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# Fee-for-Service Medicare in a Competitive Market Environment

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*Since its inception, the Medicare Program has allowed for the participation of private health plans, but the relationship of private plans to the government-sponsored fee-for-service (FFS) plan has been the subject of debate. Increased payments to private plans, the introduction of regional preferred provider organizations (PPOs), and a mandated demonstration of price competition that includes FFS Medicare reflect an ongoing attempt to define the role of private plans. The purpose of this article is to explore the roles of private plans and FFS Medicare and to attempt to identify the advantages and disadvantages of each.*

## INTRODUCTION AND BRIEF HISTORY

Since the inception of the Medicare Program, policymakers have debated the proper relationship between FFS Medicare and private health plans. Why are private plans offered alongside a universally available FFS insurance program? Does either sector—private plans or FFS Medicare—offer advantages to beneficiaries or to the government that are difficult for the other sector to replicate? These questions, and policymakers' answers to them, underlie recent legislation that will have a dramatic effect on the future of the Medicare Program. But the effects of policymakers'

views often are easier to identify than the views themselves. The purpose of this article is to provide a framework to help make these views of the program explicit, explore the roles of private plans and FFS Medicare, and attempt to identify the advantages and disadvantages of each sector.

Private plans originally were admitted to the Medicare Program to avoid severing longstanding patient-provider relationships in large staff model health maintenance organizations (HMOs), and they were paid on a cost-plus basis (Dowd, Feldman, and Christianson, 1996). Continued interest in the concept of competing private health plans in the 1970s led to a demonstration of capitated private plans, starting in 1982. The demonstration evolved into the Tax Equity and Fiscal Responsibility Act (TEFRA)-risk HMO program which became the Medicare+Choice program under the Balanced Budget Act (BBA) of 1997. During the 1980s and 1990s, private plans enrolled a disproportionate share of low income beneficiaries (Thorpe, Atherly, and Howell, 2002) and frequently provided generous supplementary benefit packages in areas with higher capitation payments (McBride, 1998).

Under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, Medicare+Choice plans were renamed Medicare Advantage (MA) plans. Three separate provisions of the MMA legislation directly affect the role of private health plans in the Medicare Program:

*Increased Payments*—After 7 years of 2 percent annual increases to MA plans in high payment areas under the 1997 BBA

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legislation, MMA increased payments to at least 100 percent of the average cost of FFS Medicare in each county. These increases presumably will lead to more generous benefits and lower out-of-pocket premiums in MA plans in some market areas, and possibly increased MA enrollment as well.

*Regional PPOs*—CMS has begun accepting bids from private health plans to cover beneficiaries in each of 26 large geographic regions for calendar year 2006. CMS designated 26 regions, each designed to combine traditionally underserved areas with urban markets typically served by HMOs (Centers for Medicare and Medicaid Services, 2004). To encourage participation by private plans, CMS is authorized initially to pay substantial financial bonuses and share risk with private plans.

*Comparative Cost Adjustment (CCA) Demonstration*—In this demonstration, both payments to private plans and out-of-pocket premiums for FFS Medicare will be a function of premium bids by MA plans. The CCA program is scheduled to run in six demonstration areas from 2010 to 2015.

These provisions reflect a belief that private plans enjoy some advantages and offer some benefits to beneficiaries and taxpayers that are difficult for FFS Medicare to achieve. Nonetheless, MMA preserves the structure of the traditional FFS Medicare Program in parallel with the new plans, suggesting some level of agreement that FFS Medicare has operational strengths not easily matched by private plans, and that those strengths contribute to substantial public support. Unfortunately, policy discussions about private plans in the Medicare Program often do not reflect this balanced view and instead pit those who want to jettison private plans from the program against those who want to replace FFS Medicare with an all-private system.

## PRIVATE HEALTH PLANS AND FFS MEDICARE

The Technical Note at the end of this article contains a comparison of some advantages and disadvantages of FFS Medicare and private MA plans. The information is summarized in Table 1 in a convenient side-by-side format.

While there may be political interest in basing the Medicare Program exclusively on public or private health plans, the empirical evidence summarized in Table 1 does not support either extreme. Thus, the question is not whether FFS and private plans should coexist, but how they should coexist. We devote special attention to the role of price-based competition between the two sectors because price-based competition has the potential to influence other structural characteristics of the two sectors.

## PRICE COMPETITION

FFS Medicare and private plans provide the same minimum benefit, using substantially the same medical technology, but they are subject to different rules. What is the proper role of price competition between the two sectors? Since the advent of the TEFRA-risk program, private plans and FFS Medicare have coexisted in an environment that both links and separates the payments and prices faced by beneficiaries. Except for the 1997 BBA period (1997 to 2003), private plans' payments have been a function of the cost of caring for FFS beneficiaries with similar characteristics in the local market area. However, activity among private plans had no formally recognized effect on either benefits or premiums in FFS Medicare. The CCA demonstration proposes to change that relationship by linking beneficiaries'

**Table 1**  
**Comparison of FFS Medicare and Private Plans**

Program Attribute	FFS Medicare	Medicare Advantage
Geographic Access	FFS Medicare has a proven track record of providing universal access to health insurance coverage and medical care (subject to the limits of geographic availability of providers).	Large geographic areas of the country are not served by any MA plans, but universal coverage through private plans has been achieved in FEHB and other government programs. The implementation of regional PPOs will provide a test of private health plans' ability to cover large and diverse geographic areas in Medicare.
Stability of Premiums	Historically, Part B premiums have been more stable than premiums for private plans.	Out-of-pocket premiums for the same plan can vary from year to year and from one geographically proximate area to another. However, much of the instability of MA premiums may be due to the administered pricing system of county level payments.
Integration of Coverage and Benefits	Integration of coverage is more difficult in FFS Medicare than private plans. FFS coverage historically was split into Parts A and B (and now D), and between the government program and private supplements.	MA plans cover the entitlement plus supplementary services under one payment and one organizational entity. In 2006, most MA plans are expected to offer prescription drugs as part of their combined benefits.
Disease Management and Other Care Management	FFS Medicare historically has not engaged directly in the management of care. However, CMS is beginning several important demonstrations of disease management and pay-for-performance. These initiatives could have advantages of scale, compared with plan-by-plan disease management.	MA plans have been able to do more aggressive disease management than FFS Medicare and to use provider payments aggressively, for example, to encourage adherence to practice guidelines. However, the evidence of MA plans' ability to produce better health outcomes to date is equivocal, and some more aggressive forms of care coordination and management have been curtailed in response to the managed care backlash.
Administrative Flexibility and Ease of Innovation	FFS Medicare has a demonstrated record as a policy innovator in areas such as payment policy, coverage decisions, and the technology approval processes. However, the flexibility of FFS Medicare is limited by statutory requirements that establish a fixed package of benefits, a specified set of provider pricing methods that are applied nationally, a decision process based on formal administrative procedures, and restrictions or prohibitions on many common methods of cost control used by private plans.  Current payment policy does not allow FFS Medicare to respond directly to local variations in supply and demand conditions.	Their smaller scale, comparatively streamlined decisionmaking processes, and freedom from political oversight make it easier for MA plans to experiment with new forms of coverage, payment incentives, and ways to manage care.  The incentive to explore innovative ways to reduce the cost of care is clearer for capitated private plans than for FFS Medicare.  On benefits, MA plans are held to a standard of actuarial equivalence, rather than being held to the precise terms of the statutory Medicare benefit.  MA plans (and staff model HMOs in particular) have more control over the actual use of the new technology than does FFS Medicare.  Multiple private plans may provide choices that more nearly match the diverse preferences of beneficiaries, compared to the FFS benefit package that is fixed by statute.  With respect to provider pricing, MA plans can adjust prices to local market supply and demand conditions. This ability to fit prices to market conditions may help to avoid excess supply or demand.
Administrative Transparency and Due Process	The process by which FFS Medicare distributes health care resources must satisfy rigorous administrative procedure and due process standards, thus adding legitimacy and accountability to program decisions, but raising questions of efficiency and substantive fairness.	MA plans must meet rudimentary Federal and State standards, but these requirements are not nearly as prescriptive—or transparent—as those applying to FFS Medicare.  Private plans are subject to more rigorous quality monitoring and reporting (e.g., HEDIS® measures are collected on private plans, but not FFS Medicare).

Footnotes at the end of the table.

**Table 1—Continued**  
**Comparison of FFS Medicare and Private Plans**

Program Attribute	FFS Medicare	Medicare Advantage
<b>Value for Money</b>		
Administrative Cost	FFS Medicare has substantially lower administrative costs than do most private health plans, but current administrative activities may be inadequate especially in view of the current emphasis on care management and reducing medical errors.	Private plans have greater administrative costs. The question is whether those increased expenditures provide benefits to enrollees and the Medicare Program that exceed their cost. Private plans have greater flexibility and more direct incentives to search for and implement strategies that enhance administrative efficiency.
Health Plan Market Power	FFS Medicare has considerable market purchasing power. In some cases a bilateral monopoly (FFS Medicare versus few providers) may be more efficient than multiple private plans attempting to compete for the services of a few providers.  Congress occasionally limits FFS Medicare's ability to exercise its purchasing power—e.g., the MMA prohibition on direct government negotiation of drug prices.	MA plans can negotiate prices and use preferred provider arrangements and selective contracting to combat provider market power.
Congressional Oversight and the Exercise of Provider Political Power	Medicare is a national program with statutory algorithms for determining payments, centralized rule-making and procedural transparency, giving Congress a major role in payment policy and providers major lobbying opportunities.  FFS Medicare lacks discretion to exclude qualified providers using price, quality, or other criteria commonly employed by private plans.  Rules of administrative procedure and due process limit how Medicare can exercise any available discretion.	Providers can affect Medicare's coverage policy by advocating with members of Congress, but private plans have substantial discretion with regard to how they pay providers. For example, MA plans can apply almost any quality criteria they choose and can exclude otherwise qualified providers in order to obtain deeper price discounts.
Economies of Scale	FFS Medicare is large enough to avoid some risk pooling and risk adjustment problems that arise with multiple plans.	Most MA plans currently operating in Medicare probably have sufficient enrollment to achieve efficient risk pooling.
Quality of Care	Extensive reviews of the literature have found that health outcomes generally are similar in the HMO and FFS sectors. However, quality of care for the frail and chronically ill favors FFS Medicare.	HMOs perform better than FFS plans in the coverage and delivery of preventive care.
Social Objectives	Payments to providers under FFS Medicare have been used to subsidize graduate medical education and hospitals that treat a disproportionate number of medically indigent patients. While the efficiency of that distribution mechanism is debatable, it has been effective.	MA plans have enrolled a disproportionate number of low income and minority beneficiaries (Thorpe, Atherly, and Howell, 2002), and often provided them with generous levels of supplementary benefits for no additional premium beyond the Part B premium, depending on area payment levels. Plans may be able to cover more services or offer lower point-of-purchase cost sharing for the same money. A portion of the more generous benefit packages offered by MA plans may be due to favorable selection. A recent review of the literature concluded: "Studies of Medicare HMOs during the demonstrations and the early years of the risk program consistently found evidence of strong favorable HMO selection.... More recent studies of the Medicare risk program have produced similar findings, though not as uniformly." Mello, et al. (2003). But favorable selection does not explain why competition among private plans has been shown to produce higher benefit levels and lower premiums (Pizer and Frakt, 2002).

NOTES: FFS is fee-for-service. MA is Medicare Advantage. FEHB is Federal Employees Health Benefits. PPOs are preferred provider organizations. CMS is Centers for Medicare & Medicaid Services. HMOs are health maintenance organizations. HEDIS® is Health Plan Employer Data and Information Set.

SOURCE: Additional information is available from the primary author, Bryan E. Dowd, Ph.D.

out-of-pocket payments for FFS Medicare to bids submitted by private plans. Some history will help shed light on the significance of this proposed demonstration.

### **Early Discussions of Competitive Pricing**

The relationship of FFS Medicare and private health plans was debated seriously during the 1980s and early 1990s. Private plans appeared to offer more generous benefit packages for the same level of expenditure as FFS Medicare—doubtless due, in part, to the favorable selection enjoyed by private plans (Brown et al., 1993), but also likely attributable to deeper fee discounts from providers (Cutler, McClellan, and Newhouse, 2000) and more aggressive management of care (Miller and Luft, 2002).

Since its inception in the early 1980s, the administered pricing system has had few supporters (Dowd, Feldman, and Christianson, 1996). Brown et al. (1993) found that private plans were overpaid—a result echoed in later analyses by the Medicare Payment Advisory Commission (MedPAC) (2004). Both plans and beneficiaries are frustrated by: (1) the fluctuations in plan payments, out-of-pocket premiums, and benefits from year to year, often as a result of political tinkering with payment levels, and (2) payment variation among counties in close geographic proximity. Many of the difficulties associated with private plan participation in the Medicare Program are linked to the administrative pricing system for plan payments, in which payment rates are set by the government as a function of the cost of caring for similar beneficiaries in FFS Medicare.

Based on the results of a series of CMS-funded research projects, Dowd et al. (1992; 1996) proposed competitive bidding as an alternative to administrative pricing, and suggested that FFS Medicare

be treated as simply another competing health plan, submitting local market bids equal to the average cost of caring for FFS beneficiaries in the market area. The government's contribution to premiums would be set as a function of the bids by qualified health plans in each market area, adjusted as appropriate for the risks of their enrollees and to take account of FFS Medicare's special obligations (e.g., universal access).

### **Competitive Pricing for Private Plans: 1995-2000**

Beginning in 1995, CMS began a series of demonstration projects centered on competitive pricing as a method for paying private health plans in Medicare. Instead of payments based on costs in FFS Medicare, private plans would be paid on the basis of bids in local market areas. Various benchmarks such as the median bid or enrollment-weighted average bid were considered.

The demonstration was proposed for four cities (Baltimore, Denver, Kansas City, and Phoenix). In each site, however, members of Congress from the affected area were allowed to block the demonstration (in Denver, with assistance from a Federal judge). Republicans were as quick to block the demonstration in their home State as were Democrats. In Kansas City and Phoenix, the demonstration was blocked by Congress despite the fact that Congress itself had mandated the demonstration in the 1997 BBA legislation (Dowd, Coulam, and Feldman, 2000). Despite these setbacks, however, some interesting results came to light. First, CMS demonstrated its ability to run a competitive bidding system for health plans. Second, the bids submitted by four health plans in Denver before the demonstration was stopped were found to be 24 to 38 percent below the prevailing payment rate at that time (which was set at 95 percent of the cost of care in FFS Medicare, adjusted for beneficiary risk).

## **MMA Initiatives for Private Plans, 2006**

The 2003 MMA legislation increased payments to private plans for 2004-2005. It also created a new type of private plan—the regional PPO—and created special payment arrangements for this type of plan and for local (i.e., county-level) plans. The payment arrangements for both plans are based on a comparison of benchmark prices and bids by plans for Parts A and B (non-drug) coverage. The benchmark for local plans is an enrollment-weighted average of the administratively determined county-level payment rates in the plan's service area. The benchmark for regional PPOs beginning in 2006 will be a weighted average of the: (1) county-level MA capitation rates within the region, and (2) bids by regional PPOs within the region. The weight of the regional PPOs' bids will be the percentage of beneficiaries who are enrolled in a local or regional private plan at the national level (U.S. Congressional Budget Office, 2004a).

For both local plans and regional PPOs, if a plan's bid exceeds the benchmark, the plan must charge an additional out-of-pocket premium. If the plan's bid is less than the benchmark, the difference can be converted into any combination of additional benefits or a dollar rebate up to the amount of the Part B premium. Through 2005—before the MMA bidding system begins—a plan can use 100 percent of the difference between its actuarially determined costs and its projected payments from Medicare to provide additional benefits. But if the plan chooses to give a premium rebate, the Medicare Program retains 20 cents of every rebate dollar and beneficiaries receive the other 80 cents. From 2006 on, only 75 percent of the difference between the plan's bid and its

benchmark can be used for extra benefits or premium rebates. Medicare will retain the remaining 25 percent.

The MMA thus creates a system of bids for local MA plans and regional PPOs, but plan payments respond to bids only for regional PPOs (and even then, to only a small extent, so long as the national market share of private plans in Medicare remains small). A more comprehensive bidding system—one that includes FFS Medicare and in which all health plan payments are based on bids—was relegated to a limited demonstration project: the CCA demonstration.

### **The CCA Demonstration**

The 2003 MMA legislation mandates a 6-year demonstration of the CCA program, from January 1, 2010 to December 31, 2015. The key provisions of the CCA program are:

- A minimum of six sites will be selected for the program. Each site must have at least two MA plans operated by different parent organizations.
- As in the regional PPO bidding system, payments to MA plans in the demonstration area are a function of private plan bids.
- Unlike the regional PPO bidding system, the beneficiary's premium for FFS Medicare can fluctuate (up or down) based on the results of bids by private plans.
- A benchmark premium will be set, based on the enrollment-weighted average of the bids by private plans and of FFS Medicare costs in the demonstration area.<sup>1</sup>
- If a plan's bid is below the benchmark, the beneficiary will receive 75 percent of the difference and the government will receive 25 percent.

- If a plan's bid is above the benchmark, the beneficiary will pay the difference between the bid and the benchmark out of pocket.
- Subsidy-eligible beneficiaries are excluded from adjustments to FFS Medicare premiums.
- The beneficiary's premium for FFS Medicare cannot change more than 5 percent in any year.

The U.S. Congressional Budget Office (2004b) estimated the savings from the six-site CCA demonstration at 0.3 billion dollars. Total Medicare expenditures were more than \$300 billion in 2004 (Board of Trustees, 2005). However, according to Thorpe and Atherly (2001), the savings from a national system that set the government's premium contribution at the average premium for MA plans in a local market area would be about \$16 billion annually (in 2002 dollars), primarily through increased out-of-pocket payments for beneficiaries who remain in FFS Medicare. These estimates do not include any savings that might result from FFS Medicare's efficiency-improving responses to more direct competition with private plans.

Despite the possibility of substantial savings from a national system of competitive pricing, the history of demonstration efforts to test these designs is not at all encouraging. Even bidding models that insulate FFS from the effects of the bidding have been blocked by members of Congress. CCA includes FFS in the bidding, creating an even more difficult political problem.

Political opposition to competitive pricing often has less to do with the substantive issues than with congressional opposition to having their districts singled out for any

<sup>1</sup>In 2010 the benchmark will be based 25 percent on the CCA benchmark and 75 percent on average FFS non-drug expenditures. The weight for the CCA benchmark increases gradually to 100 percent by 2015.

demonstration. Even politicians who support the idea of competition in general have opposed any demonstration of competitive pricing in their districts. As of October 2004, seven amendments in the Senate and three in the House had been introduced to repeal the CCA program in its entirety. In addition, 14 Senate and 11 House amendments had been introduced to block the demonstration in specific States. While opponents may not be able to repeal the CCA program in its entirety, the same outcome can be achieved as long as members of Congress are allowed an effective veto of the program in their districts. As Robert Reischauer commented just before the MMA passed (Freudenheim, 2003), "There is really no political constituency for competition."

Can a demonstration of competitive pricing for all Medicare health plans ever overcome the inherent political obstacles? History suggests that the key is local political support. In the late 1980s, competitive pricing demonstrations for selected durable medical equipment (DME) and clinical laboratory services were stopped by Congress, following industry pressures. A decade later, the first major competitive bidding demonstration for a Medicare benefit, DME, began in Polk County, Florida. This demonstration began against the strong opposition of industry—but, uniquely, with the strong backing of Senator Graham (1998) and Governor Chiles (1998), both of Florida.

How can local opposition be overcome? The most obvious strategy would be to provide hold-harmless payments to beneficiaries affected by the demonstration. We have suggested elsewhere (Dowd, Coulam, and Feldman, 2001) that the Federal Government could calculate the worst possible case for beneficiaries in the demonstration area and simply write a check equal to that amount to all beneficiaries in

the demonstration area. If the worst case was that a formerly free plan such as FFS Medicare with no supplementary insurance rose by \$50 per month in a site with 100,000 beneficiaries, the cost would be \$60 million for each year of the demonstration. As noted earlier, however, the budget for the Medicare Program is more than \$300 billion per year. The Federal Government spent \$80 million on the National Health Insurance Experiment in the 1970s to determine the effect of coinsurance and deductibles on health care spending, and part of that cost was hold-harmless payments to individuals and families affected by randomization to the different insurance plans. Perhaps exploration of the efficiency gains from competitive pricing is worth a similar investment.

## RECENT DEVELOPMENTS

Several recent developments might affect policymakers' thinking regarding the role of FFS Medicare and private plans in Medicare and the prospects for the CCA demonstration. The information obtained from the Denver competitive pricing demonstration site, the analysis of Pizer and Frakt (2002) regarding the beneficial effect of competition on MA benefits and premiums, and CMS' generally positive experience with bidding for DME provide further evidence, if such evidence is needed, that competition is good for both beneficiaries and the government. The DME demonstration provides an especially interesting example of successful implementation of competitive pricing over substantial industry opposition—due largely to support by local politicians. Meanwhile, the results of that competitive pricing demonstration bore out the promise of competitive bidding. CMS (2005) reported that “Estimates suggest substantial Medicare savings—17%

to 22%—resulting from the three competitions. Fees for most items were reduced by 10 to 30 percent.”

Other bidding demonstrations either are planned or are underway, many of them mandated by Congress. Congress has expressed enthusiasm for bidding not only at the service level (e.g., extending the DME competitive bidding nationally and implementing a competitive bidding demonstration for clinical laboratory services), but also at the health plan level. Bidding among private health plans is an important part of the premium-setting process in the regional PPO program that is scheduled to start in 2006, albeit in relatively gentle form. If that bidding goes well, then extensions to all private plans in the Medicare Program might be more difficult to oppose.

A second development is the research on geographic variation in costs within FFS Medicare. Fisher et al. (2003a; 2003b) found large geographic variation in FFS Medicare expenditures, adjusted for age, sex, race, and a standardized national fee schedule, with no commensurate variation in health outcomes. The fact that private plans' benefits vary directly with their capitation payments (which are based on local FFS expenditure levels) suggests that private plan costs do not vary as much geographically as FFS costs (McBride, 1998). Yet extensive literature reviews (Miller and Luft, 1997; 2002) show that health outcomes generally are similar in the HMO and FFS sectors and the majority of those studies are based on the Medicare population. Taken together, these findings suggest that the additional expenditures in FFS Medicare relative to MA expenditures in the same market area are unlikely to provide any incremental improvement in the health outcomes of beneficiaries. If that is the case, taxpayer support for those

additional FFS expenditures (over the risk-adjusted costs of MA plans) is more difficult to defend.

The third development is that differences in the degree of care management in FFS Medicare versus private plans may be shrinking. FFS Medicare has begun experimenting with new types of managed care and efficiency-enhancing initiatives (e.g., disease management demonstrations in both FFS Medicare and capitated private plans and pay-for-performance demonstrations in FFS). Meanwhile, private plans appear to have scaled back their direct management of care in response to the managed care backlash in the late 1990s. This modest, converging trend could alleviate concerns that FFS Medicare is unprepared for competition with private plans, and that direct price competition is a pre-text for the elimination of FFS.

Finally, the appearance of sub-zero premium plans—MA plans that give cash rebates to their enrollees rather than additional benefits—exposed the inefficiency of the MA payment system. Prior to the introduction of cash rebates, private health plans in areas with high capitation payments used their excess revenue to offer more generous coverage, even if the coverage was not worth to beneficiaries what it cost to provide. In other words, beneficiaries would have preferred the cash. That fact became obvious when cash rebates were permitted. In December 2004, there were 304,000 Medicare beneficiaries enrolled in MA products that gave cash rebates (Zarabozo, 2005). Although allowing MA plans to give cash rebates has made the program more efficient in the economic sense (beneficiaries now receive the benefits of plan overpayment in a form they prefer), it has made Medicare more visibly unfair, raising the ire of congressional representatives and beneficiaries in low payment areas.

## CONCLUSION

Both FFS Medicare and private health plans in Medicare have strengths and weaknesses. FFS Medicare provides universal access with relatively stable premiums. FFS Medicare also meets demanding standards of due process. FFS Medicare has a proven record as a policy innovator and leader, especially in such areas as payment policy and coverage decisions. But private plans have a more streamlined decisionmaking process. They are more nimble, and their benefits, care management processes, and provider contracts are more responsive to changing market conditions.

From this assessment we draw two conclusions. First, neither FFS nor private plans should be the exclusive provider for Medicare. Second, performance comparisons between FFS Medicare and private plans do not provide any justification for an open-ended subsidy for FFS Medicare. Based on the second conclusion, we draw a further inference: FFS and private plans should compete on equal terms. MedPAC (2001) also concluded that FFS and private plans should receive the same level of government subsidy and that recommendation was implemented in the MMA legislation. Our point of disagreement with MedPAC is our second conclusion. FFS Medicare's cost is an improper base for the equalized payments.

Price competition between private plans and FFS Medicare could be tested in a demonstration of competitive pricing. However, the history of demonstration efforts to test competitive pricing designs is not encouraging. Multiple previous attempts were killed by political opposition, and similar opposition to the 2010 CCA demonstration already is in place.

The most important step to improve the chances of implementing a demonstration of competitive pricing would be to provide

hold-harmless payments to beneficiaries. Meanwhile, the favorable experience from the Denver competitive pricing demonstration, the DME demonstrations, the accumulating evidence that higher expenditures in FFS Medicare, on the margin, are unlikely to provide significant improvements in health compared with private plans, the increased experimentation with disease management and pay-for-performance in FFS Medicare, and the evidence of overpayment provided by sub-zero premium plans all point to the need for a better pricing system. These developments might lead more policymakers to the conclusion that head-to-head price competition between FFS Medicare and private plans would be good for both beneficiaries and the Federal Government. If there is to be common ground on this point, competitive pricing cannot be used as a pretext for eliminating FFS Medicare.

## **TECHNICAL NOTE**

### **COMPARISON OF PRIVATE HEALTH PLANS AND FFS MEDICARE**

#### **Geographic Access**

The traditional FFS Medicare Program has a proven track record of providing universal access to health insurance coverage and medical care (subject to the limits of geographic availability of providers). Currently, large geographic areas of the country are not served by any MA plans, but universal coverage through private plans has been achieved in Federal Employees Health Benefits Plan (FEHBP) and other government programs. The implementation of regional PPOs under the 2003 MMA legislation will provide a test of private health plans' ability to cover large and diverse geographic areas in Medicare.

#### **Stability of Premiums**

Historically, Part B premiums have been more stable than premiums for private plans. Out-of-pocket premiums for MA plans can vary from year to year and from one geographically proximate area to another. However, much of the instability of MA premiums may be due to the administered pricing system of county level payments.

#### **Integration of Coverage and Benefits**

Integration of coverage is more difficult in FFS Medicare than private plans. Historically, FFS coverage was split into Parts A, and B (and now D), and also split between services covered by the government program and those covered by private supplements. MA plans cover the entitlement benefit package plus supplementary services under one payment and one organizational entity. In 2006, most MA plans are expected to offer prescription drugs as part of their combined benefits.

#### **Disease Management and Other Care Management**

FFS Medicare historically has not engaged directly in the management of care. However, CMS is beginning several important demonstrations of disease management and pay-for-performance. These initiatives could have advantages of scale, compared with plan-by-plan disease management. MA plans have been able to do more aggressive disease management than FFS Medicare and to use provider payments aggressively, for example, to encourage adherence to practice guidelines. However, the evidence of MA plans' ability to produce better health outcomes to date is equivocal, and some more aggressive forms of care coordination and management have been curtailed in response to the managed care backlash.

## **Administrative Flexibility and Ease of Innovation**

FFS Medicare has a demonstrated record as a policy innovator in areas such as payment policy, coverage decisions, and the technology approval processes. However, the flexibility of FFS Medicare is limited by statutory requirements that establish a fixed package of benefits, a specified set of provider pricing methods that are applied nationally, a decision process based on formal administrative procedures, and restrictions or prohibitions on many common methods of cost control used by private plans. In addition, current payment policy does not allow FFS Medicare to respond directly to local variations in supply and demand conditions.

Their smaller scale, comparatively streamlined decisionmaking processes, and freedom from political oversight make it easier for MA plans to experiment with new forms of coverage, payment incentives, and ways to manage care. The incentive to explore innovative ways to reduce the cost of care is clearer for capitated private plans than for FFS Medicare.

When designing their benefit packages, MA plans are held to a standard of actuarial equivalence, rather than being held to the precise terms of the statutory Medicare benefit. Similarly, MA plans, and staff model HMOs in particular, can exercise more control over the actual use of the new technology than can FFS Medicare. The variety of plan choices offered by MA plans may provide choices that more nearly match the diverse preferences of beneficiaries, by comparison to the FFS benefit package that is fixed by statute.

With respect to provider pricing, MA plans can adjust prices to local market supply and demand conditions. This flexibility to fit prices to market conditions may help to avoid excess supply or demand.

## **Administrative Transparency and Due Process**

The process by which FFS Medicare distributes health care resources must satisfy rigorous administrative procedure and due process standards, thus adding legitimacy and accountability to program decisions, but raising questions of efficiency and substantive fairness.

MA plans must meet rudimentary Federal and State standards, but these requirements are not nearly as prescriptive—or transparent—as those applying to FFS Medicare. Private plans are subject to more rigorous quality monitoring and reporting (e.g., HEDIS® measures are collected on private plans, but not FFS Medicare).

## **Value for Money—Administrative Cost**

FFS Medicare has substantially lower administrative costs than do most private health plans, but the current level of administrative activities in FFS Medicare may be inadequate (Butler, 2003; NASI, 2002), especially in view of the recent current emphasis on care management and reducing medical errors. Private plans have greater administrative cost. The question is whether the increased administrative expenditures in private plans provide benefits to enrollees and the Medicare Program that exceed their cost. Private plans have greater flexibility and more direct incentives to search for and implement strategies that enhance administrative efficiency.

## **Health Plan Market Power**

FFS Medicare has considerable market purchasing power. In some cases a bilateral monopoly (FFS Medicare versus few providers) may be more efficient than multiple private plans in markets with attempting to compete for the services of a few providers.

Congress occasionally limits FFS Medicare's ability to exercise its purchasing power—e.g., the MMA prohibition on direct government negotiation of drug prices. MA plans can negotiate prices and use preferred provider arrangements and selective contracting to combat provider market power.

### **Congressional Oversight and the Exercise of Provider Political Power**

Medicare is a national program with statutory algorithms for determining payments, centralized rule-making and procedural transparency, giving Congress a major role in payment policy and providers major lobbying opportunities.

FFS Medicare lacks discretion to exclude legally qualified providers using price, quality, or other criteria commonly employed by private plans. Rules of administrative procedure and due process limit how Medicare can exercise any available discretion.

Providers also can affect Medicare's coverage policy through political pressure by advocating with members of Congress, but private plans, on the other hand, have substantial discretion with regard to how they pay providers. For example, MA plans can apply almost any quality criteria they choose and can exclude otherwise qualified providers in order to obtain deeper price discounts.

### **Economies of Scale**

FFS Medicare is large enough to avoid some risk pooling and risk-adjustment problems that arise with multiple plans. However, most MA plans currently operating in Medicare probably have sufficient enrollment to achieve efficient risk pooling.

### **Quality of Care**

In extensive reviews of the literature (Miller and Luft, 1997; 2002) found that health outcomes generally are similar in the HMO and FFS sectors. Among studies containing data on both utilization and health outcomes, five found worse HMO outcomes with the same or lower levels of utilization, four found better HMO outcomes, and two found equivalent outcomes. Quality of care for the frail and chronically ill favored FFS Medicare, while HMOs performed better than FFS plans in the coverage and delivery of preventive care (Miller and Luft, 2002).

### **Social Objectives**

Payments to providers under FFS Medicare have been used to subsidize graduate medical education and hospitals that treat a disproportionate number of medically indigent patients. While the efficiency of that distribution mechanism is debatable, it has been effective.

MA plans have enrolled a disproportionate number of low income and minority beneficiaries (Thorpe, Atherly, and Howell, 2002), and often provided them with generous levels of supplementary benefits for no additional premium beyond the Part B premium, depending on area payment levels. Plans may be able to cover more services or offer lower point-of-purchase cost sharing for the same money. A portion of the more generous benefit packages offered by MA plans may be due to favorable selection. A recent review of the literature concluded: "Studies of Medicare HMOs during the demonstrations and the early years of the risk program consistently found evidence of strong favorable HMO selection.... More recent studies of

the Medicare risk program have produced similar findings, though not as uniformly” (Mello et al., (2003). But favorable selection does not explain why competition among private plans has been shown to produce higher benefit levels and lower premiums (Pizer and Frakt, 2002).

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