

**Lessons from the Competitive Pricing Advisory Committee Experience
for the Medicare + Choice Program and Long Term Reform**

Statement of Len M. Nichols*

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Mr. Chairman and Members of the Committee, I am grateful for the opportunity to discuss with you today the most important lessons that the Competitive Pricing Advisory Committee (CPAC) learned while trying to help inform the Medicare reform debate. As you know, and as the Medicare Trustees just reminded us, the long term financial outlook of Medicare is not rosy, and I applaud you and your Committee's leadership in trying to make sure that we take care to fashion reforms now that will make sense later for our seniors, our taxpayers, and our health system.

History. The CPAC was created by the Balanced Budget Act of 1997, which was passed when reining in Medicare cost growth was of paramount concern. The BBA had many provisions which did help reduce cost growth, and not all have been repealed or rolled back since. Consequently the short-to-intermediate term financial outlook for Medicare has improved considerably. In a way, this financial turnaround, in conjunction with a temporary reduction in general health care cost growth and the near term federal budget surpluses, provides a unique but not everlasting window of opportunity to choose, deliberately and wisely, exactly the kinds of long term reforms that make the most sense for Medicare.

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The drafters of the BBA shared the vision of informed reform, and tried to promote it in two separate but related provisions. One created the Bi-Partisan Commission to study and recommend long term reform possibilities, and another provision created the CPAC, which was charged with designing and implementing at least four and up to seven competitive pricing demonstration projects that could inform the larger and longer term reform debate. CPAC's existence was put into legislation because previous attempts to implement competitive pricing demonstrations projects through the usual research arm of the Health Care Financing Administration were stymied by direct Congressional intervention.¹ The theory was that statutory authority would enable a competitive pricing experiment to actually get off the ground, since Congress had already explicitly sanctioned the idea.

CPAC's 15 members were appointed by the Secretary of Health and Human Services and included 2 physicians, 2 actuaries, 3 health plan executives, one corporate purchasing executive, a former Senator (Durenberger, R-Minn) with extensive knowledge of Medicare and health policy generally, a law professor, top executives and lobbyists from the Health Insurance Association of America, the American Association of Retired Persons, and the Service Employees and Industrial Union, and 2 economists, one of whom was a former head of the Congressional Budget Office, Robert Reischauer. The CPAC was ably chaired by James Cubbin, the VP for health purchasing at General

¹ See Bryan Dowd, Robert Coulam, and Roger Feldman, "A Tale of Four Cities: Medicare Reform and Competitive Pricing," *Health Affairs* 19(3) (September/October 2000), pp. 9-29, for an illuminating discussion of past failed attempts to implement competitive pricing demonstration projects. Also in the same issue are Len M. Nichols and Robert Reischauer, "Who Really Wants Price Competition in Medicare Managed Care?", and various perspectives on Medicare pricing experiments from Karen Ignani, Barbara Cooper and Bruce Vladek, Rep. Bill Thomas and Linda Fishman, and Nancy-Ann Min DeParle and Robert Berenson.

Motors, one of the most successful and innovative purchasers of health insurance and health care in the world.

CPAC was charged with designing the pricing demonstrations, selecting sites in which the demonstration projects would take place, and working with local area advisory councils (AACs), which were also called for in the BBA. The very good idea behind the AAC provision was that for Medicare competition to work on the ground, local stakeholders are going to have to be given an opportunity to have input into important design choices. Health care and health insurance markets are inherently local, and no one from outside can possibly know the local situation better than health plans, providers, and beneficiary representatives in the communities selected. This is particularly true for Medicare, since it has been using formulaic instead of competitive pricing for too long. This administered pricing -- based on fee-for-service costs -- has created very serious inefficiencies which have led to inequities and windfalls in the extra benefits which Medicare payment supports in some areas of the country but not others. One cannot suddenly repeal 15 years of Medicare managed care history and practice and re-impose the statutory benefit package from Washington without engendering significant beneficiary discontent, which is certainly not anyone's intention, and not the way to get Medicare reform off to a popular start.

CPAC began meeting in May of 1998 and completed all the design choices -- with the outstanding intellectual assistance of contractors from the University of Minnesota and Abt Associates and timely staff work from the HCFA professionals in Baltimore -- by October of 1998. These choices included: (1) whether to include FFS in the demonstration, as many health plans and some CPAC members wanted; (2) how to

determine eligibility for plan participation in the demonstration; (3) whether to have a standard benefit package to facilitate comparison shopping; (4) where and how to set the government payment level for health plan enrollees; (5) whether to require more quality reporting by plans competing on price than by those being paid by administrative formula.²

Next came site selection, and the proverbial beginning of the end. Recall one of the main purposes of creating CPAC in the statute was to create a group of knowledgeable and distinguished Americans who could more easily withstand the "political heat" better than the civil servant bureaucracy at HCFA could; heat was expected for creating specific demonstration projects that Congress had asked for in the abstract. This expectation proved prescient.

Moving blithely along, CPAC believed that the Congressional leadership would not allow some Members to stop the demonstrations when a clear majority in Congress had voted for the BBA. So, after reviewing practically all the objective criteria that were obtainable, in January of 1999, CPAC selected two sites -- Phoenix and Kansas City -- to begin the competitive pricing demonstration projects in January in 2000. Suddenly, in these two communities anyway, a year did not seem to be a very long time at all.

By late March, opposition in Phoenix was united; health plans, providers, and beneficiaries were all correctly convinced that the reform experiment was going to either cost them money or benefits or both. At that point in Kansas City, by contrast, opposition was less bold, except for physicians, who opposed the demonstration project from the first week it was announced. But the leader of the AAC in Kansas City, E. J.

² Details about CPAC's committee members, its meetings' agendas and minutes, and its reports explaining all of its choices and rationales can be found at www.hcfa.gov/cpac.

Holland, Jr., was in charge of purchasing health insurance for Sprint, a major employer in the area. Prior to that position he had long been a lawyer for local hospitals, so he had clout with plans and credibility with providers, and importantly, he thought competitive pricing for Medicare was not only good for beneficiaries and the country in the long run but would also likely be good for private employers and workers and as they try to make the health care system more accountable and cost effective. However, he was adamant on one point from the beginning: while with a little luck he could deliver the Kansas City AAC and meet all the demonstration project's rather tight deadlines, the Kansas City AAC would never agree to enter into this kind of experiment alone. Thus, CPAC had to make it happen in Phoenix, or nowhere.

And Phoenix had no constituency on the ground in favor of the project except a few local employers. By July of 1999, opponents of the demonstration projects had attached an amendment to the Patient Protection Act which said that no funds could be expended implementing a competitive pricing demonstration project in Arizona, Kansas, or Missouri. The passage of this amendment signaled that the Senate leadership was not going to deny local Members' strong desire to serve their constituents and squelch the nascent competitive pricing experiment.

The House health policy leadership, notably Chairman Bill Thomas, as well as Chairman Roth and Senator Bob Graham and senior Finance Committee staff, tried to save the demos somehow, and the Clinton administration also considered it important to try. In the end the Balanced Budget Refinement Act delayed but did not end the CPAC demos, and called for four useful questions to be answered before new demonstrations were designed: (1) how might fee-for-service Medicare best be included in a competitive

pricing experiment? (2) what quality reporting requirements should Medicare + Choice plans vs. fee-for-service Medicare? (3) how might a competitive pricing demonstration project be implemented in a rural area? (4) Is benefit package standardization a necessary feature of competitive pricing demonstrations and what are its benefits and costs? CPAC answered these questions in its most recent report, delivered to Congress in January of this year.³

Lessons. There are at least 6 primary lessons from the CPAC experience, and a host of smaller ones that are contained in the cited reports that were submitted to Congress.

Lesson # 1: To learn about health plan pricing reform in Medicare, the country must invest resources initially. Opposition to competitive pricing is based upon perceived self-interest, which was probably accurate, given the constraints of our design. Budget neutrality requirements, while imminently sensible in most contexts, were simply devastating to CPAC. Forcing each site to be budget neutral each year, as the BBA statute did, guaranteed that no more money could flow into an area than would have under the regular program rules. Since the BBA kept most health plans' revenues per beneficiary growing at 2% per year in areas where Medicare HMOs had substantial market share, plans saw that this constraint would be binding sooner rather than later, especially given their prescription drug cost growth.

Plus, competition alone is likely to lower the average price paid when moving from an administered system to a competitive one, so those savings would also cost the plans. If plans perceive that they are likely to end up with less revenue after competition

³ Report to Congress by the Competitive Pricing Advisory Committee of the U.S. Department of Health and Human Services, January 19, 2001 (www.hcfa.gov/cpac).

takes hold, then so are providers and beneficiaries. And the typical Medicare + Choice beneficiary in markets with high managed care penetration is already receiving extra benefits that most Medicare beneficiaries can get only by paying quite a lot out of pocket. The source of these extra benefits is payments to health plans greater than their costs in the current formulaic system. Reducing the excess payments then must reduce the amount of the extra benefits, and so beneficiaries were worried. Thus, with budget neutrality, there was precious little tangible benefit that CPAC could offer stakeholders on the ground in either site.

The way to invest in reform is to relax the budget neutrality constraint, and let bidding run its course. Health plans know they need to offer benefits beyond the current Medicare benefits package if they are to successfully compete with fee-for-service. But budget neutrality and forced competitive bidding threaten the ability to offer extra benefits, the very lifeblood of the Medicare + Choice plans.

Relaxing budget neutrality, however, would restore essential flexibility to the demonstration design. First, just allowing payments to be higher than baseline in year 1 makes it possible to get the competitive process started with much less fear. Second, any savings that do occur could be earmarked for a local quality pool that is paid out to those plans that perform best in agreed upon criteria. This had the added virtue of emphasizing that Medicare pricing reform is ultimately about a lot more than just saving money. Third, relaxing budget neutrality would allow a prescription drugs benefit to be added to the benefit package upon which plans bid. If competition ultimately will save money, these early investments could be recouped in the out years (3-5) of the demonstration. If

competitive bidding does not save money in the long run, then Medicare policy makers would be better off knowing that as soon as possible, and why.

Lesson #2: Without the support of Congressional leadership, no demonstration project can withstand sustained constituent fear and opposition. Once local opposition galvanized, CPAC members and HCFA professional staff were not well equipped to solicit defensive support among Members of Congress. If one Member cares a lot, and most other Members are basically indifferent, he can get what he wants, eventually. So, Medicare pricing reform will occur only when the leadership decides it really wants to do that, and prevents amendments like the one that stopped the CPAC demos in their tracks. Perhaps a kind of congressional “ownership” would help. Members of Congress who are leaders in reform efforts could volunteer to work with local stakeholders from their states and with CPAC to discover the conditions under which willing participation in health plan pricing demonstrations might be met in a way that serves the program, beneficiaries, and providers.

Lesson #3: Standard benefit packages are essential for a meaningful comparison of competitive bids to take place. Unless the benefits are the same, price differential are harder to evaluate. But we also learned that the standard benefit does not have to be identical in every area, and that it is best to let local stakeholders design the details of the benefit, given broad federal requirements. Both the Phoenix and the Kansas City AAC got as far as finalizing their benefit packages. Both ended up with drug benefits substantially more generous than CPAC required, and in each case it fit what their local market place had been providing prior to the expected start of the demonstration. In addition, the public process of determining what the drug benefit

should be served as a tremendous community education device, wherein all came away with much more understanding of the drug benefits now attached to various Medicare + Choice plans in the marketplace.

Lesson #4: *Premium rebates are a relatively low risk way to allow competition between fee-for-service and Medicare + Choice plans.* The BBRA gave CPAC the authority to allow plans to use premium rebates in lieu of higher benefits when their costs are below what Medicare pays. In the past, they have been forced to rely on benefit competition, and to fill any gap between costs and payment with benefits. BIPA spread the right to grant a rebate to all plans, not just demo plans, starting in 2003. Health plans were adamant with CPAC that no demonstration project could be fair and fully informative without fee-for-service also competing. Rebates enable Medicare + Choice plans to use price incentives to draw beneficiaries from fee for service, without subjecting those fee-for-service enrollees who remain so to potentially high premium payments, which some Medicare overhaul bills would do.

Lesson # 5: *Postponing Medicare + choice pricing reform experiments is costly.* The alternative to pricing experiments is to someday implement reform everywhere simultaneously, with no prior experience purchasing health care services in a competitive environment, i.e., to go "cold turkey." Cold turkey is for young heroin addicts with VERY strong hearts. There is much to be learned about how best to meld the best practices from the private sector with the special needs and obligations of the Medicare program. The good news is, new pricing demonstrations could be fit to virtually every serious Medicare reform proposal, so that we might before too long have evidence-based policy disputes, which would surely be an improvement over competing

ideologies. Medicare must learn to modernize its purchasing techniques, for while price competition can be a friend to the Medicare program in the long run, the key to beneficiary and citizen acceptance of price competition is to simultaneously enhance our ability to demand accountability for quality outcomes. Policy makers must decide to let Medicare become an efficient purchaser, to use its inherent market power wisely. This will take discretion, like GM and Sprint and other private sector purchasing managers have. For Medicare employees to be granted this essential discretion, they'll need to re-earn Congress' trust. I believe they can, and the time to start is this afternoon.

Lesson #6: The problems of rural Medicare beneficiaries are fundamentally different from the problems with Medicare in urban areas, and the power of competitive pricing per se to help solve them is limited, but potentially useful.

Competitive pricing is designed to solve the problem of excess use and cost in the 3/4 of the country with plenty of everything and too much of some things; providers, insurance, utilization of services, and unit charges for those services. The fundamental problem in rural America is low population density, which retards or prevents the economies of scale that make managed care and integrated delivery systems feasible. This low density also leads to fewer providers for they can not make as good a living as in a city. Plus, rural Medicare beneficiaries are more likely to be low income, to have less supplemental insurance, and to face long travel times in order to see a provider than their urban counterparts. The fundamental rural issue is fairness: we are not now providing them with near what urban beneficiaries have come to expect in terms of services, even though they pay the same taxes as everyone else.

There are some options for using competitive pricing to encourage the development of integrated delivery systems that serve rural beneficiaries, explained in the January 2001 CPAC report (one winning bid, geographic capitation, allowing Medicare contributions to be used to buy into Medicaid managed care networks), but there are limits to what health plan pricing policy alone can do to encourage physician location decisions. To improve the geographic distribution problem, direct subsidies may be necessary. There is no doubt that budget neutrality will have to be waived for the competitive pricing demonstration to be of any use to rural Medicare beneficiaries.

I would now be glad to answer any questions my testimony may have provoked.