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A Competitive Bidding Approach to Medicare Reform

Roger Feldman and **Bryan Dowd**
University of Minnesota

Robert Coulam
Simmons College

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Medicare reform is a critical issue for the public agenda. The most promising option for addressing Medicare reform is competitive bidding—using health plans' bids to determine the government's contribution to a basic set of benefits in every market area.

Competitive bidding proposals have a long history in Medicare.[1] Competitive bidding brings market pricing to Medicare, but providers have resisted this system for decades. What is different now, and what makes competitive bidding a realistic alternative for discussion, is that Medicare reform is an urgent matter and competitive bidding is a tested means for changing the financial prospects of the program. Competitive bidding is not the only necessary Medicare reform, but it is an essential component.

We begin this paper with a review of the history of competitive bidding in Medicare. Then we move to a definition of terms, which is crucial in any discussion of competitive pricing because the often-heated public debate around these issues frequently distorts positions and confuses issues by conflating different terms and making some arguments appear other than they are. Following this terminological exercise, we move to a series of sections discussing competitive bidding in Medicare, with special focus on the challenges to introducing it.

In the course of this discussion, we show that competitive bidding has been extensively tested in Medicare applications. It should be relatively easy to implement because so many steps required of the Medicare program already are in effect without notable problems. And it is amenable to political consensus because it allows decisions on key parameters to accommodate widely different political judgments. Put differently, competitive bidding is not a right-wing or left-wing approach. It can be adapted to choices all along the political spectrum and still bring at least some benefits of market pricing to the Medicare program.

HISTORY OF PRIVATE PLANS AND COMPETITIVE BIDDING IN MEDICARE

At a minimum, competitive bidding requires bidders: multiple, identifiable "health plans" that are able and willing to submit bids to provide some defined health care benefit. We will define these terms with greater precision in due course. For now, it is worth considering the history of their use.

Nothing about private health plans in the Medicare program is new. Private plans have been offered to Medicare beneficiaries since its inception in 1965.[2]

Nor is anything new about proposals that use competitive bidding. Ralph Saul of the Insurance Company of North America (INA) first proposed a fixed government contribution to Medicare premiums based on health plans' bids in 1979.[3] Walter McClure made a similar proposal in 1982, followed by Alain Enthoven in 1988.[4] Researchers at the University of Minnesota developed a detailed competitive bidding proposal for the Centers for Medicare and Medicaid Services (CMS), then the Health Care Financing Administration (HCFA), in the late 1980s and later assisted CMS in attempts to demonstrate competitive bidding in four US cities during the Clinton administration.[5]

Years later, we showed that competitive bidding had been attempted almost constantly since the program's founding for many different parts of the Medicare benefit—including Medicare health maintenance organizations (HMOs) for Part A and B benefits; prescription drug plans for Part D benefits; and particular elements of coverage such as durable medical equipment (DME), clinical laboratory services, and coronary artery bypass grafts.[6] Bidding designs were employed in these efforts, and in all of them, competitive bidding proved to be practical and (when bids were received) more economical than the standard pricing arrangements of the traditional Medicare program. However, almost all of these efforts were unsuccessful, largely because of the politics of Medicare or judges acting at opponents' behest to block the programs.

In this paper, we focus not on a particular service like DME but on the whole of the traditional, nondrug Medicare entitlement benefit and how health plans realistically can bid on that benefit. The bidders we envision include Medicare Advantage plans such as HMOs, preferred provider organizations (PPOs), and other private plans but also include the traditional fee-for-service (FFS) Medicare program. We will refer to the traditional program as the "government plan" in the discussion that follows.

Competitive bidding is not the only necessary Medicare reform, but it is an essential component.

We will not include Part D drug coverage in the bidding model we discuss because of special statutory constraints in this area and complexities of drugs and Part D that require separate discussion.

Our discussion focuses on plans eligible to enroll the core population of aged and disabled beneficiaries in Medicare for the basic entitlement benefit. We exclude plans that enroll beneficiaries with special needs and special care arrangements such as social HMOs and the Program of All-Inclusive Care for the Elderly, as each of these populations or programs raises special technical issues. We discuss certain special populations: dual eligibles and the Specified Low Income Medicare Beneficiary and Qualified Medicare Beneficiary subsidy programs.

THE NEED FOR PRECISE TERMS

Defining terms is a challenge. In this section, with some humility regarding the prospects for success, we attempt to clarify and insist upon certain distinctions.

Assuming the Medicare beneficiary is offered a choice of several different health plans, there are basically two ways to set the price of the benefit:

1. **Administrative pricing** determines the price of health coverage based on calculations from administrative records such as prior years' health claims in the traditional Medicare program.

2. **Competitive bidding** sets the government contribution based on the bids submitted by competing health plans within a market area, such as a county. We noted:

> The most glaring problem with [administrative pricing] … is that information about the costs of care flows in the wrong direction: from the organization that knows very little about [private plan] costs (the federal government) to the organizations that know as much as possible (the [private] plans). A common response to the problems of the current administrative payment system is some form of competitive pricing. Competitive pricing reverses the flow of cost information; that is, [private] plans tell the government how much it costs to care for Medicare beneficiaries. Plans submit bids under a system that rewards low bids and penalizes high bids. An important distinction between competitive pricing and the current payment system is that rewards and penalties are linked primarily to the prices submitted by plans, rather than to the level of benefits they provide.[7]

Note that these two ways of determining the price of coverage do not establish any necessary relationship between that price and the government contribution to the premium. Under either system, government can contribute less than, the same amount as, or more than the price of a given benefit. However, the administrative pricing system cannot get the prices right in any systematic way. Variations in the underlying cost in relation to the administrative price ensure that the amount of government support also varies, likely in unsystematic ways since the underlying costs are not revealed in any reliable way in an administrative pricing system.

Competitive bidding requires precisely specifying the benefits associated with the government contribution because the competing health plans have to bid on something specific. An administrative pricing system does not require this specification, as the administrative calculations can be based on whatever the government chooses. In competitive bidding, the requirement to specify the benefits does not mean that the product on which health plans bid has to be identical across all plans—"actuarial equivalence" or some other standard of uniformity can be sufficient for a meaningful comparison of the bids.

A second set of terms fundamentally important to the current debate revolves

around whether the government is purchasing a benefit or providing a contribution to purchase a benefit: whether there is a "defined benefit" or a "defined contribution."

"Defined contribution" simply means that the government's contribution to premiums is the same across all the health plans. This term tells us nothing about how that contribution is determined or its relation to the cost of the benefit. Similarly, the term "defined benefit" often is interpreted to mean that the government will pay whatever it takes to provide the defined benefit; that also is misleading because this term tells us nothing about the different types of health plans that might provide the defined benefit or their cost of doing so.

Competitive bidding is a defined-contribution approach because the government's contribution to premiums is the same whether the beneficiary chooses the government plan or a private plan. But it also is a defined-benefit approach because the bids submitted by the government and private plans are based on their cost of providing a defined entitlement benefit. The government's contribution is set to fully fund (net of the Part B premium) the cost of the most economical plan or plans, leaving beneficiaries to pay only additional costs of more expensive options.

In this paper, we do not use the term "premium support" because it is too vague—it refers to widely varying bidding models with widely varying political and economic consequences. We will focus on competitive bidding to set a benchmark price (for example, at the lowest or second-lowest bid) that accomplishes two things: it sets the level beyond which higher bidders have to charge a premium and the amount of the government contribution based on the bids. In other words, competitive bidding is both a defined-contribution and defined-benefit program, in the sense described above.

In the model of competitive bidding we consider here, both the government plan and private health plans submit bids to provide the entitlement benefits to Medicare beneficiaries in a defined market area. The government's contribution to premiums is based on those bids and, except for adjustment for enrollee risk, is the same regardless of the health plan the beneficiary chooses. If a beneficiary wishes to enroll in a more expensive plan (whose bid is above the government's contribution), the beneficiary pays the added amount. This is the key to any market-based system: the added cost of more expensive options must be worthwhile to the beneficiary.

The competitive bidding proposal we discuss in this paper is essentially identical to our proposal 20 years ago, with further detail added in two later pieces.[8] That proposal envisioned continuation of both the government plan and private health plans and the specification of entitlement benefits on which all plans will bid.

We realize that there is concern in some quarters that competitive bidding is a covert attempt to drive the government plan from the market or to convert the government's contribution into a voucher that has no reference to the cost of the entitlement benefits.[9] While acknowledging

the seriousness of the budgetary problems associated with entitlement benefits, any plain reading of our work over the past 20 years will demonstrate our consistent position that both the government and private health plans have a legitimate role to play in the Medicare program and that rather than abandoning the concept of an entitlement benefit, competitive bidding requires it.

Moreover, as we have stated repeatedly, the case for competitive bidding is not based on Medicare's fiscal problems. We would recommend competitive bidding even if Medicare were in fine fiscal condition because (a) competitive bidding is the most reliable way to discover the health plans' true cost of providing the entitlement benefits and (b) setting the government contribution to premiums at any amount greater than the competitively determined price of the entitlement benefits wastes money.

A different way of looking at this issue is simply to examine the data: would the government plan always be the highest bidder? In a recent paper, the authors demonstrated that in fact the government plan would be the low bidder in counties in which 50 percent of beneficiaries live.[10] The import of this analysis is that, at the outset of a new competitive bidding regime, the government plan may be in a better position to compete than is casually assumed.

Legitimate questions have been raised about whether risk adjustments can be so finely devised to compensate the government plan if it is selected by individuals with high risk. Without adequate risk adjustment, the government plan's bid would be compromised, undermining the place of the government plan in Medicare. This could be an important problem, given the freedom of private plans to design benefits to attract low-risk individuals and the more cumbersome, congressionally governed structure and administration of the government plan. We will treat issues of risk adjustment later in the paper. Here, it will be useful to summarize the types of flexibility the government plan might be allowed that would enhance its ability to compete over time.

We believe the rules of competition should be simple: the government plan should be permitted to do no more nor less than any other Medicare health plan, subject to (a) reaching a general agreement on what constitutes a "level playing field" between the government plan and private plans; and (b) the requirement that the government plan offer the entitlement benefit package to all beneficiaries throughout the country.

At the outset of a new competitive bidding regime, the government plan may be in a better position to compete than is casually assumed.

What does this mean in practice? What might the government plan do that it cannot or is not doing now? Some new directions the government plan might take include the following:[11]

- The government plan could be allowed to offer any supplementary benefit it

likes. The bids would be based on an entitlement benefit package required of all health plans, and beneficiaries would pay the marginal cost of supplementary benefits out of their own pockets.

- The government plan could be allowed to make cost-saving coverage decisions or offer additional services beyond the entitlement if beneficiaries are willing to pay for those services.
- The same rules that apply to coverage also should apply to investments in administrative improvements. If a particular administrative initiative has a positive return on investment and does not raise other issues (such as violating the universal eligibility to Medicare benefits), then the government plan should be able to make such investments.
- The government plan could be permitted to offer an alternative plan that features selective provider contracting based on the price and quality of providers.
- The government plan could be able to offer "one-stop shopping" for Part D and supplementary coverage. MA enrollees can purchase basic Medicare coverage, coverage of outpatient prescription drugs, and any supplementary coverage they choose from a single health plan. The government plan is prohibited from offering Part D coverage and supplementary insurance. We have argued elsewhere that this one-stop shopping might correct certain existing sources of market failure, though it would elicit intense political opposition over government negotiation of drug prices.[12]
- In the future, the government plan could be allowed to pay providers any way it likes, including withholdings and other shared-savings arrangements. A form of this payment is already slated to begin in 2015, under the value-based purchasing requirements of the Affordable Care Act. Future changes *might* be incompatible with the accountable care organization (ACO) model as we know it today. The compatibility of innovations in the government plan with ACOs and other initiatives is not very important, in our opinion, as long as the innovations do not introduce extraordinary obstacles to our main goal, establishing competitive bidding.

This is just a tentative list. The important point is that the government plan should be given greater freedom to compete in an equitable way with private plans and that may require rethinking parts of the government plan.

If these possibilities would allow the government plan to compete better with private plans, a number of considerations would cut the other way: burdens borne by private plans that the government plan avoids. The first is the requirement that private plans report Healthcare Effectiveness Data and Information Set quality-of-care measures. The second is the requirement that private plans provide adequate access to providers throughout their service areas. The government plan is not subject to either requirement. If Congress believes that both requirements are legitimate qualifications for any health plan to participate in the Medicare program, it should impose them to an equal degree on the government plan.[13]

THE BIDDING MODEL

With the understanding of the background, purposes, and terminology of competitive bidding we have outlined, the question becomes: how can it be done? In the sections that follow, we summarize a practical bidding model and certain technical issues that competitive bidding raises. The main elements of the bidding model are:

- **Eligibility and participation of plans.** As it does now, CMS would require that private plans report high-quality measures and meet minimum levels of quality before allowing them to participate in Medicare. Given certain issues of plan behavior and risk adjustment that we discuss, we believe private plans should provide more complete information about the cost and utilization of each enrollee.

- **Benefit package.** Congress would determine a national entitlement benefit package (for example, the current benefits).

- **Structure and conduct of the bidding process.** All health plans would submit bids on the entitlement benefits for a standardized enrollee in each payment area. The government plan's bid would be the average fee-for-service cost of a standardized enrollee in each payment area. Private plans would choose their service areas; the government plan would serve all areas. Initially, the payment areas would be counties, as at present.

- **Adjustments to bids.** To permit equitable comparison of bids—a "level playing field"—the full cost of the government plan must be allocated to its bid.

- **Determination of government payments from the bids.** The government premium contribution for all plans, including the government plan, would be set as a function of the risk-adjusted bids of the qualified health plans able to enroll some minimum proportion of the beneficiaries in the local area (plans able to serve only marginal numbers of enrollees would not set the contribution). We prefer the government to set its premium contribution at the lowest or second-lowest risk-adjusted bid of a qualified plan, subject to capacity limits.

It is worth emphasizing again that this bidding model does *not* contain a cap on the government contribution to what beneficiaries pay. The model is designed to get the price of the entitlement right and to ensure that beneficiaries have at least one option available at no charge over the Part B premium. It does not address the question of whether the government can afford the current entitlement or the question of what entitlement the government can afford. Those are important but different questions for Medicare reform. We do not attempt to answer them here.

However, the answer we do provide to the question we do ask is also crucial for Medicare reform. Simply put, the government is paying too much for the entitlement benefit. Once we know what that benefit costs, we can better address the larger fiscal issues.

The short message of our paper is actually encouraging: competitive bidding requires little extension of administrative practices already in place—it is a major change in policy tied to a tractable, evolutionary change in administrative practices. We can have a reasonable discussion about buffering the abruptness of any changes competitive bidding brings, but the methods for this are administratively simple. Certain key technical issues, notably risk adjustment, require new thinking, but the advent of competitive bidding can expedite workable solutions, given the availability of more detailed, beneficiary-level information.

Qualifying Plans to Bid. The first step in any bidding model is determining who can bid. This is straightforward for competitive bidding because CMS already qualifies private plans in a process that is more extensive than provider qualification in the government plan.

Arguments exist for using the bidding platform to make quality more transparent under competitive bidding. We noted in a recent article that establishing additional qualification requirements for bidders (such as enhanced accreditation as a condition of bidding) and additional data requirements (such as enhanced monitoring of quality and access) may be desirable.[14] The nationwide competitive bidding program for durable medical equipment included such enhancements. Through bidder qualification and closer oversight, competitive pricing could bring scrutiny to areas of the Medicare benefit that currently get only cursory review.

The Payment Area. A key parameter in any bidding system is the geographic area for which a plan submits a bid to provide coverage. The geographic areas relevant to competitive bidding have two components: the "payment" area formally established for the activity being bid and the health plan's "service" area. A payment or bidding area is the area in which beneficiaries choose among competing health plans at a fixed government premium contribution. A "service area" is the geographic area over which a health plan can market its product to beneficiaries. Plans typically choose multiple payment areas to comprise their service area.

Simply put, the government is paying too much for the entitlement benefit.

In the current MA program, the bidding area is the county, as it has been since the early years of private plan participation in the program. Private plans are familiar with that system, and the average cost of caring for beneficiaries in the government plan already is calculated at the county level. Administrative and information systems, as well as plans' estimates of risk and other bid attributes, are well established at the county level. If competitive bidding were implemented, it would make sense in terms of administrative ease and the extent of change attempted in the first steps of a bidding program to continue using the familiar county bidding units, at least for a transition period.

But the disadvantages of county-level payment areas have long been noted. Counties can be extraordinarily diverse. Moreover, counties have no necessary relationship to the number or type of health plans offered or beneficiaries' access to those plans. Welch noted that the county-based payment system is complex and inaccurate and incorporates the effect of high HMO market penetration on FFS costs.[15] He suggested payment areas consisting of urban cores versus suburban rings to bring greater homogeneity to payment areas.[16] Rossiter and Adamache proposed setting metropolitan statistical areas (MSAs) as the geographic payment area and aggregating all non-MSA counties into a single rural payment area.[17]

Because competitive bidding relies on competition among health plans to set the government's contribution to premiums, the geographic payment area should be set with an eye to maintaining a healthy degree of competition among the health plans serving beneficiaries in that area—keeping in mind that private plans can select which areas they will enter. Pizer and Frakt showed that counties with more competing MA plans had lower average out-of-pocket premiums, independent of benefits offered.[18] They also found that plans in more competitive counties offered more generous supplementary benefits, controlling for the level of the government payment. Feldman and colleagues showed that price competition increases significantly when health plans are of the same type—for example, plans with broad provider networks.[19] Thus, a payment area ideally should contain several health plans of the same type. Beneficiaries' access to competing plans also is important. Good transportation networks could justify a larger payment area.

In 2012, only 0.3 percent of Medicare beneficiaries lacked access to a Medicare Advantage plan (the most common type of private plan), and on average, beneficiaries could choose from 12 different MA plans in their market area. Eighty-eight percent of beneficiaries have access to an MA plan that offers Part D drug coverage at no additional premium beyond the Part B premium.[20] Thus, indications exist that competition in a bidding system would be robust, although we do not know how private plans would change their service areas in a competitive bidding regime after payment levels are reduced by the bidding.

MA plans are required to define their service area (the geographic area in which they are able to establish provider networks to care for their enrollees). The government plan is offered to all beneficiaries in all areas, but it is not required to guarantee that beneficiaries can find a provider who is willing to treat them.

Although it would be foolish to force a private plan to expand its service area to places where it is unable to establish provider networks, regional PPOs have agreed to cover beneficiaries in at least 1 of 26 regions established by CMS.[21] Currently, regional plans are available to 76 percent of Medicare beneficiaries.[22] Again, however, plans' willingness to bid by regions is related to the high levels of payment such plans have enjoyed, something unlikely to continue under competitive bidding.

Private plans' ability to choose their service (and thus payment) areas raises the possibility that they might attempt to collude on market entry and thus segment the market, gaining market pricing power. There are several responses to this concern. First, virtually all Medicare beneficiaries have access to a private plan; on average, beneficiaries can choose from 12 MA plans.[23] Second, even if private plans were reluctant to enter a market area, that does not necessarily imply that beneficiaries or taxpayers are worse off. The government plan is universally available, and if private plans do not feel they can offer a competitive product in a market area, beneficiaries still have access to the government plan at the Part B premium.[24] Third, the price of the government plan always checks any attempt at collusion by private plans.

In our view, the serious concern about collusion is that private plans might together "shadow price" the government plan's premium in areas where that premium is high, rather than submitting a bid that reflects their true cost. Although this may be a serious antitrust concern, it should not be a barrier to competitive bidding in Medicare. Currently, market concentration among physicians and hospitals appears to be a greater problem than concentration of health plans.[25]

Thus, we envision a bidding system that begins by using county-level payment areas, then through research and monitoring considers larger payment areas and tracks whether plan behavior suggests notable gaming that undermines the purposes of the bidding system.

One key to developing the bidding system will be the risk adjustment system that is used. We consider that in the next section.

Risk Adjustment. Concerns about risk selection in competitive bidding systems generally are driven by the desire to have the relative prices of competing health plans reflect only differences in efficiency, not differences in the health risk of the plans' enrollees. These concerns are present for risk adjustment in any pricing system, not only competitive bidding. Although that desire has considerable appeal, it should not be left unexamined. The prices of many products reflect the characteristics and consumption habits of the people who buy them (for example, safe-driver discounts on automobile insurance). The assumption underlying the desire for risk adjustment appears to be that a beneficiary's health risk is "exogenous" to both the beneficiary and health plan, and thus it is not fair to hold either the beneficiary or the health plan responsible for costs associated with higher health risks. Another concern is that if the differences in health risk among competing plans are uncompensated, plans will shun high risks by discouraging their enrollment or encouraging their disenrollment in overt and covert ways.

The most important point about risk adjustment is that CMS already has an elaborate system for it that represents the culmination of years of work and several increasingly sophisticated iterations. CMS uses the hierarchical condition category (HCC) risk adjustment system that captures many different health conditions. One of those risk categories is arbitrarily given the weight 1.0. Lower-risk categories

have weights less than 1.0, and higher-risk categories have weights greater than 1.0. If the payment rate for a 1.0 enrollee is $700 per month and the weight for a particular beneficiary is 1.1, then the health plan receives $770 a month for that enrollee. Currently, the weights are derived from the cost of caring for beneficiaries in the government plan.

Suppose that private plans enroll beneficiaries who are healthier than beneficiaries choosing the government plan and some of those differences are not captured by the risk adjustment system. As a result, the government overpays private plans. That is what happened with the government's original rudimentary risk adjustment system—the adjusted average per capita cost. Over the years, the government has refined its risk adjustment system to improve the accuracy of payments to private plans. However, the Government Accountability Office recently reported that payments under the current HCC risk adjustment system may be affected by the propensity of private plans to code more complete diagnostic information than is typical in the government plan—not surprising since the private plans' payments depend on their coding, while the government plan is under no such incentive.[26]

How would uncompensated risk differentials affect a competitive bidding system? In a competitive bidding system, all plans bid for the 1.0 enrollee. Suppose that private plans enjoy favorable risk selection that is not captured by the HCC risk adjusters. Thus, the 1.0 enrollee in a private health plan really is, say, a 0.95 enrollee. Competition will force plans to submit bids that are close to their cost, and as a result, private plans' bids will be lower than the government plan's bid. This is due, in part, to this favorable risk selection not accounted for in the HCC risk adjustment system. As a result, the premium differential between the government plan and the private plans, and thus the beneficiary's out-of-pocket premiums, will be distorted (too large).

What can be done if Medicare is truly unable to adjust the bids for risk selection? Overt attempts by private plans to recruit low risks are illegal, and CMS monitors those activities (the effectiveness of that monitoring is unknown). In addition, that annual Medicare Current Beneficiary Survey, which collects extensive information about the beneficiary's health and functional status, could be used to monitor some types of selection that the HCC risk adjusters might not pick up. Additional enrollee-level data could be collected from health plans if competitive bidding were introduced.

Frakt and others have emphasized the limitations of available risk adjustment methods.[27] To ensure that selection is not getting out of control, Frakt suggests the need for a "full-court press" in monitoring risk selection by plans that have the ability to rapidly adjust how they enroll beneficiaries.

Administrative Costs. Most analysts understand that the optimal expenditure on administration is not likely to be the minimal level in absolute terms, on a per capita basis, or as a percent of total plan expenditures. Administrative costs can be minimized simply by paying every claim that is submitted with no scrutiny whatsoever. The likely result would be rampant fraud and abuse. An efficient health plan should be willing to spend a

dollar on administration if doing so saves more than a dollar. As a result, the ratio of administrative costs to total spending will rise, not fall.

An efficient health plan acting as a responsible agent for its enrollees also would spend an additional dollar on administration even if it yielded no savings, as long as the expenditure resulted in better service for which enrollees were willing to pay at least a dollar. For example, a health plan might add staff to its telephone help lines if enrollees were willing to pay for those additional staff.

Thus, as with spending on services, the right question is not, "How much are we spending on administration?" but "What are we getting for our money?" Private health plan spending on administrative costs might be inefficiently high or low, and the same is true of the government plan. The most reliable way to answer the efficiency question is to put both types of plans to a market test.

Proper accounting for administrative cost is particularly worrying to those who believe that the government plan's bid might not reflect its full cost. To appreciate this concern it is important to understand that CMS actually has two different functions. The first is managing the government heath plan. The second is managing the system of competing health plans that are offered to beneficiaries. Enthoven called that entity the "sponsor" of the managed competition system.[28] The sponsor operates at a level above the competing health plans. The concern is that CMS, in its role as sponsor, will give an unfair advantage to its own plan versus those of the private competitors, rather than offering both types of plans on a level playing field.

Establishing a truly level playing field will be a difficult and ongoing task. For example, the Medicare website that allows beneficiaries to compare all the plans in their market area is a sponsor-level activity, so the cost of maintaining it should not be charged to the government plan. However, the cost of mailing marketing material to beneficiaries that mentions only the government plan should be charged to the government plan and included in the its bid. The cost of collecting the Part B premium is another sponsor-level activity because the Social Security Administration collects the Part B premium for both the government plan and private plans. However, the government should include the cost of collecting the *additional* premium in areas where a private plan is the low bidder in its plan bid.

The right question is not, "How much are we spending on administration?" but "What are we getting for our money?"

Many cost allocation decisions will be contentious because of spillover benefits. For example, detecting and prosecuting fraud among providers of services to the government plan may catch some providers that were defrauding private plans, and vice versa.

For the playing field to be truly level, the government plan must be allowed to spend as much as it likes on administration, as suggested earlier. Currently, the government plan can pay for administrative expenses only from a fund earmarked by Congress for administration, not from the funds that pay for beneficiaries' health expenses.[29] Thus, the government plan may be constrained from additional investment on administration, even when such investment would save money. Private plans face no such constraint.[30]

Regulating Bidders and the Problem of Collusion. How would competitive bidding work after 10–15 years in the field? It is important to take this longer-run perspective because some problems may come up that are not addressed in our analysis of how to set up a bidding system. The problem of most concern is collusion among bidders.

One solution, as noted earlier, is to make the bidding process and the behavior of all plans as transparent as possible. Another solution is sound design of the bidding process. In this regard, it is useful to examine a recent case of bidder collusion in a private bidding system. In 2009, Hewitt Associates conducted an Internet auction in which more than 50 health plans competed for the business of three employers—IBM, Morgan Stanley, and Ikon Office Solutions.[31] The auctions resulted in premium rates falling by 2 to 8 percent in an environment where annual increases in premiums paid by employers were running from 4 to 6 percent above the general rate of inflation. The next year, 100 health plans and 9 employers participated in the auction. But only four employers returned in 2011. The auctions failed to generate appreciable cost savings and were discontinued.

A 2012 analysis by Gupta, Parente, and Sanyal suggests this auction failed because of two built-in design flaws.[32] The first was that the bids were open, so all participants knew what the other plans were bidding. This is an efficient bidding system in "common value" auctions, where the value of the auctioned good is the same for everyone (a Rembrandt painting, for example). Open bids can give the participants information about the value of the painting. However, open-bid auctions can be a format to signal prices to other bidders, leading to collusion.

The second flaw was that the winners were determined by the buyers on the basis of prices and nonprice attributes such as plan performance ratings. The participating plans did not have a clear idea of how the winners would be chosen, and they appear to have believed that their likelihood of winning would not increase significantly by lowering their bids. Even though all bids were disclosed, the lower-ranked plans rarely revised their bids.

These are real problems, and they suggest that designing a bidding system that can survive in the long run is not trivial. But it is not impossible, either. Because winning the auction by being the lowest-priced health plan does not have the same value for every participant, the bids should be sealed. Equally important, participants need to know how the winner will be selected. Our advice is to make all plans meet certain performance standards to be qualified to

bid, then pick the lowest bid, period. Plans will know that the probability of winning is determined directly, and solely, by submitting lower bids.

The important message here is that sound design from the beginning is the best way to sustain the bidding system over time. The design should be supplemented by active monitoring and regulation as needed to facilitate transparency but should not rely on that to prevent collusion.

Consumer Information and Enrollment. Competitive bidding changes the terms under which beneficiaries make choices about their Medicare coverage. Beneficiaries who do not even feel they have made a choice in the past—because they have stayed in the traditional government plan or have stayed with their original choice for a long time—may face different prices for their current options. They can avoid any change in premium by changing plans under the bidding model we have outlined, but will they understand the need to make this change?

Frakt has described the problem:

> There is research [for example, analyzing elders' Part D choices[33]] that suggests beneficiaries have difficulty making good choices among the myriad of available plans. Many on Medicare lack the cognitive ability to do the work to do so. Not all of them have children or spouses who can help. Thus, some suggest the right thing to do is to simplify Medicare, not make it more (or even keep it as) complex… This argument also relates to the feeling among some that private plans will take advantage of beneficiaries. If plans make obtaining care difficult in some way, some beneficiaries could lose access to necessary care. Finally, there are ways to help beneficiaries navigate plan choices and obtain the care they need. For example, additional resources could be spent on counselors available by phone or in the community.[34]

It is clear that the introduction of competitive bidding, even with generous transitional terms to buffer the abruptness of any effects, will make it more difficult for elders to understand and navigate the benefit successfully.

Sound design from the beginning is the best way to sustain the bidding system over time.

There are analogues in other Medicare experience, such as the introduction of Part D and the demonstration and rollout of competitive pricing for DME. Although the analogies are not perfect, they suggest that program changes do not necessarily wreak havoc on beneficiary choices. For example, in a review of the DME competitive bidding demonstration submitted to Congress, the US Department of Health and Human Services (2004) concluded, "Substantial early efforts to educate beneficiaries, referral agents, and suppliers about the demonstration helped to ease the transition to the competitively bid fees and suppliers list."[35]

These earlier experiences do not settle the issue, but they provide a mixture of caution and reassurance. Perhaps the most important caution is about assuming that elders are good at making choices in the current program, much less in a new landscape of competitive prices. But means exist to help beneficiaries navigate plan choices and enable reasonable transitions to the new price structure. Such efforts will be essential to avoid unnecessary opposition to the change based on misunderstanding.

Distributional Issues. One indisputable distributional effect of competitive bidding concerns the loss of "free"[36] supplementary benefits by beneficiaries in areas where the government plan's costs, and thus payments to private plans, currently are high. As noted earlier, this result is not necessarily undesirable. We know of no efficiency or fairness arguments that justify providing more government-financed benefits simply because some beneficiaries live in areas where risk-adjusted health care costs are higher. Medicare originally was envisioned as a national program with uniform entitlement benefits. Keeping that vision in mind, free supplementary benefits are a sure sign of something wrong with Medicare. Private plans are able to provide sometimes-substantial benefits for free because the government pays too much for the entitlement benefit.[37]

Obviously, we need a renewed agreement about what is already settled in statute—that the federal government should be a prudent purchaser of the entitlement benefit. Prudent purchasing through competitive pricing has to mean eliminating free benefits.

Nonetheless, the effects on beneficiaries of losing free supplementary benefits need to be taken seriously, because areas that "lose" under competitive bidding will resist it. If nothing else, this is an important political problem. Second, evidence exists that private plans enroll a disproportionate share of vulnerable beneficiaries. Thorpe and Atherly found that a plurality of Medicare beneficiaries with incomes between $10,000 and $20,000 were enrolled in Medicare HMOs, as opposed to the government plan.[38]

The loss of free supplementary benefits for low-income beneficiaries could have important implications for both the Medicare program and state budgets. When low-income beneficiaries lose their free supplementary benefits, they may find it necessary to become dually enrolled in Medicaid and Medicare. Atherly and Dowd found that a $10 decrease in monthly government payments to private plans increases the probability of dual enrollment by 4 percentage points.[39]

When low-income beneficiaries become dually enrolled, states will be required to pay approximately 45 percent of these beneficiaries' expenses for services covered by Medicaid (the average state match percentage). States would have a strong incentive to influence the beneficiary's decision, and if permitted, might be willing to subsidize low-income beneficiaries who remain enrolled only in the government plan—for example, to replace the free benefits lost as a result of competitive bidding. Those subsidies might be coordinated with, or independent of, the Qualified Medicare Beneficiary and Special

Low Income Medicare Beneficiary subsidies currently in place.

Requiring Beneficiaries to Choose among Competing Health Plans. It is important to remember that Medicare beneficiaries currently choose among competing health plans. Nonetheless, competitive bidding is designed to bring new price signals to the choice of health plans, communicating to beneficiaries when any plan costs more than the Part B premium because its bid is higher than the benchmark bid (for example, the second-lowest bid). Beneficiaries who wish to remain in a higher-cost plan will have to pay that difference. That is a good thing for the long-term solvency of Medicare, but it raises questions about whether the changes that elderly individuals will have to make are desirable. It will be useful to consider those questions.

Is the beneficiary's choice between the government plan and private plans a public policy issue? That choice might be a public policy issue if there were systematic differences in quality between the government plan and private health plans, but there are not.[40] The quality of private plans is variable, but so is the quality of the government plan. The best that can be said on this score is to follow the suggestion of others: in competitive bidding, it makes sense to maintain both intensive monitoring and transparency of public quality data in both private plans and the government plan. The first step is to have the government plan begin reporting the same quality measures now required of the private plans.

Can elders make this choice? A second point is obvious: while many elders are frail, it is ludicrous to imagine that most cannot change plans, as they routinely did when using private insurance during their working lives. This is the normal experience for anyone with employment-based insurance.[41] And an elder whose current plan is more expensive will *always* have a no-cost option.

Should Medicare provide resources for frail or incapacitated elders, especially those without family or other resources, to assist in their decision? Yes. It is worth noting the plight of these beneficiaries is not much addressed in current arrangements. But with competitive bidding, it would be more important to make community and other resources available to assist such elders.

Should the government give special consideration to areas where beneficiaries face large, abrupt changes under competitive bidding? Abrupt changes required to achieve worthy long-term goals may be inappropriate, given the reasonableness of settled beneficiary expectations and the time it takes to educate beneficiaries. Accordingly, introducing competitive bidding may have to include a transition to buffer *large* changes. That is easily done as a technical matter through ceilings on the rate of change, blended transitions, or other provisions. But there is a caveat, in the spirit of "no free lunch": transition provisions can substantially reduce the savings from competitive bidding. A balance should be struck, and it is reasonable to worry that the political system will indefinitely postpone any reckoning with the need to change.

DYNAMIC SAVINGS FROM COMPETITIVE BIDDING

Shortly after the Patient Protection and Affordable Care Act of 2010[42] was passed, *Managed Care Magazine* (2010), a trade journal, published an article that expressed a variety of opinions about how private plans will react to the payment cuts required by ACA.[43] Some commentators predicted that private plans would cut benefits and raise premiums. But others, perhaps more perceptive, focused on how plans might navigate the cuts by changing the way they organize and deliver care. We refer to these changes as the "dynamic savings" from competitive bidding. The idea is that plans might adjust to the increased financial pressure of payment cuts by becoming more efficient over time.

The notion of dynamic savings is important for proposals that would use competitive bidding to set the government's contribution to premiums. Many people believe that such changes will promote the incentives for dynamic savings. For example, the Domenici-Rivlin Debt Reduction Task Force argued that making a fixed contribution would create incentives for Medicare plans to be more efficient.[44]

A Kaiser Family Foundation report summarized the central issue in the debate over dynamic savings as being "whether or not competition among plans would achieve these intended efficiencies or simply shift costs to beneficiaries is the heart of the debate about recreating Medicare as a premium support program."[45]

Regrettably, little empirical evidence exists to support or refute the claim for dynamic savings. But analogies to past experience are promising. There are at least seven arguments why competitive bidding may create dynamic savings for either private health plans or the government plan.

1. Competitive bidding has produced dynamic savings before. Coulam and coauthors showed that competitive bidding produced savings across widely varying parts of the Medicare benefit, in all instances that actual bids were received.[46] For example, the Denver bids in the Medicare competitive pricing demonstration of the late 1990s were significantly lower than the cost of the market-norm benefit package for private plans in Denver. This evidence suggests that private plans will bid less than their current costs. However, the Denver program was canceled before it was possible to determine whether its plans actually reduced their costs to match the bids. Furthermore, this evidence does not show, either positively or negatively, whether bidding will reduce the rate of growth of costs.

2. When Medicare beneficiaries in some market areas have to pay out-of-pocket premiums for the government plan, they may be so "shocked" by this new requirement that lose their loyalty to the government plan. Antos's paper in this series (*Plan Competition and Consumer Choice in Medicare: The Case for Premium Support*) emphasizes this point. Private plans, sensing they can gain more enrollees by submitting low bids, may be more inclined to reduce their bids. We are 100 percent in favor of low bids, but, unless accompanied by appropriate

changes in plan behavior, they will not lead to an increase in efficiency. It will only decrease plans' profits.

3. Under the current payment system, private plans bid against a known benchmark—the government plan's cost. In a competitive bidding system, the benchmark is not known. This may create an incentive for plans to submit lower bids.[47] As we described in point number 2, without other changes in plan behavior, this is a cut in profits rather than a gain in efficiency. However, if we are interested in getting plans to submit lower bids, the reason for the low bids may not matter.

4. Baker found cost-reducing spillovers into the government plan when the private Medicare sector as a whole grows.[48]

5. Some studies show that firms in more-competitive markets have lower costs.[49] However, the relevance of these findings is questionable because competitive bidding does not change Medicare's market structure—instead, it changes how the government payment is set.

6. The current tax on low bids encourages plans to submit high bids and provide tax-free amenities. While our proposal would eliminate the tax on low bids, this problem could be corrected without competitive bidding, just by eliminating the tax.

7. Getting more people into private plans that accept a predetermined payment for all medical services may reduce the flow of cost-increasing technology over the long run, although that result is not certain.

Although the evidence is lacking, these arguments point in the direction of dynamic efficiency—or at least toward lower bids—not the other direction. The odds are that efficiency will improve, providing important support for competitive bidding.

> We are 100 percent in favor of low bids, but, unless accompanied by appropriate changes in plan behavior, that will not lead to an increase in efficiency.

CONCLUSION

Medicare pays too much for the entitlement benefit. Part of Medicare reform is getting the price of the entitlement right, meaning the government should pay the efficient cost of producing coverage for beneficiaries in each area of the country. Competitive bidding is the only serious reform that promises to do that while preserving whatever entitlement is established.

For so substantial a change, competitive bidding is remarkably well-tested and administratively modest. It will not be a big deal to implement. However, it will be a big deal to ensure that the bidding system runs smoothly and fairly. We have highlighted those areas throughout this paper, including:

- **Leveling the playing field.** Competitive bidding requires that the bids be as comparable as possible, so the full cost of the government plan must be allocated to the government plan's bid.

- **Transitional bidding rules.** Even if competitive bidding is the right goal for the Medicare program, the transition to competitive bidding should be moderated for beneficiaries facing the largest changes in benefits and premiums. These adjustments are technically easy but can be very costly.
- **Risk adjustment.** Given the technical problems of risk adjustment, it will be important to monitor plan behavior under competitive bidding, to provide some reassurance and enable technical refinement. This and other aspects of bidding urge more complete reporting of beneficiary-level data by plans.
- **Protection of beneficiaries.** Imperfect risk adjustment and other factors can give scope to plan-gaming that harms beneficiaries and undermines the purposes of bidding. A more transparent system of monitoring and reporting is needed to provide reassurance about what actually happens when bidding is implemented. Meanwhile, other aspects of the system (for example, possible beneficiary confusion with a new program) are ordinary concerns with a new reform but warrant close monitoring to enable early warning of problems.

Competitive bidding will save a substantial amount of money, the exact amount depending on the bidding rules ultimately selected and any transition rules adopted to moderate the pace of change for beneficiaries. Although bidding would save money by bringing more efficient prices to the entitlement benefit, it would leave unanswered whether the government can afford this or some other entitlement. But it is the right goal for setting prices.

Whatever the political process deems appropriate for the entitlement, it is difficult to argue that the government should not be a prudent buyer of that benefit. A broad spectrum of political opinion currently agrees. It is the right time to reach agreement on the questions that divide opinion and begin making the necessary reforms.

About the Authors

Roger Feldman (feldm002@umn.edu) is the Blue Cross Professor of Health Insurance and Professor of Economics at the University of Minnesota. **Bryan Dowd** (dowdx001@umn.edu) is Mayo Professor in the Division of Health Policy and Management, School of Public Health, and cochair of the Program in Human Rights and Health at the University of Minnesota. **Robert Coulam** (coulam@simmons.edu) is senior lecturer and director of the Center for Health Policy Research at the Simmons College School of Management.

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ENDNOTES

[1] Robert Coulam, Roger Feldman, and Bryan Dowd, "Competitive Pricing and the Problem of Cost Control in Medicare," *Journal of Health Policy, Politics, and Law* 36, no. 4 (August 2011): 649–89.

[2] Bryan E. Dowd, Roger Feldman, and Jon Christianson, *Competitive Bidding for Medicare* (Washington: AEI Press, 1996).

[3] Senate Committee on Aging, *Medicare Reimbursement for Elderly Participation in Health Maintenance Organizations and Health Benefit Plans,* 96th Cong., 1st sess., 1979.

[4] W. McClure, "Implementing a Competitive Medical Care System through Public Policy," *Journal of Health Politics, Policy and Law* 7, no. 1 (Spring 1982): 2–44; A. C. Enthoven, *Theory and Practice of Managed Competition in Health Care Finance* (New York: North Holland, 1988); A. C. Enthoven, "Managed Competition: An Agenda for Action," *Health Affairs* 7, no. 2 (Summer 1988b): 25–47.

[5] Dowd, Feldman, and Christianson, *Competitive Bidding for Medicare*; Bryan Dowd, Robert Coulam, and Roger Feldman, "A Tale of Four Cities: Medicare Reform and Competitive Pricing," *Health Affairs* 19, no. 5 (2000): 9–29.

[6] Coulam, Feldman, and Dowd, "Competitive Pricing and the Problem of Cost Control."

[7] Dowd, Coulam, and Feldman, "A Tale of Four Cities."

[8] Bryan E. Dowd et al., "Issues Regarding Health Plan Payments under Medicare and Recommendations for Reform," *Milbank Quarterly* 70, no. 3 (1992): 423–53; Dowd, Feldman, and Christianson, *Competitive Bidding for Medicare*; Coulam, Feldman, and Dowd, "Competitive Pricing and the Problem of Cost Control."

[9] Certain prominent proponents of "premium support" made it clear they wanted to replace the public plan with private plans, and certain proposals, such as the original Ryan Plan, encouraged this reading as they paired competitive bidding with a defined contribution unrelated to the bids. But the connection is not a necessary one. We have never linked the two, and indeed the Ryan Plan, as modified, now ties the contribution to the level of the bids.

[10] Roger Feldman, Robert Coulam, and Bryan Dowd, "Competitive Bidding Can Help Solve Medicare's Fiscal Crisis," AEI *Health Policy Outlook* (February 2012), www.aei.org/outlook/health/healthcare-reform/competitive-bidding-can-help-solve-medicares-fiscal-crisis.

[11] For a more complete discussion of these alternatives for the government plan, see chapter 5 in Robert Coulam, Roger Feldman, and Bryan E. Dowd, *Bring Market Prices to Medicare: Essential Reform at a Time of Fiscal Crisis* (Washington, DC: American Enterprise Institute, 2009).

[12] Ibid.

[13] For example, if we are going to emphasize data equality between private plans and the government plan, we should insist that private plans provide encounter-level data, which is readily available in the government program.

[14] Coulam, Feldman, and Dowd, "Competitive Pricing and the Problem of Cost Control."

[15] W. P. Welch, "Improving Medicare Payments to HMOs: Urban Core versus Suburban Ring," *Inquiry* 26 (Spring 1989): 62–71. If private plans were more efficient than the government plan and the medical practice style in private plans spilled over to the government plan, increased private market penetration would reduce costs in the government plan. See Laurence Baker, "Association of Managed Care Market Share and Health Expenditures for Fee-for-Service Medicare Patients," *Journal of the American Medical Association* 281, no. 5 (February 3, 1999): 432–37. Under the current payment system, that would translate into lower payments to private plans. Under competitive bidding, it would translate into a lower bid by the government plan.

[16] Welch's proposal does not solve the spillover problem. He notes that "(i)f HMOs substantially influence the local AAPCC (FFS costs), the rationale for using the AAPCC is lost" (our parentheses).

[17] L. F. Rossiter and K. W. Adamache, "Payment to Health Maintenance Organizations and the Geographic Factor," *Health Care Financing Review* 12, no. 1 (Fall 1990): 19–30.

[18] S. D. Pizer and A. B. Frakt, "Payment Policy and Competition in the Medicare+Choice Program," *Health Care Financing Review* 24 (2002): 83–94.

[19] Roger Feldman et al, "The Demand for Employment-Based Health Insurance Plans," *Journal of Human Resources* 24, no. 1 (Winter 1989): 115–42.

[20] Medicare Payment Advisory Commission, *Report to Congress,* 2012, www.medpac.gov/chapters/Mar12_Ch12.pdf.

[21] Medicare Payment Advisory Commission, "Medicare Advantage Program Payment System: Payment Basics," 2011, www.medpac.gov/documents/MedPAC_Payment_Basics_11_MA.pdf.

[22] Medicare Payment Advisory Commission, *Report to Congress.*

[23] Ibid.

[24] Beneficiaries and taxpayers could be worse off in those areas if the MA plans' reluctance to enter the market is due to unchecked provider concentration that has resulted in market pricing power and inefficiently high prices of health care.

[25] John E. Schneider et al., "The Effect of Physician and Health Plan Market Concentration on Prices in Commercial Health Insurance Markets," *International Journal of Health Care Finance & Economics* 8, no. 1 (March 2008): 13–26.

[26] US Government Accountability Office, *CMS Should Improve the Accuracy of Risk Score Adjustments for Diagnostic Coding Practices* (Washington, DC, January 2012), www.gao.gov/assets/590/587637.pdf.

[27] Austin Frakt, "Premium Support Proposal and Critique: Objection 4, Complexity," The Incidental Economist, December 16, 2011, http://theincidentaleconomist.com/wordpress/premium-support-proposal-and-critique-objection-4-complexity/.

[28] Enthoven, *Theory and Practice of Managed Competition*.

[29] Robert Berenson and Bryan E. Dowd, "Medicare Advantage Plans at a Crossroads—Yet Again," *Health Affairs* 28, no. 1 (2009): 29–w40.

[30] Note that private plans will face a constraint on administrative costs beginning in 2014. The ACA implements a medical loss ratio (MLR) requirement for MA plans of at least 85 percent, beginning in 2014. Private plans that fail to meet this requirement will be required to rebate to CMS the percentage of the plan's revenue equal to the difference between 85 percent and the plan's actual MLR. Private plans that do not meet the 85 percent MLR requirement for three consecutive years will not be permitted to accept new enrollees in the subsequent year and plans that do not meet the requirement for five consecutive years will be terminated.

[31] Alok Gupta, Stephen Parente, and Pallab Sanyal, "Competitive Bidding for Health Insurance Contracts: Lessons from the Online HMO Auctions," *International Journal of Health Care Finance & Economics* 12, no. 4 (2012): 303–22.

[32] Ibid.

[33] Jason Abaluck and Jonathan Gruber, "Choice Inconsistencies among the Elderly: Evidence from Plan Choice in the Medicare Part D Program," *American Economic Review* 101, no. 4 (June 2011), 1180–210.

[34] Frakt, "Premium Support Proposal and Critique."

[35] Tommy G. Thompson, Secretary of Health and Human Services, *Final Report to Congress: Evaluation of Medicare's Competitive Bidding Demonstration for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies,* 2004, www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/CMS_rtc.pdf.

[36] By "free," we mean no premium other than the Part B premium.

[37] Some of the free benefits are due to other factors—for example, if a plan is more efficient than its competitors, it can offer free benefits for the difference. However, on average, private plans are not more efficient than the government plan.

[38] K. E. Thorpe and A. Atherly, "Medicare+Choice: Current Role and Near-Term Prospects," *Health Affairs* Web Exclusive (July 17, 2002): W242–52.

[39] Adam Atherly and Bryan E. Dowd, "The Effect of Medicare Advantage Payments on Dually Eligible Medicare Beneficiaries," *Health Care Financing Review* 26, no. 3 (Spring 2005): 93–104.

[40] Robert H. Miller and Harold S. Luft, "HMO Plan Performance Update: An Analysis of the Literature, 1997–2001," *Health Affairs* 21, no. 4 (July 2002): 63–86.

[41] Starting in 2014 under the ACA, it will also be normal for working-age people without employer-sponsored insurance to choose among competing private plans in health insurance exchanges.

[42] *Patient Protection and Affordable Care Act,* Public Law 111-148, 111th Cong., 2d sess. (January 5, 2010).

[43] John Carroll, "Some Plans May Prosper Despite Medicare Advantage Payment Cuts," *Managed Care* (April 2010), www.managedcaremag.com/archives/1004/1004.MA_cuts.html.

[44] Bipartisan Policy Center, "Domenici-Rivlin Protect Medicare Act," updated June 15, 2012, www.bipartisanpolicy.org.

[45] Beth Fuchs and Lisa Potetz, Kaiser Family Foundation, "The Nuts and Bolts of Medicare Premium Support Proposals," June 2011, 6, www.kff.org/medicare/upload/8191.pdf. Note that the Kaiser Family Foundation report assumes that reform is backed by a "hard cap" on the rate of growth of Medicare spending.

[46] Coulam, Feldman, and Dowd, "Competitive Pricing and the Problem of Cost Control."

[47] Coulam, Feldman, and Dowd, *Bring Market Prices to Medicare*.

[48] Baker, "Association of Managed Care Market Share and Health Expenditures."

[49] Kira Fabrizio, Nancy Rose, and Catherine Wolfram, "Do Markets Reduce Costs? Assessing the Impact of Regulatory Restructuring on U.S. Electric Generation Efficiency," *American Economic Review* 97 (September 2007): 1250–77.