



**Center for Health Quality, Outcomes, and Economic Research
Edith Nourse Rogers Memorial VA Hospital, Bedford, MA
and Boston University School of Public Health**



Competition in the Medicare+Choice Program

**Presented to the Federal Trade Commission/Department of Justice
Hearing on Health Care and Competition Law and Policy
April 23, 2003**

Steven D. Pizer, Ph.D.

*Center for Health, Quality, Outcomes & Economic Research,
Department of Veterans Affairs and
Boston University School of Public Health*

CHQOER

Topics To Consider

- When should agencies be concerned about coordinated effects from a merger?
- When products are substitutes (lack of differentiation).
- When demand is inelastic (brand loyalty).
- When industry concentration already has demonstrable effects on price and quality.

Why Focus On Medicare?

- Less group purchasing and self-insurance (makes markets more local).
- Product differentiation is constrained by regulation.
- Demand becomes less elastic with age.
- Medicare reform proposals rely on competing private plans.

What is Medicare+Choice?

- M+C provides coverage to 5 million Medicare beneficiaries mostly through private HMOs.
- Plans are paid by the government according to administratively determined rates and may also charge a premium.
- Plans may offer benefits above the standard Medicare package (e.g., prescription drug coverage).

Competition in Medicare+Choice

- Attempts to introduce competitive pricing have been blocked.
- Since zero-premium plans are common, competition may be limited to benefits.
- Herfindahl index and actions of other plans affect premium and benefit decisions.
- New “private fee-for-service” plan entered counties where HMOs exited.

Two Studies

- Passage of new payment law in late 2000 created a natural experiment.
 - Opportunity to separate effects of payment rates and competition from effects of unobservable costs.
 - Compare effects of payment rates to effects of competition.
- First PFFS plan began enrolling beneficiaries in June 2000.
 - Opportunity to study market entry.

Study 1: A Natural Experiment

- Congress passed Benefits Improvement and Protection Act (BIPA) in late 2000.
- Payment rates for 2001 had been implemented in January, then changed (most increased) in March.
- Created unique opportunity: variation in payments without confounding variation in costs.

Data

- Data constructed for January and March of 2001.
- Merged several files:
 - benefits data from Medicare Compare,
 - payments and enrollments from State/County/Plan file,
 - county characteristics from Area Resource File,
 - PIP-DCG risk scores from CMS.

Sample

- Sample contained 1,132 plan-counties for January and 1,136 for March.
- Dropped plan-counties with zero or missing enrollment, missing premium or benefit data.
- 4 million out of 5.6 million (71%) M+C enrollees were in the remaining plan-counties in March.

Methods: Benefits Equations

$$\text{premium}_t^{p,c} =$$

$$\mathbf{b}_1 \text{payment}_t^c + \mathbf{b}_2 \text{march}_t + \mathbf{b}_3 \text{supply}_t^c + \mathbf{b}_4 \text{demand}_t^c +$$

$$\mathbf{b}_5 \text{Herfindahl}_{t-1}^{p,c} + \mathbf{b}_6 \text{other premium}_{t-1}^{p,c} + \mathbf{d}^p + \mathbf{e}_{2t}^{p,c}$$

$$\text{benefit}_t^{p,c} =$$

$$\mathbf{b}_1 \text{payment}_t^c + \mathbf{b}_2 \text{march}_t + \mathbf{b}_3 \text{supply}_t^c + \mathbf{b}_4 \text{demand}_t^c +$$

$$\mathbf{b}_5 \text{Herfindahl}_{t-1}^{p,c} + \mathbf{b}_6 \text{other benefit}_{t-1}^{p,c} + \mathbf{d}^p + \mathbf{e}_{1t}^{p,c}$$

Methods: Covariates

- Supply: historical Part A spending, number of MDs per capita, urban/rural status, hospital beds per capita, PIP-DCG risk scores.
- Demand: per capita income, proportion of population over 65.
- Competition: Herfindahl index, premiums charged and benefits offered by other plans in county.
- Plan-level fixed effects.

Results: Lagged Herfindahl Index

	Premium > 0?	Drug coverage?	Generic Rx copay	Doc copay
Payment	-0.034***	0.013	-0.012***	-0.026***
10% effect	-35%	10%	-\$0.60	-\$1.30
Herfindahl	3.4**	-6.2***	1.5*	1.1**
10% effect	7%	-7.6%	\$0.15	\$0.11

Results: Lagged Other

	Premium \$	Brand Rx copay	Doc copay	Dental?
Payment	-0.065***	-0.057***	-0.026***	0.12**
10% effect	-\$3.25	-\$2.85	-\$1.30	0%
Other	0.32**	0.27***	0.15***	6.3**
10% effect	\$0.25	\$0.39	\$0.09	57%

Study 2: PFFS Market Entry

- Private fee-for-service (PFFS) is a new option under M+C.
- Same payment rates, risk bearing, risk-adjustment rules as other M+C plans.
- PFFS plans have low entry costs (no network to establish), but potentially vulnerable to adverse selection.

Sterling PFFS

- Sterling PFFS entered M+C in June of 2000. Approved for offer in 25 states.
- By spring 2002, had approx. 20,000 enrollees.
- Coverage similar to Medigap Plan C; no drug coverage.
- Does PFFS compete with M+C HMOs?
What about with Medigap plans?

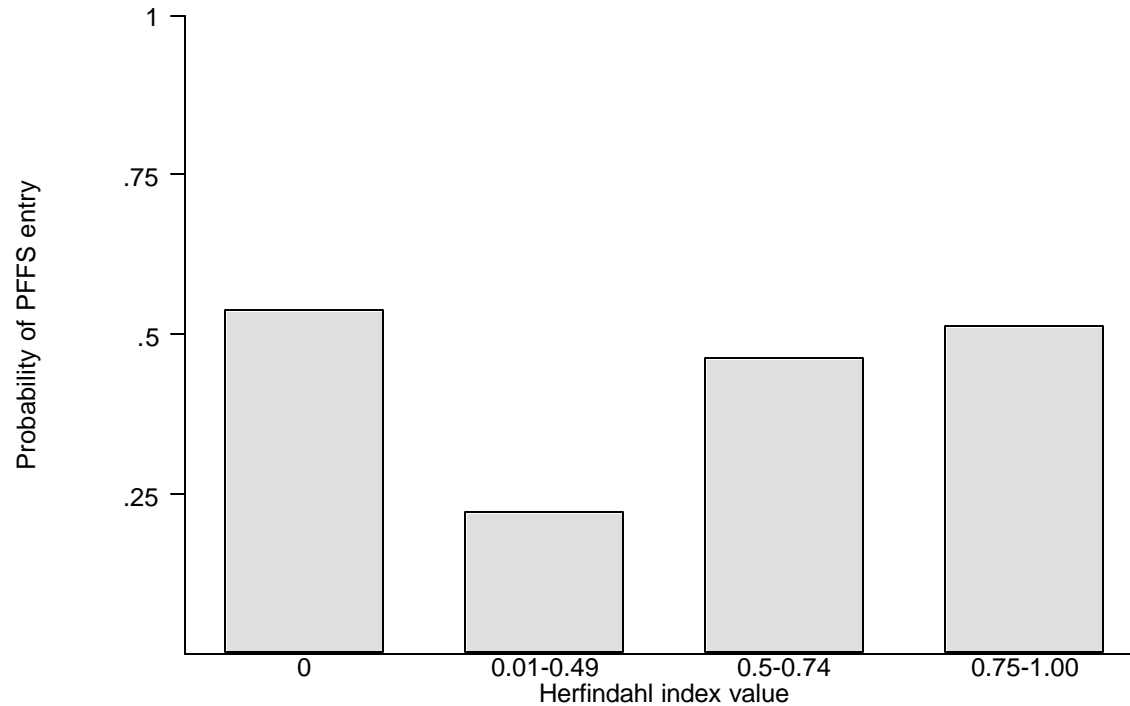
Data & Methods

- 3,129 counties in U.S.
- Sterling entered 1,621 counties as of December 2001 (52%).
- Average number of enrollees per county was 6.
- Estimated entry model (probit) and enrollment model (tobit).

PFFS Entry: Regression Results

	Entry (y/n)	Marginal	Enrollment
Market pen.	1.44***	5.7%	-15.7
Medigap prem.	-0.017***	-0.7%	0.64***
No. of plans	-0.12**	-4.7%	-12.7***
Δ no. of plans	-0.14***	-5.7%	-34.4***
Herfindahl	0.22	0.9%	7.1

PFFS Entry and Herfindahl



CHQOER

Main Findings

- Industry concentration affects premiums, benefits, and market entry.
- M+C plans adjust premiums and benefits in response to other M+C plans in the county.
- Effects of competitiveness variables are smaller than effects of payment rates, but still substantial.
- PFFS competes with both M+C and Medigap plans.

Discussion

- Markets for Medicare + Choice insurance are small-- counties or MSAs.
- HMO, PFFS, and Medigap plans compete for enrollees.
- HMOs experience favorable selection relative to PFFS, FFS, and Medigap plans.
- Markets are not “competitive.” Oversight is justifiable.