CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Dan L. Crippen, Director

September 24, 2002

Honorable W. J. "Billy" Tauzin
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

On June 24, 2002, CBO produced cost estimates for the versions of H.R. 4954, the Medicare Modernization and Prescription Drug Act of 2002, ordered reported by the Committee on Ways and Means and by the Committee on Energy and Commerce. Those bills, and H.R. 4954 as passed by the House of Representatives, included a provision to expand and make permanent a demonstration project in which certain durable medical equipment (DME) and orthotics are acquired through competitive bidding instead of paying on the basis of a fee schedule. A paper by Rodgers and Smith of PricewaterhouseCoopers L.L.P. (PwC) raises a number of questions about CBO's estimate and provides an alternative "illustrative calculation" of the budgetary effect of that provision.[1] This letter discusses both the basis of CBO's estimate and issues raised by the PwC paper.

CBO estimated that implementing the provision establishing competitive bidding for DME would reduce direct spending for Medicare by $7.7 billion over the 2003-2012 period, before taking into account the effect of that reduction in spending on premiums paid by beneficiaries. Lower premiums would offset about 25 percent of those savings, resulting in an estimated net reduction in direct spending of $5.8 billion over the 10-year period.[2] The PwC paper provides an illustrative example of alternative calculations that yield savings of about $1 billion over the same period.

Competitive Bidding Proposal. The act would require the Secretary of Health and Human Services to establish a competitive bidding program for durable medical equipment beginning in 2004, with

1. Rodgers, J. and L. Smith, "Misunderstandings and Uncertainties Overstate Likely Savings from Competitive Bidding in the Medicare DME Market," PricewaterhouseCoopers, July 19, 2002.

2. Those estimates reflect changes in spending for beneficiaries in Medicare's fee-for-service sector only, and do not reflect the interaction of changes in spending for beneficiaries in the fee-for-service sector with payments for beneficiaries in group plans.

full implementation in all designated bidding areas by 2006. It would make permanent and expand demonstration projects for competitive bidding for DME that currently are being conducted in Polk County, Florida, and San Antonio, Texas. The Secretary would have the authority to exempt certain items or services for which estimated savings would not be significant and certain geographic areas with low population density. The Secretary would accept bids for certain items or services from contractors and would award contracts to multiple bidders in each area. Non-bidding and non-winning contractors in competitive areas would be ineligible for reimbursement from Medicare for competitively bid items or services.

Projected Spending Under Current Law. In CBO's baseline, DME is included with other non-physician services covered under Part B of Medicare, for which claims are processed and paid by contractors known as carriers. Spending for DME accounts for around 35 percent of 2002 spending on nonphysician, carrier-paid services. In recent years, DME spending has increased by more than 10 percent a year. Some of that rapid growth was due to unusually large increases in payment rates. We project that Medicare spending on DME services under current law will grow at an average annual rate of about 8 percent—from $6.5 billion in 2002 to $14 billion in 2012. That growth rate is based on projected increases in enrollment and prices (based on inflation), plus expected increases in the number of services furnished per capita and the complexity of those services.

The PwC illustrative calculation asserts that the Centers for Medicare & Medicaid Services' (CMS's) baseline for DME in the fee-for-service sector is 25 percent lower than CBO's baseline, and therefore, calculates that savings from competitive bidding for DME would be 25 percent lower under CMS's baseline. Actually, CMS's baseline for DME is only about 6 percent lower than CBO's projection over the 2003-2012 period. That difference has little effect on the projected savings from competitive bidding.

Geographic Coverage of the Program. The act would require the Secretary to establish "competitive bidding areas" throughout the United States for contract award purposes. CBO assumed that competitive bidding areas would include most metropolitan areas, and would include rural areas for certain items that generally are mailed or shipped to beneficiaries in rural areas (such as ostomy bags and inhalation drugs). CBO's analysis of Medicare's Standard Analytic File indicates that, for major categories of DME items, between 65 percent and 75 percent of spending occurs in Metropolitan Statistical Areas. (About 75 percent of Medicare beneficiaries live in urban areas.) CBO's estimate assumed that, by 2006, about 50 percent of current-law spending for DME would occur in areas that would be covered by the competitive bidding program.

The PwC illustrative calculation assumed that competitive bidding would be implemented only in counties at least as large as Polk County, Florida (the site of a current demonstration project for competitive bidding for DME). Only 35 percent of Medicare beneficiaries reside in counties at least as large as Polk County. But there is no reason to assume that Polk County represents the minimum viable size for competitive bidding.

Coverage of DME Items and Services. The competitively bid items and services in the demonstration projects in Polk County, Florida and San Antonio, Texas include hospital beds, wheelchairs, oxygen equipment, inhalation drugs, simple orthotics, ostomy supplies, wound care supplies, and enteral and parenteral supplies. Medicare has chosen to conduct bidding on the high-volume items within each of these classes of devices. The proportion of spending subject to competitive bidding ranged from 70 percent for wheelchairs to over 99 percent for oxygen equipment. Based on discussions with CMS staff, CBO assumed that similar items and services would be included in the proposed competitive bidding program, and that some other high volume items and services, like diabetic supplies, would also be subject to competitive bidding. Our estimate of the competitive bidding provision in H.R. 4954 assumed items accounting for 85 percent of DME spending in the competitive bidding areas would be eligible for competitive bidding. (The PwC illustrative calculation assumed that only 50 percent of such spending would be subject to competitive bidding.)

The 85 percent factor takes into account payments for low-volume items, items for which the Secretary is not likely to achieve significant savings, and items that would be excluded from competitive bidding by H.R. 4954. For example, the act would exclude fitted orthotics and prosthetics from the competitive bidding program.

Achievable Savings. Preliminary results from the Polk County, Florida and San Antonio, Texas demonstrations indicate that competitive bidding produced savings in all DME categories. CBO applied lower savings rates than those achieved in the demonstrations for each category of DME, except for inhalant drugs, in our estimates of H.R. 4954 because we assumed that Medicare would not realize savings at those levels in all competitive bidding areas. In general, we assumed savings rates ranged from 10 percent for enteral and parenteral supplies to 25 percent savings for inhalant drugs, with an overall average of 19 percent. (Savings averaged 17 percent across all of the DME categories subject to competitive bidding in Polk County and 22 percent in San Antonio.)

The overall average savings rate for the CBO estimate is higher than the Polk County average because CBO assumed that bidding for inhalant drugs, where the highest percentage of savings would be achieved, would be conducted on a nation-wide basis (that is, in both urban and rural areas), whereas bidding for most other DME items and services would be limited to metropolitan areas. As a result, CBO expects that inhalant drugs would account for a higher proportion of affected spending under H.R. 4954 than in the demonstration counties.

CBO's estimate assumed relatively little erosion from the savings rates observed in the demonstrations because several differences between the proposal and the demonstration projects would tend to keep bids low. In the demonstration projects, losing and non-bidding contractors can maintain their relationships with beneficiaries who are already clients. Under the proposal, only winning bidders would be eligible for payment for items and services subject to competitive bidding. The demonstration projects are of limited duration. By contrast, the proposal would extend the

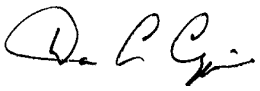
length of contracts to three years and the program would continue in areas indefinitely. Those differences would increase the stakes for medical equipment suppliers and would lead to downward pressure on bid prices.

Administrative Costs. The PwC calculation includes an estimate of the cost to CMS of administering the competitive bidding program. CBO has not estimated the cost of administering the competitive bidding program. (Spending on those administrative activities is subject to appropriation, and, therefore, is not included in CBO's estimate of changes in direct spending.) However, PwC's estimate of the administrative costs (2 percent of spending on the items that are competitively bid) accounts for only a small portion of the difference between the two estimates.

Quality, Choice, and Access. The PwC paper implies that the implementation of competitive bidding may be limited because of reductions in the quality of service and access to services beneficiaries receive. The First Annual Report to Congress released by CMS on November 30, 2000, chronicled both access and quality problems, but these were all resolved. The paper also stated that there had been some possible improvements in access in Polk County. We saw no indication in the report and in our discussions with officials at CMS that there were significant problems with access or quality under competitive bidding. We assumed that similar problems would occur with the implementation of a nation-wide program, but that these problems would be resolved as they have been in the demonstration.

I hope this information is helpful to you. If you would like further details on CBO's estimate, we would be pleased to provide them.

Sincerely,



Dan L. Crippen
Director

cc: Honorable John D. Dingell
Ranking Member

Identical letters sent to the Honorable William "Bill" M. Thomas and the Honorable Max Baucus.