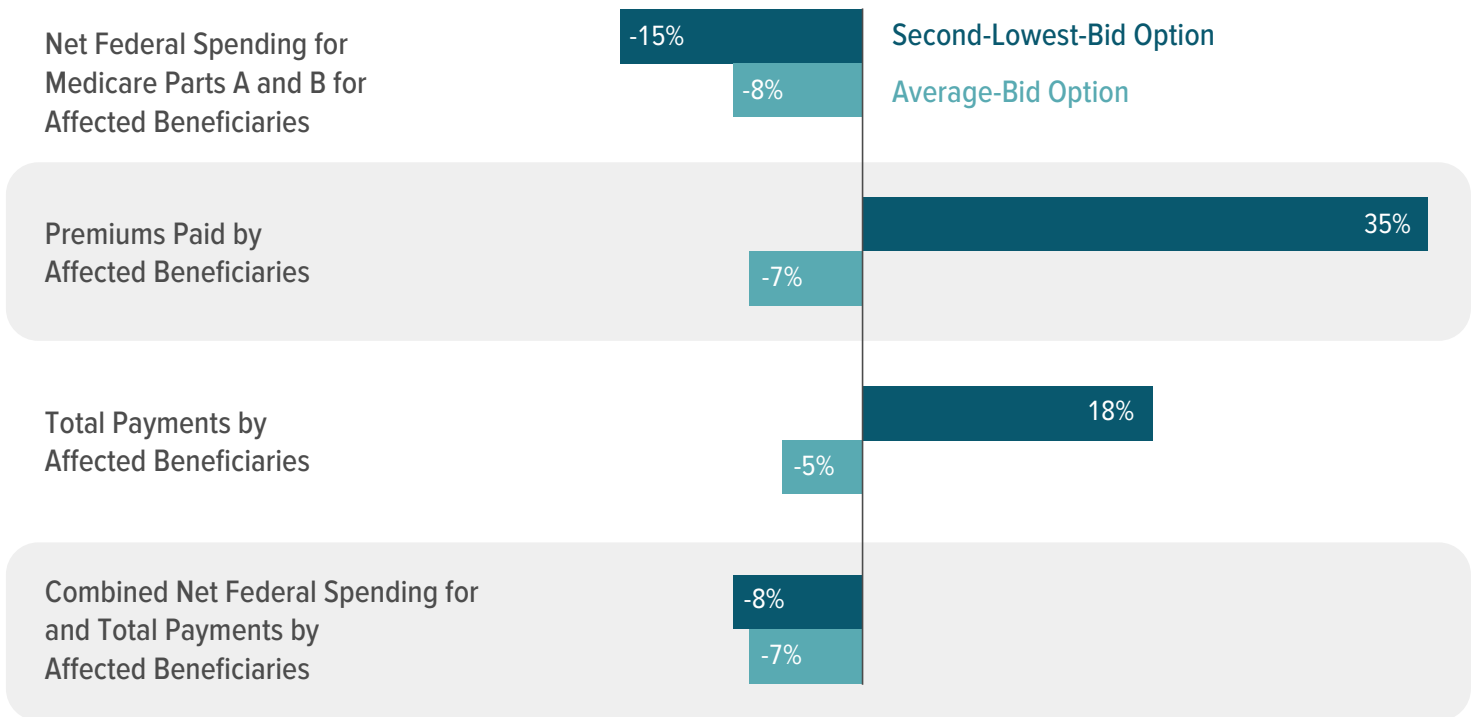


CBO

A Premium Support System for Medicare: Updated Analysis of Illustrative Options



Estimated Difference From Outcomes Under Current Law, Without Grandfathering, in 2024

OCTOBER 2017

Notes

All years referred to in this report are calendar years. The estimates were generated using the Congressional Budget Office's March 2016 baseline projections of Medicare spending.

The amounts in the text and tables are in nominal (current year) dollars. Numbers in the text, tables, and figures may not equal totals because of rounding.

Supplemental information accompanies this report on CBO's website (www.cbo.gov/publication/53077).



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A Premium Support System for Medicare: Updated Analysis of Illustrative Options

Summary

Over the past two decades, policymakers and analysts have advanced a variety of proposals for converting Medicare to a premium support system as a way to reduce federal spending. Under such a system, beneficiaries would choose health insurance from a list of competing plans, and the federal government would share the cost of their premiums. The proposals have differed in many respects, notably in the way that the federal contribution would be set and how that contribution might change over time.

The Congressional Budget Office has in the past analyzed the budgetary effects of some illustrative options for a premium support system.¹ This report updates the agency's work on the topic, presents new estimates of the budgetary effects of those options, and examines the reasons for the changes in the estimates, including changes in law that have affected the Medicare program. CBO constructed its estimates for this report under the assumption that the system would be implemented in 2022. Depending on their details, future cost estimates for legislative proposals that resemble the options analyzed in this report could differ substantially from the estimates presented here.

In the options CBO analyzed, the federal government's contribution would be determined from insurers' bids, and Medicare's traditional fee-for-service (FFS) program would be included as a competing plan. CBO examined two approaches for determining the federal contribution: One would set the contribution on the basis of the second-lowest bid in each region; the other would use the region's average bid. CBO also examined the effects of grandfathering, which would keep beneficiaries in the current Medicare program if they were eligible for Medicare before the premium support system took

effect instead of requiring all beneficiaries to enter the premium support system once it began.

What Are CBO's New Estimates?

CBO's new estimates indicate the following:

- Without grandfathering, the second-lowest-bid option would reduce net federal spending for Medicare by \$419 billion between 2022 and 2026; the average-bid option would reduce such spending by \$184 billion.
- With grandfathering, the second-lowest-bid option would reduce net federal spending for Medicare by \$50 billion between 2022 and 2026; the average-bid option would reduce such spending by \$21 billion.

Those savings would arise because private insurers' bids would generally be lower than FFS costs per capita and would substantially influence the federal contribution. Savings would be much smaller if the options included a grandfathering provision because only a small portion of the Medicare population would be covered by the new system initially, and that portion would increase gradually.

On average, CBO estimates, beneficiaries' total payments for Medicare premiums and cost sharing (enrollees' out-of-pocket spending on copayments, coinsurance, and deductibles for Medicare-covered benefits) would be higher under the second-lowest-bid option, but lower under the average-bid option, than under current law. Under either option, the total payments made by particular beneficiaries could differ markedly from the national average. For example, in many regions, total payments by beneficiaries who chose to enroll in Medicare's FFS program would be substantially higher than under current law because of the increases in beneficiaries' premiums.

1. See Congressional Budget Office, *Options for Reducing the Deficit: 2014 to 2023* (November 2013), pp. 204–210, www.cbo.gov/content/options-reducing-deficit-2014-2023, and *A Premium Support System for Medicare: Analysis of Illustrative Options* (September 2013), www.cbo.gov/publication/44581.

How Much Did CBO's Estimates Change and Why?

CBO's current estimates of the federal savings from the premium support options without grandfathering are much higher than its earlier estimates. In a November

2013 report, CBO estimated that if a premium support system was implemented without grandfathering, the second-lowest-bid option would reduce net federal spending for Medicare by \$275 billion between 2018 and 2023 and the average-bid option would reduce net federal spending over that period by \$69 billion.²

CBO's savings estimates increased primarily because the agency's current projections of the bids that Medicare Advantage plans would submit under current law are lower relative to FFS spending per capita than the projections used in its earlier analysis. Medicare Advantage plans submit bids to Medicare for the amount that it would cost to provide enrollees with Medicare benefits covered under the Hospital Insurance (Part A) and Medical Insurance (Part B) programs. Medicare pays plans based on those bids, and then Medicare Advantage plans assume responsibility for paying providers for beneficiaries' care. (In contrast, Medicare's FFS program pays providers directly for services covered under Parts A and B.) CBO used its projections of the bids Medicare Advantage plans submit under the current program to estimate the bids of private insurers under the premium support options. The lower current projections of Medicare Advantage bids suggest that those insurers' bids would be lower than CBO had previously anticipated. Other factors also affected CBO's budgetary estimates, but with smaller net effects.

CBO lowered its projections of Medicare Advantage bids relative to FFS spending per capita for two reasons. First, Medicare Advantage bids have declined relative to FFS spending in recent years. Second, legislation affecting updates to Medicare's FFS physician payment rates caused CBO to revise its projections of how much Medicare Advantage bids will change relative to FFS spending.

What Is the Current Role of Private Plans in Medicare?

In 2016, about 30 percent of Medicare's 57 million beneficiaries were enrolled in Medicare Advantage plans. Almost all other beneficiaries were enrolled in Medicare's FFS program. Insurers who wish to participate in Medicare Advantage submit bids to the government

indicating the per capita payment they will accept for providing benefits to enrollees under Medicare Parts A and B. The resulting federal payments depend in part on the insurers' bids and on how those bids compare with county-level benchmarks, which range from 95 percent to 115 percent of local spending per capita in Medicare's FFS program. Federal payments to insurers are adjusted to account for the health status of their enrollees, and plans receive bonus payments if they earn high ratings for quality of care. (Private insurers also participate in a separate bidding process that determines payments under Medicare Part D, the prescription drug program.)

What Policy Options Did CBO Analyze?

In the current analysis, CBO examined two sets of illustrative options for converting Medicare to a premium support system. For each, the federal government's contribution would be determined from insurers' bids, including the "bid" of the Medicare FFS program, which would be a competing plan. The nation would be divided into regions within which competing private insurers would submit bids indicating the amount they would accept to provide Medicare benefits to a beneficiary in average health.³ Similarly, Medicare's FFS bid in each region would be based on the projected cost of providing benefits in Medicare FFS to an enrollee in average health.

Insurers would submit bids for a benefit package that covered the same services as Parts A and B of Medicare (with a few exceptions, noted below) at the same actuarial value as Parts A and B combined. (That is, each policy would cover the same benefits and percentage of total expenses for a given population that would be covered under current law by Medicare's FFS program.) As under current law, Medicare Part D would be administered separately.

The options CBO examined differ from each other along two dimensions: the approach used to determine the federal contribution, and whether the option included a grandfathering provision so that beneficiaries who became eligible for Medicare before the premium support system took effect would remain in the current

2. For that estimate, CBO assumed implementation in 2018, four years earlier than the current estimate. See Congressional Budget Office, *Options for Reducing the Deficit: 2014 to 2023* (November 2013), pp. 204–210, www.cbo.gov/content/options-reducing-deficit-2014-2023.

3. Throughout this report, the term *bid* refers to the standardized bid for a beneficiary in average health. As under current law, federal payments to plans would be adjusted to account for differences in their enrollees' health.

Medicare system rather than enter the new system. Other program features would be the same.

The Federal Contribution

CBO analyzed two approaches to determining the benchmarks for setting the federal contribution:

- A second-lowest-bid approach would set the regional benchmark at the lower of a pair of bids: either Medicare's FFS bid or the second-lowest bid submitted by a private insurer.
- An average-bid approach would set the regional benchmark at the weighted average of all bids, including the FFS bid, with weights equal to the proportion of beneficiaries enrolled in that plan in the preceding year.

For each enrollee, the federal government would pay insurers an amount equal to the benchmark for the region minus the standard premium paid by enrollees (discussed below). Insurers would receive larger or smaller payments for beneficiaries whose health was worse or better than average. Neither the amount nor the growth rate of the federal payment would be capped.

Beneficiaries who enrolled in a plan with a bid that equaled the benchmark would pay a standard premium directly to the insurer. That premium would be the same everywhere and would be set to cover approximately one-fourth of the total cost, excluding cost sharing, for services covered in Part B (physicians' services, hospital outpatient care, durable medical equipment, and other services, including some home health care)—a formula that is similar to that under current law for Part B premiums. Beneficiaries who chose a plan with a bid above the benchmark would pay the insurer the standard premium plus the difference between the bid and the benchmark. Those who chose a plan with a bid below the benchmark would pay the standard premium minus the difference between the benchmark and the bid. Income-related Part B premiums for higher-income beneficiaries would continue as under current law.

Grandfathering

For each approach to determining the benchmark, CBO analyzed options with and without grandfathering. (Grandfathering would keep current beneficiaries from having to adjust to a new system.) Under grandfathering, only a small portion of the Medicare population would

participate in the premium support system initially, but that portion would increase gradually over the long term.

Other Features

The other features of a premium support system were common to all options. Some 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 variations are possible, and none of the options presented in this report should be considered a recommendation by CBO.

Under each option, beneficiaries would choose a plan when they first entered the premium support system. Beneficiaries who did not select a plan at that time would be assigned (with equal probability) to a plan that had submitted a bid at or below the regional benchmark, including the FFS program if it met that criterion. Beneficiaries would remain in the plan they chose (or were assigned to) in subsequent years, unless they chose a different plan during an annual enrollment period.

To clarify the choices for beneficiaries (and thereby heighten competition based on differences in premiums), private insurers would be allowed to submit bids for the basic Medicare package for just one or two plans in each region. If they chose to submit bids for two plans, each could have different features—offering a larger or smaller provider network, for example—but both would need to have the same actuarial value. Insurers also could offer a package of enhanced benefits (with a single, fixed, higher actuarial value that would be the same for all insurers) to accompany each basic package offered. Enrollees would pay the full additional cost of the enhanced packages through higher premiums.

CBO assumed that there would be no changes to the current FFS program, either in the mechanisms for setting the rates paid to providers or in the tools available to contain costs. As under current law, beneficiaries who remained in the FFS program could purchase supplemental coverage (known as medigap coverage) from private insurers. Such policies cover some or all of Medicare's cost sharing and may also cover certain services that are not covered by Medicare.

To simplify the analysis, CBO assumed that the premium support system would not affect certain types of federal spending for Medicare. Specifically, the agency 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. CBO made that assumption because of the additional complexity of structuring a premium support system to include dual-eligible beneficiaries, although a system could be devised to include them.

In a change from past analyses, CBO assumed that beneficiaries with coverage only for Medicare Part A would be excluded from the premium support system and that federal spending for their benefits would continue as it would under current law. CBO chose that feature because most such beneficiaries have primary coverage through employment-based insurance and have secondary coverage through Medicare.⁴

CBO also assumed that Medicare's spending for Part D would continue as projected under current law, as would spending for items and services that are not included in the calculation of the benchmarks or bids for current-law Medicare Advantage plans—such as Medicare's additional payments to hospitals for medical education, hospice benefits, and certain benefits for patients with end-stage renal disease.

The categories of spending that CBO assumed would be unaffected by the premium support system—which include spending for dual-eligible beneficiaries and beneficiaries enrolled in Part A only, all spending on Medicare Part D, and the other categories of spending discussed above—made up about 40 percent of net federal spending for Medicare in 2016. (Net spending consists of total Medicare spending minus beneficiaries' premiums and other offsetting receipts.)

CBO made many other detailed assumptions concerning the options that have been described previously.⁵ With the following three exceptions, the specifications used in this analysis were the same as those that applied in 2013.

First, CBO assumed that beneficiaries who had Part A-only coverage would be excluded from the premium support system. That analytical choice resulted in modestly smaller budgetary savings, relative to CBO's prior estimate, because Medicare is the secondary payer for most such beneficiaries and thus typically spends much less to cover them.⁶

Second, CBO assumed that the federal government would apply a greater reduction in the risk scores of private-plan enrollees under the premium support options than it would under the current Medicare Advantage program. Risk scores are computed for all Medicare beneficiaries on the basis of their diagnoses and other characteristics, and the government uses those scores to adjust payments to plans. (CBO assumed that a comparable risk-adjustment system would be used for the premium support options.) Research published in the past few years has shown that, on average, Medicare Advantage enrollees have higher risk scores than FFS beneficiaries in similar health and that the difference has increased recently.⁷ The difference between risk scores for the two groups of enrollees appears to arise more from the intensive diagnostic coding used by Medicare Advantage plans than from actual differences in health among the two groups.⁸ In the current analysis, CBO assumed that the federal government would take steps to ensure that the risk scores of private-plan enrollees would be no more than 5 percent higher, on average, than the risk scores of Medicare FFS beneficiaries with

4. Under current law, beneficiaries must be enrolled in both Part A and Part B of Medicare to be eligible to enroll in a Medicare Advantage plan.

5. See Congressional Budget Office, *A Premium Support System for Medicare: Analysis of Illustrative Options* (September 2013), pp. 7–15, www.cbo.gov/publication/44581.

6. In certain situations—such as when a Medicare-eligible beneficiary has health insurance coverage through a current employer or a spouse's employer—Medicare acts as the secondary payer. That is, Medicare only pays for covered benefits after the primary payer has met its responsibility for the beneficiary's costs of care.

7. For example, see Medicare Payment Advisory Commission, "MA Risk Adjustment and Coding Intensity Adjustment," in *Report to the Congress: Medicare Payment Policy* (March 2016), pp. 344–346, www.medpac.gov/-documents/-reports; and Richard Kronick and W. Pete Welch, "Measuring Coding Intensity in the Medicare Advantage Program," *Medicare & Medicaid Research Review*, vol. 4, no. 2 (2014), pp. E1–E19, <https://go.usa.gov/xN5DU>.

8. Because they receive larger payments for covering enrollees with higher risk scores, Medicare Advantage plans have an incentive to code all diagnoses that are included in the risk-adjustment mechanism. Many providers (particularly physicians) have no such incentive to code every diagnosis for their Medicare FFS patients; they are paid on the basis of the services furnished, not the diagnoses reported.

similar health status.⁹ That difference is smaller than the published estimates of the difference under current law.

Third, for this analysis, CBO assumed that legislation to establish a premium support system would be enacted late in 2017. To allow time for the federal government to develop the necessary administrative structures and for beneficiaries and insurers to prepare for the new system, CBO assumed that the system would not be implemented until 2022.

Key Design Decisions for Future Proposals

Options considered by the Congress, and the resulting costs or savings, could differ significantly from the options analyzed in this report. Policymakers who wished to develop such proposals would need to make many complex decisions about the design of a premium support system, with important implications for Medicare spending. In its earlier report, CBO discussed several such decisions that would be specific to a system with grandfathering.¹⁰

Some more broadly applicable design questions include the following:

- Would dual-eligible beneficiaries be included in the premium support system, and if so, how would the system accommodate them?
- Would enrollment in Part B remain voluntary, and if so, how would beneficiaries who are enrolled only in Part A be treated by the new system?

9. Recent trends informed CBO's expectation that, under current law, the unadjusted difference between the risk scores of Medicare Advantage enrollees and FFS beneficiaries would be greater than it anticipated in 2013 and substantially above 5 percent. For the premium support options, CBO assumed that coding differences would be limited to 5 percent. That limit is illustrative and arbitrary. Pressure to have a low limit would stem from concerns that a greater divergence between risk scores under premium support would allow private plans to reduce their bids. Reductions in those bids would tend to lower the federal contribution but would not affect the FFS bid. Thus, premiums would increase for beneficiaries who chose to remain in the FFS program.

10. See Congressional Budget Office, *A Premium Support System for Medicare: Analysis of Illustrative Options* (September 2013), pp. 32–33, www.cbo.gov/publication/44581.

- What rules would be established for beneficiaries who receive retiree coverage from a former employer or union?
- How would the federal government change risk adjustment to account for differences in the health status of enrollees in various plans (including Medicare FFS)?

What Were CBO's Analytical Methods?

CBO's estimates of the effects of the premium support options on federal spending and beneficiaries' total payments were based on detailed modeling of the behavior of buyers and sellers of health insurance policies. That modeling was similar for both sets of options.¹¹

First, the agency projected the amounts of the bids that would be submitted by plans in the Medicare Advantage program under current law. Then, the agency adjusted those projected bids, given the downward and upward pressures that would be a likely result of a premium support system. CBO used that information (and data about past enrollment for the average-bid option) to estimate regional benchmarks and premiums for each plan.

CBO then simulated the enrollment choices 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 that estimate of total federal spending with its baseline projection of federal spending under current law. 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 estimates of the plans' premiums.

What Are CBO's New Estimates?

CBO estimates that the options considered in this analysis would reduce net federal spending for Medicare but that the savings would be substantially greater for the second-lowest-bid option than for the average-bid option. Beneficiaries' total payments, on average, would be higher under the second-lowest-bid option but lower under the average-bid option than under current law. For

11. For additional information, see Congressional Budget Office, *A Premium Support System for Medicare: Analysis of Illustrative Options* (September 2013), Appendix A, www.cbo.gov/publication/44581.

Table 1.

Estimated Change in Net Federal Spending for Medicare Under Illustrative Premium Support Options, Relative to Spending Under Current Law, 2022 to 2026

Billions of Dollars

	2022	2023	2024	2025	2026	Total, 2022–2026
Without Grandfathering						
Second-Lowest-Bid Option	-61	-80	-84	-91	-102	-419
Average-Bid Option	-14	-33	-41	-46	-50	-184
With Grandfathering						
Second-Lowest-Bid Option	-2	-5	-9	-14	-20	-50
Average-Bid Option	*	-2	-4	-6	-8	-21

Source: Congressional Budget Office.

Options without a grandfathering provision would apply to everyone who would be enrolled in Medicare under current law other than dual-eligible beneficiaries (those enrolled simultaneously in Medicare and Medicaid) and those with coverage under Medicare Part A only.

With a grandfathering provision, all beneficiaries who became eligible for Medicare before implementation of a premium support system would remain in the current Medicare program, and all beneficiaries who became eligible after that would be included in the premium support system. Dual-eligible beneficiaries and beneficiaries with Part A–only coverage also would be excluded.

Net federal spending for Medicare consists of total Medicare spending minus beneficiaries' premiums and other offsetting receipts. CBO used data from 2016 for its current analysis.

* = between zero and \$500 million.

this analysis, CBO considered total payments to consist of premiums plus cost sharing for Part A and Part B benefits.

Under either option, a particular beneficiary's total payments could differ markedly from the national average. For example, in many regions, premiums would be much higher for Medicare's FFS program, which would result in substantially higher total payments by FFS beneficiaries than would be the case under current law. Moreover, under either option, the savings over the next decade would be substantially lower if a grandfathering provision was included.

Budgetary Effects Without Grandfathering

If the premium support system covered currently eligible and future beneficiaries (but excluded dual-eligible beneficiaries and those with coverage under Part A only), the second-lowest-bid option would reduce net federal spending for Medicare by \$419 billion between 2022 and 2026, CBO estimates (see Table 1). The average-bid option would reduce net federal spending over that period by \$184 billion. Compared with projected spending under current law, by 2024 (an illustrative year shortly after implementation of the new system) the second-lowest-bid option would reduce net federal

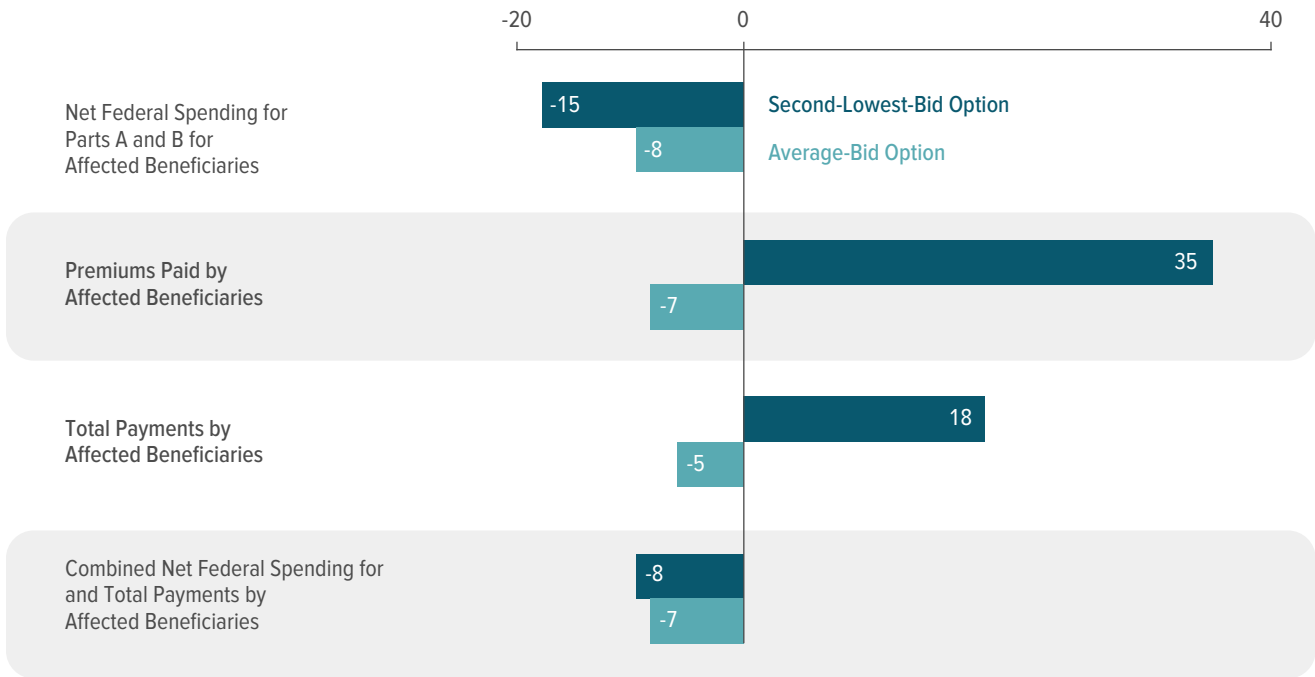
spending for Medicare by 9 percent, and the average-bid option would reduce that spending by 4 percent.

Another way to measure the options' effects is to examine their impact on net federal spending just for affected beneficiaries for benefits that would be included in the premium support system—rather than for the Medicare program as a whole. That group would include everyone (other than dual-eligible beneficiaries and those with Part A–only coverage) who would have enrolled in Medicare under current law. (The measure of spending included in that calculation consists of federal spending for those beneficiaries for Part A and Part B benefits, excluding spending for items and services not covered by Medicare Advantage bids, minus beneficiaries' premiums and other offsetting receipts.) Without a grandfathering provision, the second-lowest-bid option would reduce net federal spending for affected beneficiaries in 2024 by 15 percent, and the average-bid option would reduce such spending by 8 percent, CBO estimates (see Figure 1). Those percentages are larger than the percentage reductions in total Medicare spending because the savings are measured relative to the portion of Medicare spending that would be covered under the premium

Figure 1.

Estimated Difference From Current Law in Net Federal Spending for and Total Payments by Affected Medicare Beneficiaries Under Illustrative Premium Support Options, Without Grandfathering, 2024

Percent



Source: Congressional Budget Office.

Net federal spending consists of Medicare spending for affected beneficiaries on services covered under the premium support system, minus beneficiaries’ premiums and other offsetting receipts. Medicare spending includes all spending for services under Part A and Part B except spending that was excluded because it is not covered by the bids that Medicare Advantage plans submit under current law: spending for medical education, hospice benefits, and certain benefits for patients with end-stage renal disease. Spending for prescription drug coverage under Part D also is excluded.

Affected beneficiaries consist of everyone who would be enrolled in Medicare under current law other than dual-eligible beneficiaries (people who are enrolled simultaneously in Medicare and Medicaid) and those with coverage under Part A only.

Total payments by beneficiaries include premiums and out-of-pocket spending for copayments, coinsurance, and deductibles for services and supplies covered by Part A and Part B. Premiums are for the basic package of Medicare benefits covered in the premium support system. They exclude any additional amounts paid for enhanced benefits or supplemental (medigap) coverage.

support system, rather than relative to total Medicare spending.

Under either option, the savings to Medicare between 2022 and 2026 would be similar in percentage terms to the savings estimated for 2024, with one exception. Under the average-bid option, CBO estimates, federal savings in 2022 would be about half the savings in the other years, mainly because CBO assumed that the weights applied to the bids in constructing benchmarks in the first year of the new system would reflect the share of beneficiaries enrolled in 2021 in Medicare’s FFS program and in private plans under current law.

Beginning in the second year, CBO anticipates, lower-bidding plans would capture a larger share of enrollment under premium support than under current law, which would reduce benchmarks under the average-bid option.

In CBO’s estimation, the two premium support options would yield federal savings because the benchmarks in most regions—and hence, the federal spending per beneficiary—would be lower than federal spending per beneficiary under current law. That would occur even if private plans’ bids were no lower than the bids Medicare Advantage plans would submit under current

law, which CBO projects would average about 10 percent less than FFS spending per capita. Specifically:

- Under the second-lowest-bid option, the benchmark would be either Medicare's FFS bid or the second-lowest bid submitted by a private insurer. In most cases, the latter would be lower.
- In the average-bid option, the benchmark—the weighted average of all bids—usually would be reduced by the inclusion of lower-bidding plans in its calculation.

Additionally, under both options, CBO anticipates that private insurers would face greater price competition than under the Medicare Advantage program, which would lead them to reduce their bids to attract more enrollees and thus increase federal savings even more. A third important source of federal savings in the average-bid option is the projected shift of enrollees from FFS into private plans in many areas, and from higher-cost to lower-cost private plans, which would reduce benchmarks.¹²

For roughly another decade after 2026, under either option, CBO expects that annual federal savings would remain roughly stable in percentage terms, although the dollar amounts would increase. Over the longer term, increased price competition from implementing either option would probably reduce the growth of Medicare spending by decreasing demand for expensive new technologies and treatments and by increasing demand for cost-reducing technologies, although the magnitude of such changes is highly uncertain.

The potential for a premium support system to produce additional savings, however, would be limited because certain provisions of current law are already designed to restrain the growth of Medicare spending. For example, updates to Medicare's payment rates for most providers in the FFS program are scheduled to be smaller than the projected increases in the costs of their inputs (such as

labor and equipment), and the federal government has broad authority under current law to expand demonstration projects that successfully reduce spending for Medicare. Those provisions are discussed in more detail in CBO's earlier report.¹³

Budgetary Effects With Grandfathering

Federal savings would be much smaller under a premium support system that excluded people who already were eligible for Medicare. CBO estimates that if a system applied only to beneficiaries who qualified for Medicare in 2022 or later, spending on such a system for the 2022–2026 period would be only 10 percent of the spending on a system without grandfathering. With grandfathering, CBO estimates, the second-lowest-bid option would reduce net federal spending for Medicare by \$50 billion through 2026; the average-bid option would reduce such spending by \$21 billion.

Thus, modifying the second-lowest-bid option to include grandfathering would yield savings between 2022 and 2026 that were 12 percent of the savings that would be achieved without such a provision. Under the average-bid option, the estimated savings with grandfathering would be 11 percent of the savings without it. Those percentages are similar to the share of Medicare spending that would be covered by the premium support system with grandfathering relative to the share without grandfathering. The savings differ slightly because some factors affect the bids of private plans differently if a grandfathering provision is included.

In the longer term, grandfathering also would reduce the incentives created by a premium support system to limit the development and use of new medical technologies. Thus, the constraints on the growth of Medicare spending that would probably occur under a premium support system would be substantially weaker for many years.

Other Effects

The premium support options would affect the premiums that Medicare beneficiaries paid for Part A and Part B benefits, their total payments for those benefits (premiums plus cost sharing), the combined payments of the federal government and beneficiaries, and enrollment in private plans. CBO estimated those effects for 2024,

12. Most beneficiaries live in counties where CBO expects enrollees would shift from FFS to private plans under the premium support options. However, many beneficiaries live in areas where FFS would be the least expensive option, and the opposite would occur. CBO anticipates that beneficiaries also would shift to lower-bidding plans in the second-lowest-bid option, but that change would not affect benchmarks and thus would not be a source of additional federal savings.

13. See Congressional Budget Office, *A Premium Support System for Medicare: Analysis of Illustrative Options* (September 2013), pp. 19–20, www.cbo.gov/publication/44581.

focusing on beneficiaries affected by the two options without grandfathering. Although the options also could affect beneficiaries' access to care and the quality of that care, CBO does not have the tools to study such effects and does not anticipate having them in the near future.

Effects on Beneficiaries' Premiums. CBO estimates that under the second-lowest-bid option, affected beneficiaries in 2024 would pay a total premium that was about 35 percent *higher*, on average, than the current-law Part B premium projected for that year.¹⁴ (The total premium for a beneficiary enrolling in a given plan under a premium support system would be the standard Medicare premium, plus or minus any difference between the bid of that plan and the benchmark.) Under the average-bid option, the total premium would be about 7 percent *lower*, on average, than the current-law Part B premium. Under either option, those amounts would depend on the premiums charged by the available plans (which would vary by region) and on beneficiaries' choices of plans. CBO expects that those choices would depend partly on premiums but also would be affected by other plan features, such as the size and composition of the provider network, the reputation of the insurer, and its customer service.

The standard premium under either option would be lower than the current-law Part B premium, CBO estimates, because both options would reduce federal Medicare spending, and thus the standard premium (which would be equal to the same share of spending that the Part B premium equals under current law). That reduction in the standard premium is the main reason that the average premium paid by beneficiaries under the average-bid option would be lower than the projected current-law Part B premium. The additional amounts paid by beneficiaries who enrolled in plans with bids above the benchmark would roughly offset the reductions for beneficiaries who enrolled in plans with bids below the benchmark. Under the second-lowest-bid option, however, the regional benchmarks would generally be lower than they would be under the average-bid option, so CBO expects that many beneficiaries would enroll in plans with bids above the relevant benchmark, resulting in much higher average premiums than under current law.¹⁵

14. Under current law, most Medicare beneficiaries do not pay Part A premiums.

15. On the basis of past research, CBO anticipates that in choosing plans, beneficiaries would consider additional characteristics beyond premiums, including a plan's quality, its reputation, or the providers included in its network.

Under all of the options, including those with grandfathering, beneficiaries in all regions would be offered at least one plan with a premium that was at or below the standard premium. Although it is possible that some regions would have no participating private insurers, CBO estimates that, in 2024, only about 1 percent of beneficiaries would live in such areas. In those cases, Medicare's FFS program would be the only plan available, and beneficiaries would enroll in that program and pay the standard premium.

Although all beneficiaries could select a plan with a premium below the current-law Part B premium, most who wished to remain in the FFS program would pay much higher premiums under either option than they would under current law (because the benchmarks in most regions would be lower than the FFS bid).¹⁶ CBO estimates that the premium for enrolling in the FFS program under the second-lowest-bid option in 2024 would be about twice as much, on average, as the current-law Part B premium projected for that year. Under the average-bid option, the premium would be 57 percent more, on average, than the projected current-law Part B premium.

The increase in the premium required to enroll in the FFS program would be larger in regions in which FFS spending per beneficiary was higher. For example, under the second-lowest-bid option, CBO estimates, the FFS premium in 2024 would be about three times higher than the current-law Part B premium that year in counties in the top fourth of FFS spending per beneficiary. It would be about 2.5 times more than the current-law Part B premium under the average-bid option in those same counties. In counties where spending was in the nation's bottom fourth of FFS spending per capita, the FFS premium would be 20 percent higher under the second-lowest-bid option and roughly equal to the current-law Part B premium under the average-bid option.

As a result of those increases in premiums for the FFS program, CBO estimates, in 2024, about 20 percent more beneficiaries would be enrolled in private plans

16. Based on the findings of prior research on beneficiaries' choice of health plans, CBO anticipates that some beneficiaries would enroll in the FFS program even though they would pay higher premiums than under current law because that program would offer greater freedom of choice among providers and fewer restrictions on care than private plans. However, CBO estimates that fewer beneficiaries would enroll in the FFS program under the premium support options than under current law.

under both the second-lowest-bid and the average-bid options than under current law. Changes in the percentage of beneficiaries enrolled in private plans would vary across the country, depending, in part, on FFS spending per beneficiary and on changes in premiums for the FFS program. For example, enrollment in private plans would roughly double under both options in counties in the top fourth of FFS spending per beneficiary because the increase in premiums for the FFS program would be greatest in those places. The share of beneficiaries enrolled in private plans would increase by smaller amounts in most other areas of the country, and that share would decline in some areas where the FFS spending per beneficiary is lower.

Effects on Beneficiaries' Total Payments. CBO estimates that affected beneficiaries' total payments for Part A and Part B benefits in 2024 under the second-lowest-bid option without grandfathering would be about 18 percent higher, on average, than under current law. In general, the premiums paid by beneficiaries would increase under that option, but beneficiaries' out-of-pocket costs would decline slightly (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).¹⁷ That reduction would offset part, but not all, of the increase in premiums.

Under the average-bid option without grandfathering, beneficiaries' total payments for Part A and Part B benefits in 2024 would be about 5 percent lower, on average, than under current law. That reduction would result both from lower average premiums, which are lower than in the second-lowest-bid option because the federal contributions are higher, and from lower out-of-pocket costs. As in the previous option, the difference in beneficiaries' out-of-pocket costs would be attributable primarily to larger enrollment in lower-bidding private plans.

17. Under the options evaluated in this report, plans would be required to maintain the same actuarial value as current-law FFS Medicare, or cover, on average, the same proportion of total expenses covered by Medicare's current-law benefit package. CBO expects that beneficiaries enrolled in lower-bidding plans would use less health care and would therefore pay less in cost sharing than would enrollees in higher-bidding plans. CBO's analysis did not account for possible differences among plans in the additional cost sharing enrollees might incur for services received outside a plan's network.

Under either option, the change in total payments for individual beneficiaries could differ markedly from the national average. For example, people who chose to remain in Medicare's FFS program would generally face much higher premiums and would not see any reduction in their cost sharing.

Effects on Combined Spending by the Government and by Beneficiaries. The sum of net federal spending for Medicare and beneficiaries' total payments in 2024 under the second-lowest-bid option would be about 8 percent lower than under current law, CBO estimates, and about 7 percent lower under the average-bid option than under current law. (Those effects are measured as a percentage of projected net federal spending and beneficiaries' total payments, measured for beneficiaries and benefits affected by the premium support system.)

The estimated reduction in total spending is slightly larger under the second-lowest-bid option because the federal contribution would be smaller under that option. The result would be increased competitive pressure, lower bids by private plans, and more enrollment in lower-bidding plans. The federal savings would be much larger under that option than under the average-bid option, but those larger savings would be partly offset by larger payments by beneficiaries.

How Much Did CBO's Estimates of Effects Without Grandfathering Change and Why?

CBO's current estimates of the federal savings from the two options without grandfathering are much higher than its earlier estimates, primarily because the agency's current projections of the bids that Medicare Advantage plans would submit under current law are lower relative to FFS spending per capita than were the projections used in its earlier analysis.

Changes in the Estimates

In a November 2013 report about approaches to reducing the federal deficit, CBO estimated that if a premium support system was implemented without a grandfathering provision, the second-lowest-bid option would reduce net federal spending for Medicare by \$275 billion between 2018 and 2023, and the average-bid option would reduce such spending over the same period by \$69 billion.¹⁸ By comparison, CBO now estimates that

18. See Congressional Budget Office, *Options for Reducing the Deficit: 2014 to 2023* (November 2013), pp. 204–210, www.cbo.gov/content/options-reducing-deficit-2014-2023.

the second-lowest-bid option would reduce net federal spending by \$419 billion between 2022 and 2026 and the average-bid option would reduce spending over the same period by \$184 billion.

Those comparisons of multiyear totals are affected by two differences in the projection periods for the two analyses. First, CBO's use of a later projection period for the current analysis increased estimated savings because those savings are expressed in nominal dollars and Medicare spending has grown over the period. Second, in the current analysis, the premium support policy would be in effect for fewer years of the projection period, which would reduce cumulative savings.¹⁹ Without those changes, however, the savings estimated would still be substantially higher in the current analysis than previously.

For any given year, savings are larger in CBO's current analysis than in the earlier analysis. For instance, earlier, CBO estimated that the net federal savings in 2023 would be \$56 billion for the second-lowest-bid option and \$17 billion for the average-bid option. CBO now estimates that net federal savings in 2023 would be \$80 billion for the second-lowest-bid option and \$33 billion for the average-bid option. Savings would be significantly larger in 2023 in the current analysis, even though that year would occur sooner after the implementation of the premium support options. (CBO expects that federal savings would be slightly smaller in percentage terms in the early years of the premium support options than in later years.)

Estimates of the effects of the premium support options on federal spending for the next decade are highly uncertain, given the substantial changes to the Medicare program that would be required, the government's lack of experience with such a system, the rapid evolution of health care and health insurance, and the significant changes occurring in the Medicare program under current law. Estimates for the period after 2026 are even more uncertain.

In its September 2013 report, CBO characterized uncertainty in its estimates by specifying ranges of

19. Because of differing assumptions about when legislation establishing the premium support system would be enacted, *Options for Reducing the Deficit: 2014 to 2023* presented budgetary estimates for 2018 to 2023 (six years); the current report presents such estimates for 2022 to 2026 (five years).

values for five key parameters and determining the effects of varying those parameters in 2020 (an illustrative year shortly after that new system would be implemented).²⁰ The results from that exercise indicated that for the second-lowest-bid option, net federal spending for affected beneficiaries in 2020 would probably be reduced by between 9 percent and 14 percent (CBO's central estimate was 11 percent). For the average-bid option, net federal spending would probably be reduced by between 1 percent and 7 percent (the central estimate was 4 percent).

CBO's current estimates of savings are slightly greater than the high end of those ranges: The second-lowest-bid option would reduce net federal spending in 2024 for affected beneficiaries by an estimated 15 percent; the average-bid option would reduce such spending by 8 percent, CBO now estimates.²¹ Some of the changes in CBO's projections result from legislative actions, which were not included in CBO's estimates of the likely range of savings. (For instance, changes to Medicare's physician payment system enacted after the 2013 analysis caused an increase in the savings estimates, as discussed below.)

Reasons for the Changes in the Estimates

In both the current analysis and the earlier one, CBO estimated the budgetary effects of the premium support options by using the most recent bids of Medicare Advantage plans to project what those bids would be under current law. The agency then estimated the bids that private plans would submit under the premium support options by estimating certain downward or upward pressures on the projected Medicare Advantage bids. Such pressures would result from important differences

20. See Congressional Budget Office, *A Premium Support System for Medicare: Analysis of Illustrative Options* (September 2013), www.cbo.gov/publication/44581. The ranges for the parameters' values were chosen on the basis of CBO's judgment that, accounting for many sources of uncertainty, there would be about a two-thirds' chance that the effect on federal spending would be within the range of values estimated (assuming that the premium support system was implemented as specified and other laws remained generally unchanged). CBO conducted that analysis for the two premium support options without grandfathering.

21. The current estimates for 2024 are comparable to the earlier estimates for 2020; in each case, they capture the third year under the new system.

between the premium support options and the Medicare Advantage program.²²

The increases in CBO's estimates of federal savings from the illustrative premium support options without grandfathering are the net effect of several factors:

- CBO's projections of Medicare Advantage bids relative to FFS spending per capita under current law are lower than in the agency's earlier analysis. That change is by far the largest contributor to the increase in estimated savings.
- CBO currently expects that some of the downward and upward pressures on bids would differ from its earlier analysis. On net, changes in those pressures lowered CBO's projections for the bids and thus increased estimated savings.
- CBO modified the specification of the premium support options based on the assumption that the federal government would ensure that the risk scores of private-plan enrollees would be, on average, only 5 percent higher than the risk scores of beneficiaries in similar health in Medicare's FFS program. The reduction in the risk scores would tend to reduce federal payments to the plans (and thus increase federal savings). But CBO expects that private insurers would raise their bids in response to that change in risk adjustment, partially offsetting the other effects of reducing the risk scores.

Reduction in Projected Medicare Advantage Bids Relative to FFS Spending per Capita Under Current Law. CBO currently projects that, under current law, the bids of Medicare Advantage plans will be lower relative to FFS spending per capita than it estimated in 2013. That reduction arises from two factors.

First, on average, the bids of Medicare Advantage plans have declined relative to FFS spending per capita in recent years. In its earlier analysis, CBO used Medicare Advantage plans' 2012 bids as the basis for its projections; for this analysis, CBO used the bids submitted for 2016. At the time of its earlier analysis, CBO estimated that the average ratio of Medicare Advantage bids to

FFS spending per capita in 2012 was 0.92; in its current analysis, CBO estimates that the average ratio in 2016 is 0.90 (see Figure 2).²³

The second reason for the decline in the projected ratio of Medicare Advantage bids to FFS spending per capita is the repeal of the sustainable growth rate (SGR) formula for updating Medicare's physician payment rates.²⁴ In CBO's earlier analysis, the agency projected that the SGR formula would result in a substantial reduction in payment rates in Medicare's FFS program but that Medicare Advantage plans would not achieve comparable reductions. As a result, CBO projected that the ratio of Medicare Advantage bids to FFS spending per capita would rise from 0.92 in 2012 to 0.96 in 2020.

CBO's current estimates incorporate the effects of 2015 legislation that replaced the SGR formula with new systems for updating Medicare's physician payment rates. CBO projects substantially higher payment rates in Medicare FFS than would have been the case if the SGR formula had been retained. CBO also now projects that Medicare Advantage plans will bid lower relative to FFS Medicare spending per capita and that those bids and FFS spending per capita will grow at roughly the same rate. As a result, in CBO's projections, the ratio of Medicare Advantage bids to FFS spending per capita will remain at 0.90 throughout the projection period. The replacement of the SGR formula was a more important contributor to the lower ratio of projected Medicare

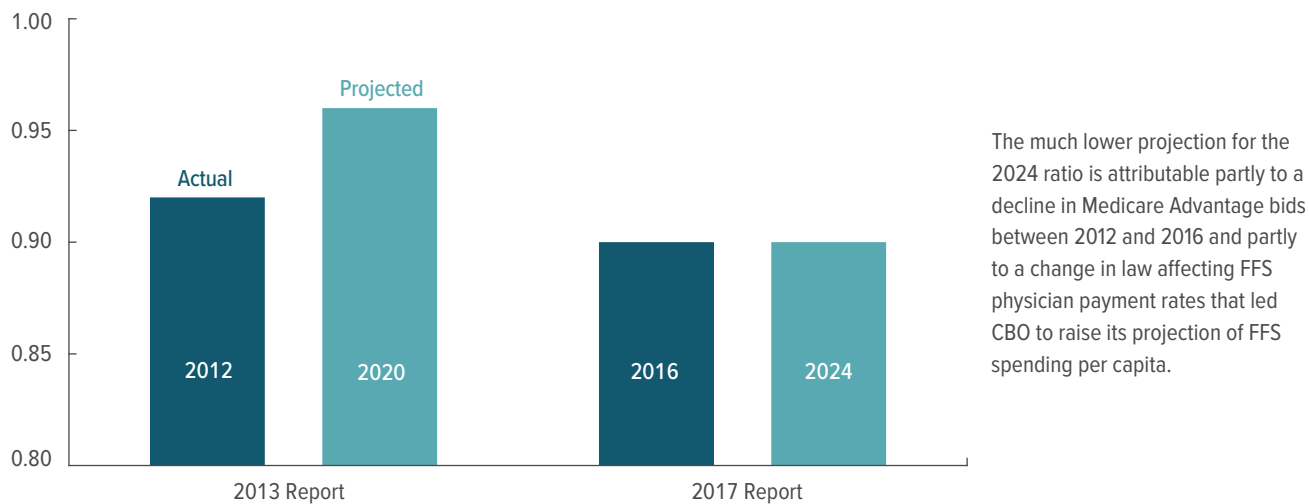
23. Those figures reflect Medicare Advantage bids and FFS spending for beneficiaries in average health. CBO excluded private fee-for-service plans, special needs plans, and employment-based group plans because the agency does not regard the bids of those plans as providing a good basis for estimating the bids that would be submitted by private insurers under the illustrative premium support options. For each future year in its analyses, CBO estimated the FFS spending per capita in the service areas of Medicare Advantage plans by using projections of county-level FFS spending per capita developed by the Centers for Medicare & Medicaid Services and adjusting those values so that the national estimate matched CBO's estimate in its most recent baseline budget projections. CBO included in its calculations the government's cost of administering the FFS program.

24. The SGR mechanism was designed to control spending for physicians' services in Medicare FFS by setting an overall target amount for such spending (measured both annually and cumulatively). Payment rates were to be adjusted each year to reflect differences between actual spending and the spending target. The Medicare Access and CHIP Reauthorization Act of 2015 replaced the SGR formula with new systems for establishing the annual updates to the payment rates.

22. For details, see Congressional Budget Office, *A Premium Support System for Medicare: Analysis of Illustrative Options* (September 2013), www.cbo.gov/publication/44581.

Figure 2.

Ratio of Actual and Projected Medicare Advantage Bids to Medicare FFS Spending per Capita Under Current Law, in Two CBO Studies



Source: Congressional Budget Office.

Data on Medicare Advantage bids exclude private fee-for-service plans, special needs plans, and employment-based group plans. Those bids reflect spending for a beneficiary in average health. Data on Medicare’s FFS spending per beneficiary exclude spending on benefits not covered by the bids that Medicare Advantage plans submit under current law: spending for medical education, hospice benefits, and certain benefits for patients with end-stage renal disease. Medicare Advantage bids and Medicare FFS spending per beneficiary exclude spending for prescription drug benefits covered under Part D.

CBO used data from 2012 for its 2013 analysis and data from 2016 for its current analysis. Projections are shown for the third year of an illustrative premium support option: 2020 for the 2013 report and 2024 for the 2017 report.

FFS = fee for service.

Advantage bids to FFS spending than the decline in that ratio between 2012 and 2016.

Changes in the Pressures on Bids Specified in the Earlier Analysis. CBO has changed its estimates of two of the pressures on bids that were incorporated into the agency’s earlier analysis, resulting, on net, in lower projected bids and greater federal savings. In addition, CBO has incorporated a new upward pressure on bids, described in the next section.

Reduction of Upward Pressure. In its 2013 analysis, CBO anticipated that a reduction in the share of beneficiaries enrolled in Medicare’s FFS program would tend to increase the prices that private insurers paid providers and thereby lead those insurers to increase their bids.²⁵

At that time, no data were available on the provider payment rates of Medicare Advantage plans. However, discussions with industry sources suggested that the rates private insurers paid to providers in their Medicare Advantage plans were, on average, similar to Medicare’s FFS rates and much lower than the rates they paid to providers in their commercial plans. Because there was considerable uncertainty regarding insurers’ payment rates to providers, CBO had anticipated that those rates could reasonably be connected to the proportion of Medicare beneficiaries enrolled in private plans. As a result, CBO expected that a decline in the market share of the FFS program under the premium support options would reduce the importance of FFS payment rates in determining private insurers’ rates for Medicare enrollees, causing those rates to increase.

25. For the rationale, see Congressional Budget Office, *A Premium Support System for Medicare: Analysis of Illustrative Options* (September 2013), pp. 39–40, www.cbo.gov/publication/44581.

Box 1.

The Role of the Medicare Fee-for-Service Program and Its Provider Payment Rates

The Congressional Budget Office assumed that the provision of the Social Security Act that prohibits out-of-network providers from charging more than Medicare's fee-for-service (FFS) rates to treat Medicare beneficiaries in private plans would be retained under the premium support options. CBO also assumed that the Medicare FFS program would be offered as a competing plan within the premium support options analyzed in this report. If either feature was removed, CBO anticipates, private insurers' payment rates to providers would be higher than those projected in this analysis and the savings from the premium support options would be smaller (or federal spending could be more than it would be under current law).

The prices that private insurers pay providers under their Medicare Advantage plans are generally similar to Medicare's FFS prices; insurers pay much higher prices under their commercial plans. Industry sources have identified the provision of the Social Security Act mentioned above as an important

factor in enhancing insurers' negotiating power with providers and enabling them to pay Medicare's FFS rates for their Medicare Advantage plans.¹ CBO expects that if such a provision was excluded from the premium support options, private plans would pay providers higher rates than they would under current law.

In CBO's assessment, eliminating the FFS program entirely could cause a substantial increase in the rates that private insurers pay providers and could cause a concomitant increase in the costs of providing Medicare coverage. In the agency's assessment, the presence of Medicare's FFS program as an alternative constrains the rates that private insurers pay providers in Medicare, and eliminating the FFS program would cause those rates to rise toward commercial rates.

1. See Robert A. Berenson and others, "Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices," *Health Affairs*, vol. 34, no. 8 (August 2015), pp. 1289–1295, <http://dx.doi.org/10.1377/hlthaff.2014.1427>.

On the basis of more recent evidence that the provider payment rates of Medicare Advantage plans are not related to the FFS program's share of beneficiaries in a plan's service area, CBO eliminated that upward pressure from its analysis.²⁶ The agency now expects that insurers' payment rates under the premium support options would not increase if there was a decline in the share of beneficiaries enrolled in the FFS program in a particular market. That change lowered CBO's projections of private insurers' bids under a premium support system, relative to its earlier analysis, and increased the amount it projected in federal savings. (Box 1 describes some of the ways that changes in the options would increase upward pressure.)

Reduction in Downward Pressure. In its earlier analysis, CBO estimated that the increased competitive pressure created by the premium support options it analyzed

would cause private insurers to reduce their bids relative to the bids that would be submitted under the Medicare Advantage program, with a resulting increase in federal savings. That downward pressure on bids is 25 percent weaker in CBO's current analysis than it was in the earlier work, resulting in smaller federal savings, partially offsetting the effect discussed above.

For this analysis, CBO reduced its estimate of the amount of downward pressure that would result from increased competition, for two reasons. First, in 2013, CBO expected that increased competition would result in insurers' reducing costs, by, for instance, lowering administrative costs or profit, improving care management, restricting provider networks, or adopting new technologies more slowly. Since 2013, insurers have reduced their bids relative to Medicare FFS spending per capita, but how they did so is unclear. If, for instance, insurers reduced bids primarily by cutting profit margins, it is unlikely that they would be able to cut margins by a similar magnitude again. Conversely, if they used different coding practices to increase the risk scores of Medicare Advantage enrollees relative to those of similar FFS beneficiaries—and thereby reduced bids while

26. That change reflects the findings of CBO's analysis of private insurers' hospital payment rates in their Medicare Advantage plans. See Jared Lane Maeda and Lyle Nelson, *An Analysis of Private-Sector Prices for Hospital Admissions*, Working Paper 2017-02 (Congressional Budget Office, April 2017), www.cbo.gov/publication/52567.

keeping payments from the federal government the same—they might be able to achieve further reductions through the mechanisms that CBO described in 2013. Given the uncertainty about how insurers reduced their bids, CBO projected that plans could still achieve most, but not all, of the reductions that the agency considered possible in its 2013 report.

CBO's consultation with outside experts also led it to reduce its estimates of downward pressure from competition. The agency now places greater weight on the possibility that the incentives insurers face to reduce bids would be countered to some extent by their understanding that the federal contribution would be increased if they raised their bids. The strength of the incentive to raise bids (or to limit their reduction) could depend on the number of competitors in a given market and on such other factors as the market share of the FFS program and the differences between private insurers' bids and the FFS bid.

Change in the Specification of Risk Adjustment Under the Premium Support Options. To adjust for differences in coding, federal law currently requires Medicare to apply an across-the-board reduction to the risk scores of Medicare Advantage enrollees. A minimum reduction is specified each year, and although larger reductions are permitted, to date Medicare has applied only the minimum. Despite that, the evidence suggests that the reductions have not fully compensated for Medicare Advantage plans' more intensive coding.²⁷

In its earlier analysis, CBO projected that the federal government would reduce the bids of private-plan enrollees by just the minimum amount required by law under the Medicare Advantage program. In this analysis, CBO anticipates that the federal government would apply a greater downward adjustment to the risk scores of private-plan enrollees under the premium support options than it has under the Medicare Advantage program because the consequences of a divergence between the risk scores would be greater under the premium

support options.²⁸ Specifically, CBO now estimates that the federal government would reduce private-plan enrollees' risk scores such that they would exceed those of FFS beneficiaries in similar health by an average of only 5 percent. Without that adjustment, CBO expects, the average difference in risk scores between FFS and private-plan enrollees would be substantially greater than 5 percent (assuming that a risk-adjustment system comparable to that used in the Medicare Advantage program would be used under premium support).

The reduction in the risk scores would tend to reduce federal payments to the plans (and thus increase federal savings) because those payments would be risk adjusted. However, CBO expects that private insurers would respond by increasing their bids, which would tend to increase federal payments to the plans, partially offsetting the other effects of reducing the risk scores.

How Much Did CBO's Estimates of Effects With Grandfathering Change and Why?

CBO's current estimates of federal savings in the first few years under the illustrative premium support options with grandfathering are similar to its earlier estimates. In 2013, CBO estimated that in the third year of such a system, the second-lowest-bid option would reduce net federal spending for Medicare by \$8 billion and the average-bid option would reduce net federal spending by \$3 billion.²⁹ CBO currently estimates that the second-lowest-bid option with grandfathering would reduce net federal spending by \$9 billion in the third year of operation and that the average-bid option would reduce net federal spending in that year by \$4 billion.

CBO's current and earlier estimates are similar because of two offsetting factors. On the one hand, the reduction in CBO's projection of Medicare Advantage bids relative

27. See Medicare Payment Advisory Commission, "MA Risk Adjustment and Coding Intensity Adjustment," in *Report to the Congress: Medicare Payment Policy* (March 2016), pp. 344–346, www.medpac.gov/-documents-/reports; and Government Accountability Office, *Medicare Advantage: 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.

28. If the use of more intensive diagnostic coding led to substantially higher risk scores for private-plan enrollees, private plans could reduce their bids, which would lower the federal contribution and increase the premiums for beneficiaries who chose to remain in the FFS program. CBO did not specify a larger reduction in its earlier analysis because, at that time, it expected that the risk scores of private-plan enrollees would exceed those of similar FFS beneficiaries by a much smaller amount than the current analysis indicates.

29. See Congressional Budget Office, *Options for Reducing the Deficit: 2014 to 2023* (November 2013), pp. 204–210, www.cbo.gov/content/options-reducing-deficit-2014-2023.

to FFS spending per capita under current law increased the agency's estimates of federal savings, compared with its earlier estimates. On the other hand, as a result of technical improvements to its modeling, CBO now estimates that a smaller share of Medicare spending would be included in a premium support system with a grandfathering provision, which reduced the estimate of savings.

Some factors identified above as contributing to changes in CBO's estimates resulted in much smaller changes for options implemented with grandfathering. Two—the downward pressure on bids related to increased competition and the upward pressure related to changes in the market share of the FFS program—would have small effects on federal savings in the early years because only a small proportion of the Medicare population would be included in the new system. Changes in those factors had little effect on CBO's estimates.

In an approach similar to that described above, CBO changed the specification of the premium support options to include an assumption that the federal government would limit the risk scores of private-plan enrollees to be, on average, no more than 5 percent higher than the risk scores of FFS enrollees in similar health. CBO expects that the limits on coding differences would have a smaller effect on private plans' bids in the early years under grandfathering, for two reasons. First, in the initial year, all enrollees in the premium support system would be new Medicare beneficiaries. Because a history of Medicare claims would not be available for those enrollees, their risk scores would be computed only on the basis of demographic characteristics (as is done

under current law). Because health plans cannot increase demographically based risk scores, there is limited scope for coding differences between private plans and FFS Medicare for those beneficiaries. Under grandfathering, new beneficiaries would make up a larger share of people who were affected by premium support in the early years. As a result, CBO projects, the limits on coding differences imposed on private plans would have a much smaller effect on plan payments, and thus those plans would need to increase their bids by correspondingly smaller amounts.

The second reason that CBO expects a smaller gap between the risk scores of private-plan and FFS enrollees in the early years under grandfathering is that the private-plan enrollees would be in those plans for relatively short periods. CBO's internal analysis suggests that differences between the risk scores of private-plan enrollees and similar FFS beneficiaries increase with the length of time enrollees are in a given private plan. Because insurers have more opportunity to identify diagnoses for long-time enrollees, those insurers will be less able to increase risk scores for beneficiaries who are new to Medicare.

CBO therefore anticipates that the reduction in private plans' risk scores to account for coding differences would have a smaller effect on revenue for those plans in a system with a grandfathering provision than in a system without one. Consequently, CBO anticipates that private insurers would increase their bids by smaller amounts under grandfathering; as a result, that new specification had a minimal effect on CBO's estimates of federal savings.



About This Document

This Congressional Budget Office report was prepared in response to interest expressed by Members of Congress. It is a supplement to the 18 budget options related to health that CBO published in December 2016, and it updates *A Premium Support System for Medicare: Analysis of Illustrative Options*, which CBO published in 2013. In keeping with CBO's mandate to provide objective, impartial analysis, this report makes no recommendations.

Daria Pelech and Lyle Nelson prepared the report with contributions from Tamara Hayford and Paul Masi (formerly of CBO). Elizabeth Bass, Tom Bradley, Holly Harvey, and David Weaver provided comments. Ru Ding and Romain Parsad assisted with programming, and Paul Jacobs (formerly of CBO) and Eamon Molloy provided technical assistance.

Jeffrey Kling and Robert Sunshine reviewed the report, Kate Kelly edited it, and Jorge Salazar prepared it for publication. An electronic version and supplemental information are available on CBO's website (www.cbo.gov/publication/53077).

A handwritten signature in black ink, appearing to read "Keith Hall".

Keith Hall
Director
October 2017