COMPETITIVE BIDDING PROCESS FOR HEALTH PLANS FOR MEDICARE PART A AND B BENEFITS

Medicare Advantage Bidding

Medicare Advantage plans will use a competitive bidding process to determine their costs for coverage of Part A and Part B original Medicare benefits, though the form of the bidding differs from the drug bid process, described in a separate paper. In brief, Medicare Advantage plans will submit bids for how much it would cost to provide medical benefits to a "typical" beneficiary in the geographic area served by the plan, where a typical beneficiary has the statistical average age and health status for Medicare beneficiaries in the nation. The bids will then be compared to a benchmark price. If a plans' bid is above this benchmark, the federal payment (adjusted for beneficiary health status) is the benchmark amount and enrollees will have to pay the difference between the bid and benchmark in the form of a basic premium. If the bid is below the benchmark, the plan will receive its bid amount (adjusted for beneficiary health status) for providing Medicare services plus 75 percent of the difference as a rebate. The plan must use the rebate to provide extra benefits or to reduce beneficiary costs (discussed below).

The basic process outlined in the preceding paragraph for Medicare Part A and B health care benefits is described in more detail below, with a short illustrative example of a comparison of bids and benchmarks, and the resulting beneficiary premium or rebate amount.

- Medicare Advantage plan **bids** for both local and regional plans will have 3 parts:
  - A bid amount for coverage of Medicare Part A and B medical benefits;
  - A supplemental benefit bid (if any); and,
  - A bid amount for basic coverage (if any) of Medicare prescription drug benefits (described in a separate paper).

  Regional plans must serve all of a CMS-designated region--and the law indicates there must be at least 10 and no more than 50 regions nationwide—while local plans serve single or multi-county areas they choose to serve.
- The **benchmarks** for both local and regional plans represent the maximum amount that Medicare will pay a plan for coverage of Part A and B benefits.
  - For local plans, benchmarks will be determined exclusively by CMS according to formulas set in law for calculating Medicare Advantage county capitation rates.
  - For regional plans, the benchmarks will be a blend of two components: the weighted average of the county capitation rates across the region and a weighted average of all the A/B bids in the region. The blend will reflect the market share of traditional Medicare (for the county rates) and the market share of Medicare Advantage (for the bids) in the Medicare population nationally.
- CMS will review plan bids to make sure they are actuarially sound and will negotiate with Medicare Advantage plans for additional information or

adjustments of bid amounts. CMS has the authority to negotiate with the plans similar to negotiations conducted by the Office of Personnel Management with the Federal Employees Health Benefits Program. Plans may also charge separate premiums for supplemental benefits and for prescription drug coverage.

- **If the bid is lower than the benchmark**, 75 percent of the difference is a **rebate** amount that the plan must use to:
  - Provide extra benefits or reduce the beneficiary's cost sharing for Medicare Part A and B services;
  - Reduce the beneficiary's Part B premium;
  - Reduce the beneficiary's drug premium or cost sharing;
  - Reduce the beneficiary's premium for the plan's supplemental benefits; or,
  - Any combination of the above.

  For local plans, the remaining 25 percent of the difference will be retained in the Medicare trust funds. For regional plans, half of the 25 percent will be retained in the Medicare trust funds and the other half will be placed in the regional plan stabilization fund. The federal payment to the plan will be the plan's risk-adjusted bid plus the rebate amount. Beneficiaries will not have to pay a premium in these plans for the basic A/B benefit, though they may have a supplemental or drug premium.
- **If the bid is equal to or higher than the benchmark,** the beneficiary will pay 100 percent of the difference as a **premium.** The federal payment to the plan is the risk-adjusted benchmark amount.
- The payment to the plan, whether based on the bid or the benchmark, is adjusted for beneficiary health status using each individual enrollee's risk score to ensure that the Medicare Advantage plans are paid appropriately for the health status of their enrollees.

General Example:

	Plan A	**Plan B**
Benchmark Amount	$700	$700
Basic A/B Bid	$600	$750
Difference (bid is subtracted from benchmark)	$100	($50)
If bid is lower than benchmark, rebate (75% of any difference), if any	$75	None
If bid is higher, beneficiary basic A/B premium, if any	None	$50

The net result of the bidding for the 3 parts above will be presented as a consolidated premium amount for beneficiaries electing a Medicare Advantage plan.

Comments on the proposed regulations will be accepted until October 4, 2004. Comments should be submitted to the Centers for Medicare & Medicaid Services at www.cms.hhs.gov/regulations/ecommentsT