



STUDY SUMMARY: THE IMPACT OF COMPETITIVE BIDDING ON THE MARKET FOR DME¹

"COMPETITIVE BIDDING" BACKGROUND:

- The Centers for Medicare and Medicaid Services (CMS) has paid for durable medical equipment (DME), and supplies based on "reasonable cost" as defined by CMS. Strangely, they've determined there's a problem with DME spending, even though they fix the DME price.
- CMS justifies this scheme in terms of market efficiency: CMS claims that by bidding for the ability to provide medical equipment, the lowest prices will be assured, thereby garnering cost savings for Medicare. (In 2006, the average Medicare premium increased 13.2% making the lure of reducing costs at any level quite attractive.)
- CMS plans to extend the "competitive bidding program" to 10 MSAs in 2008 and to 70 more in 2009. Unsuccessful bidders will be excluded from the market.
- However, as the study shows, the "competitive bidding" policy will lead to serious, long-term, unintended consequences: Any short-term cost savings will be more than offset by long-term increases as successful bidders gain market power over time.

ECONOMIC THEORY OPPOSES RESTRICTING THE NUMBER OF COMPETITORS IN A MARKET FOR GOOD REASON:

- Interference with competitive markets leads to higher, not lower, prices. The customer base for medical equipment is expected to grow dramatically during the next 20 years. Restricting the market now will lead to substantial market failure in 10-20 years.
- Government intervention in the market for DME will produce reduced efficiency, fewer transactions, and job losses.
- The health care industry is generally characterized by "special interest capture." This is undesirable, but will occur with DME just as it has occurred with hospitals and health insurers.

ESSENCE OF A COMPETITIVE MARKET MATCHES THAT OF DME MARKET:

- Many small businesses: Most DME suppliers are small in comparison to large health insurers and the CMS itself. Medicare enrolls these suppliers and at last count, there were tens of thousands of them.
- Homogenous products: Durable medical equipment and supplies are produced in accordance with published specifications as noted in CMS' Booklet on DME. Accordingly, DME and supplies are relatively homogenous products—and information regarding quality and price is well known.

WHY IS COMPETITION SO DESIRABLE?

- Prices tend to be lower and consumer options greater—Competition maximizes total "social welfare" (the greater good for everyone).
- Often, these desired outcomes run counter to the desires of business: Challenging environment in which to work, costs must be controlled, prices tend to be forced down, and profits tend to be reduced. This is good for consumers: Competition forces producers to do their best—everyone gains.

¹ "The Impact of Competitive Bidding on the Market for DME" by Brian o'Roark, PhD and Stephen Foreman, PhD, JD, MPA. January 17, 2008.

- Perfect information regarding quality and price: Beneficiaries pay 20% of Medicare-approved medical equipment costs and CMS pays 80%. DME suppliers accept CMS payment as payment in full and do not balance the bill. CMS regulates Medicare price and prices are known.
- Free entry and exit: Entry into the DME market is relatively easy. CMS approval for DME suppliers is straightforward and reinforces product homogeneity and information accessibility. Exit from the market is equally easy.

In short, the market for DME is competitive without government intervention and could reasonably be so for a long time. Regulating this industry by reducing entry, fundamentally changes the nature of the market, and while government price controls are viewed as a way around the high-priced nature of non-competitive markets, history does not provide support for such a view.

DEREGULATION (NOT MARKET RESTRICTION) PROVIDES ACCEPTED BENEFITS TO CONSUMERS (5):

- Deregulation has been the trend for industries throughout the past 20 years.
- In a competitive industry, deregulation helps establish lower price and greater availability of product to promote consumer welfare. Prices are lower and service is better.

COSTS OF REGULATION (5-7):

- In competitive markets, firms are driven to reduce costs. The least-cost provider has a competitive advantage. This is why sellers seek protection from competition such as trade barriers against foreign firms or attempting to obtain artificial barriers to entry.
- Artificial barriers are bad! Firms with market power have no incentives to innovate or to keep prices down. Higher prices mean less trade and poorer economies. In health care there are practical problems: reduced trade means less access to health care.
- “Dead weight”: as prices rise, the amount of people willing and able to buy falls. These losses are particularly significant when competition is eliminated. Artificially limiting competition increases dead weight loss, maybe not right away, but as soon as producers realize there’s no reasonable alternative to their products.
- This works against the purpose of the “competitive bidding” process which is to keep prices down.
- But holding prices artificially low causes other distortions... (6-7)
- The CMS “competitive bidding” scheme will, at best, artificially create oligopoly (too few suppliers of a good) markets for the supply of DME.
- Market *deregulation* is more likely to increase cost savings.

DME MARKET CHANGES: AN INCREASE IN DEMAND AWAITS (9-10):

- Population in the U.S. above the age of 65 is projected to increase to 20.7% of the population by 2050.
- With increases in technology, life expectancy is also becoming longer.
- Increased demand coupled with reduced supply is a recipe for huge price increases.

CONSEQUENCES OF GOVERNMENT INTERFERENCE (11-12):

- Government intervention to deal with imperfections in markets usually works to reduce social welfare rather than improving it: If there are problems in the DME market based on the lack of price competition, further limits on competition by eliminating competitors from the market will do more harm than good.
- Classically, when governments regulate price (as with DME), sellers compete based on quality and service. CMS has proposed to restrict even this limited quality and service competition by bidding “franchises” for Medicare DME.

- Medicare should investigate mechanisms that will restore full price competition to the market and reduce the dead weight losses that already exist.
- After reducing the number of firms in the industry, the remaining firms will raise prices, will increase their administrative costs and inefficiency and will increase profits. There will be no alternative suppliers available to accomplish price reductions.

FURTHER UNINTENDED CONSEQUENCES (12-13):

- Medicare beneficiaries pay 20% of cost for their DME. Medicaid pays the cost for patients who do not have Medicare. Some patients pay for DME out of pocket.
- When the patients (or their families) cannot afford the cost of DME in the home setting, they are candidates for admission to a long-term care facility.
- Long-term care can range in excess of \$60,000 per year per patient. Even a small increase in long-term care admissions will result in huge increases in medical care costs.

JOBS LOST (13-15):

- Reduced number of competitors=loss of employment in the industry...This would conservatively amount to over 21,000 jobs lost.

LARGE DME FIRMS MAY WELL “CAPTURE” THEIR REGULATORS (15-17):

- Capture theory suggests that when developing regulations, regulators naturally seek out those with expertise in the industry. Once they finish developing the rules, the regulators are often hired by the firms now under the auspices of the regulation they helped craft. The theory predicts that regulated firms will have greater profits than unregulated firms and, as a result, their customers will be worse off. This is supported primarily by the reduction in competition that the regulated firms face.
- “Captured industries” have little or no incentive to control costs, or innovate. They expend their profits to artificially maintain their protected status—by fighting off competition.
- Will those who work in CMS, who put together the competitive bidding program, ultimately find employment with the limited number of firms who are allowed to supply DME after the demise of competition? If history is any guide, they will. They will not find competition that is in the public interest—instead, they will discover an industry characterized by insider knowledge and networks, high levels of profits and substantial executive compensation.

WHY DME? (17-18):

- Only 1.3% of US health care’s spending in 2005 was for DME (\$24 billion/\$1.9 trillion). Based on these figures, a case could be made that spending for DME and supplies in the US is not a problem at all.
- Government-approved consolidation in the health insurance, prescription drug and hospital industries has led to dramatically increased costs over the past decade. A similar outcome could be expected for DME.
- From 2000 to 2005 the price of DME increased at less than the consumer price index while other forms of healthcare experienced dramatically higher increases.
- Even if DME and supply spending is somehow construed as a problem, the problem pales in comparison to other healthcare spending in terms of both size and price increases.

CONCLUSION

- The proposed “competitive bidding” for DME will increase concentration and reduce competition.
- In the long run, the bidding scheme will have traded a competitive market for a government mandated concentrated market.
- As a result, we will have traded small short-term benefits for major long-term problems—poor public policy indeed.



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