions and demographic characteristics.

In the initial years of a system with grandfathering, a substantial proportion of covered beneficiaries would not have the history of past Medicare claims data necessary to compute a risk score. For those beneficiaries, payments to plans could be adjusted using a version of the risk adjuster based entirely on demographic characteristics. That approach lacks the completeness of the standard risk adjuster, which includes information on medical conditions, so pursuing it would raise questions about the adequacy of risk adjustment in the first few years.

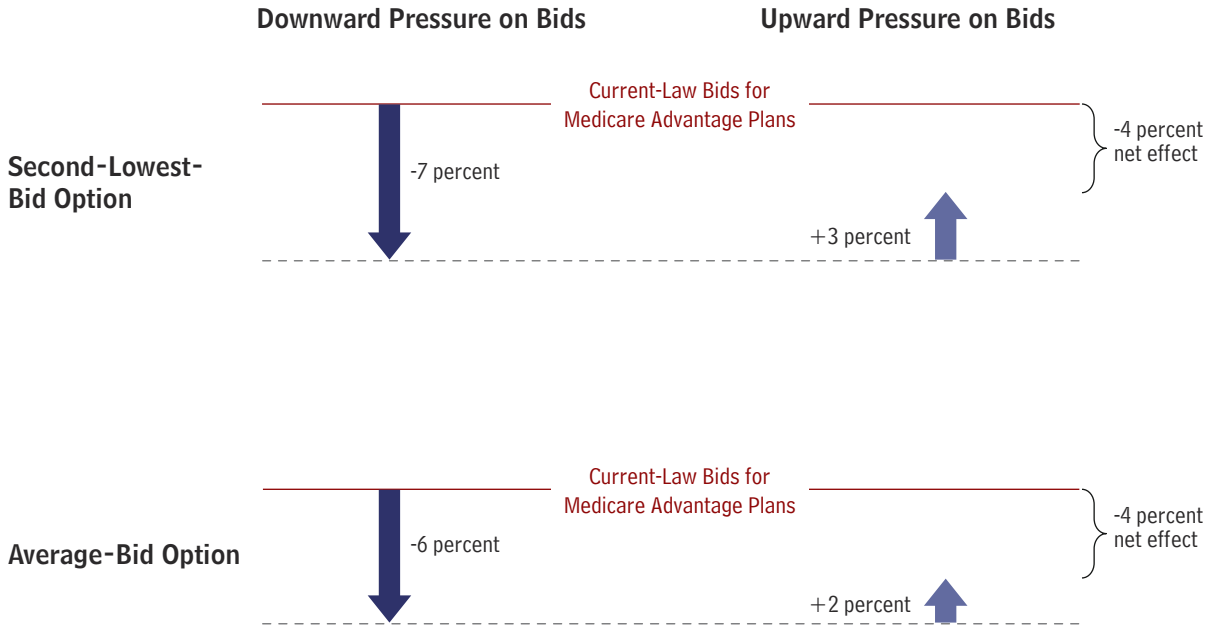
Under a grandfathering provision, the bidding and risk adjustment mechanism could reflect average expected costs for a beneficiary in the premium support system. That approach would necessitate "rescaling" the risk adjustment factors to correspond to the segment of the Medicare population enrolled in the premium support system or reestimating those factors (because particular risks are associated with costs in ways that would differ between that segment and the Medicare population as a whole). If the existing risk adjustment mechanism was used instead, insurers would base their bids on a population that differed from the population served under the premium support system. An analogous set of issues would confront the Medicare Advantage program. Once the premium support system began, the proportion of beneficiaries eligible to enroll in a Medicare Advantage plan would decline each year as new people entered the premium support system.

Beneficiaries' Premiums

For both illustrative options, CBO assumed that beneficiaries who enrolled in a plan with a bid equal to the benchmark would pay a standard premium determined using the same formula used to calculate the Part B premium under current law. With grandfathering, that premium could be determined in various ways. One approach would be to compute a single standard premium for the entire Medicare population that would apply both to beneficiaries in the premium support system and to those who were grandfathered into Medicare in its current-law form. In a second approach, separate computations could be made for a standard premium under the premium support system and for the Part B premium that would apply to the grandfathered population; a standard premium could be computed as one amount, or standard premiums could differ by beneficiaries' age. Each approach would involve a different distribution of health care costs and of potential savings from a premium support system among age groups.

Figure A-1. Return to Reference

Factors That Would Affect Bids Under Illustrative Premium Support Options, Relative to Current-Law Bids for Medicare Advantage Plans, 2020



Increased Competition

Medicare beneficiaries would face premiums reflecting the full difference in plans' bids, which is a stronger incentive to choose a low-bidding plan than under Medicare Advantage. Beneficiaries who did not make an active enrollment choice would be assigned to a low-bidding plan.

Favorable Selection

The enrollees in private plans would be healthier on average than enrollees in the FFS program (even after the adjustment to federal payments to account for the health status of enrollees), and that difference would be greater under the premium support options than under the Medicare Advantage program.

Reducing the Importance of FFS Rates

A reduction in the share of beneficiaries enrolled in the FFS program would tend to reduce the importance of rates from that program in determining how much private insurers would pay providers to treat Medicare enrollees.

Broader Provider Networks

Increased enrollment in private plans, and in lower-bidding private plans in particular, would require some insurers to expand their provider networks and, in so doing, to pay higher rates or contract with providers who have higher-cost practice styles.

Source: Congressional Budget Office.

Note: CBO assumed covered services under current law and under the illustrative premium support options would be the same. CBO used its projection of current-law bids for Medicare Advantage's private plans as a starting point and excluded three types of Medicare Advantage plans that are likely to differ substantially from plans that would be offered under a premium support system: private FFS plans, special needs plans, and employment-based group plans.

FFS = fee-for-service.