Perspective

Bringing Competitive Pricing To Medicare

Theory meets reality, and reality wins.

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The hegemony of the belief in health policy circles that competitively set prices are invariably superior to administered prices is so complete that Bryan Dowd, Robert Coulam, and Roger Feldman, in their excellent paper, were unable to find contrary positions in twenty years’ worth of the literature on managed care pricing. So the continuing paucity of actual competitive prices in Medicare (and Medicaid and many other parts of the health care system as well) constitutes something of a puzzle for policy analysts. The authors of these papers have undertaken to better understand this phenomenon by examining the experience of recent, thus far unsuccessful efforts to experiment with competitive pricing for Medicare. These two complementary papers are thoughtful, thorough, and analytic.

As members of the small, though not necessarily elite, club of persons burned by the competitive-pricing experience, we read both accounts of the attempted demonstrations with interest. We were responsible for the first two of the four failed attempts, and the narratives concerning all four rang true to us, because many of the same barriers existed in all of them. Our purpose is not to quibble with the authors’ largely accurate telling of the story. It is, rather, to draw somewhat different conclusions from the experience, which, we believe, have potentially important implications for the broader discussion of Medicare “reform” and the future of Medicare.

Lesson 1: It’s Hard To Save Money And Get Lots Of Medicare Beneficiaries Into Lots Of HMOs

Managed care plans have repeatedly demonstrated the ability to provide a defined bundle of services to a defined population at lower cost than traditional fee-for-service (FFS) arrangements, although it is not clear that they have consistently demonstrated this in providing for a Medicare population. Thus, the prevailing theory underlying the competitive-pricing demonstrations—and much of the rest of the Medicare debate—has been that if we could somehow get the prices right, managed care plans could thrive while providing services to Medicare beneficiaries who were attracted to the plans by their low-cost or no-cost supplemental benefits, and the government could save money at the same time. But the theory may simply be wrong.

Low Medicare FFS costs. In a world of voluntary enrollment, managed care plans do not have to be just more efficient than FFS Medicare, they have to be a lot more efficient. To begin with, the administrative costs of Medicare’s FFS program are small; combining Parts A and B, Medicare’s retention is less than 3 percent. The traditional Medicare program has no marketing costs, and it doesn’t require any return on invested capital. So, for starters, setting aside for the moment prob-
lems of risk selection, capitated plans—with administrative expenses in the range of 8–25 percent—have to incur medical expenditures 10–20 percent less than FFS plans do just to break even. In most markets, capitated plans cannot attract enrollees unless they offer additional benefits, which also cost money, and some of the more effective devices for reducing utilization, such as tightly limited provider networks, also may discourage enrollment. Further, the administered prices Medicare sets for some of the services it buys on a piecework basis, such as inpatient hospital care, are sometimes lower than those that many plans can negotiate in the private market over time. Finally, the cycles of the federal budgetary process add a degree of instability in a field already characterized by high levels of entry and exit of plans from individual markets, which makes long-term profitability for private plans even more unreliable. Reductions in FFS payments resulting from the 1997 Balanced Budget Act (BBA) clearly made it more difficult for plans to compete with FFS Medicare until both FFS and managed care providers achieved a partial rollback in those reductions in the 1999 Congress.

- **Managed care costs Medicare money.** As best one can tell from the aggregate numbers, the major source of profitability for Medicare managed care plans during the period of the Tax Equity and Fiscal Responsibility Act (TEFRA) (1985–1998) was favorable risk experience in a payment system that adjusted inadequately for relative risk. In the mid-1990s a transient gulf in payment rates for hospitals and postacute providers also created an attractive opportunity for managed care plans, one that was more than remedied by the BBA. Thus, under administered prices prior to the full phasing-in of risk adjustment, Medicare has lost money for every beneficiary enrolled in managed care because the people who were attracted to health maintenance organizations (HMOs), or to whom the HMOs were attracted, were healthier than average, and Medicare was paying them for the average. Instead of saving 5 percent, Medicare was spending an extra 10–12 percent.1

- **Conflicting requisites for saving money.** It’s hard to see how even the most efficient market could square this circle. For Medicare to save money, plans must provide fewer benefits, accept small or negative profits, or achieve far greater efficiency. Indeed, in markets in which Medicare prices to managed care plans have been most tightly squeezed, premiums have risen and enrollment in capitated plans has fallen.

Fewer benefits? Most beneficiaries appear reluctant to join HMOs unless they are offered lots of extra benefits. Medicare HMO enrollment has grown most rapidly where Medicare FFS rates are highest and the opportunity for extra benefits the greatest. Lower profits? There may be some textbook in which individual firms will sacrifice expected short-term profits to facilitate changes in the marketplace that might provide modest future profits. However, most firms would fiercely resist such changes. Greater efficiency? Even after the Health Care Financing Administration (HCFA) pledged to consider keeping all of the savings in the demonstration sites, and even after plans were given a one-year reprieve on the phasing-in of the health status adjuster that all other plans in the country were facing, health plans obviously made the calculation that they could not improve efficiency fast enough to protect profitability.

Nothing better illustrates the fundamental problem of trying to implement competitive pricing in the real market for Medicare managed care than the suggestion of Dowd and colleagues that “budget-neutrality makes it impossible to bring additional resources to a demonstration site to encourage willing participation by beneficiaries, plans, and providers” (page 26). But if the purpose is to benefit plans and beneficiaries at the expense of the government, we already know how to do that. Why go to the trouble of a demonstration? Nichols and Reischauer go still further, suggesting, “make sure important stakeholders are benefited.” They go on to say that “allowing anticipated savings to be ‘spent’ on benefit package enhancements in the early years of the demonstration...would be money well
spent” (page 42). Of course, it might also prove to be money thrown totally down the drain, in order to defend the superiority of theory to experience.

- **Rationale for demonstration.** Both of us were skeptical of the proposition that most managed care plans would be able to achieve enough efficiency to make money, save money for the government, and continue to provide an enriched benefits package, although we felt that there were some plans in some markets that could do so. That is why we wanted to put the proposition to an empirical test and why we thought it made the most sense to do the test in average- to high-price counties. Presumably, those are the areas in which the potential efficiency gains are the greatest. But the authors of the preceding two papers seem to be contending that under real-world conditions, the theory is likely to fail, so we should change the conditions to validate the theory.

**Lesson 2: Participants In The Public Policy Arena Are Sometimes Less Than Entirely Truthful**

In their discussion of the “lessons” from the competitive-pricing experience, Nichols and Reischauer suggest that it is necessary to “expose self-interested efforts to kill the demonstration” (page 42). They suggest that the Competitive Pricing Advisory Committee (CPAC) should have anticipated opponents’ arguments and immunized the press against them in advance. This implies a belief that truth will always triumph over lies. Again, the overwhelming weight of empirical experience seems to cast that assumption into question, especially when the “truth” is an aggregation of theoretical hypotheticals believed in most fervently by academics and analysts who are rarely significant campaign contributors.

- **Disingenuousness from the industry.** Of course, even by contemporary Washington standards, the amount of disingenuousness connected with the competitive-pricing project, and with the discourse that surrounds the Medicare program in general, is impressive. For example, the American Association of Health Plans (AAHP) has been complaining for years about the current Medicare payment system’s tie to FFS payment, urging that “market-based” methods be used instead. The AAHP has never spelled out the details of such a method, even when it was explicitly invited to do so by HCFA in the mid-1990s. Nor have they ever actually cooperated, as opposed to claiming to cooperate, with efforts to test alternative pricing approaches. When we began working on what became the Baltimore and Denver efforts and sought the AAHP’s assistance in locating a site, they first protested that it wouldn’t be right to force plans to participate—demonstration participation should be voluntary. Under their version, plans that wished to continue receiving payment under the old rules could continue to do so, and those that wished to bid could do so as well. Given the choice of bidding or receiving current payment, it is hard to imagine a plan choosing to bid and then bidding less than it would otherwise receive. Obviously, HCFA did not accept the AAHP’s suggestion.

When we persisted in our efforts to elicit the AAHP’s cooperation in identifying potential demonstration sites, they suggested that we choose one in which there were no Medicare plans. When we wondered how one could test competition if there were no competitors, they suggested offering waivers or other inducements for plans to move to the area and participate.

Third, although the AAHP has publicly advocated for the position that “if the premium of the health plan selected by a beneficiary is greater than the government contribution, the beneficiary would pay the remainder,” the industry strenuously objected to doing just that in the demonstration. In short, they would only support a demonstration if their members were protected from any adverse effects.

Of course, one would expect a trade association to take such a position. Even if a demonstration left some plans better off and some worse off, the losers would protest bitterly and blame their plight on the trade association, while the winners would remain quiet, confident in the conviction that any benefits they received were the inevitable product of
their operational and moral superiority. The real question, for students of contemporary U.S. health care policy, is why organizations like the AAHP feel compelled to give lip service to an abstract concept whose concrete applications they could never accept. Part of the reason may be the total hegemony of market rhetoric in Washington policy circles, mentioned above; part is undoubtedly the connection to broader political agendas, which we discuss below.

**HCFA-bashing in Congress.** In the debates about Medicare “reform,” it is unfair to single out the AAHP on grounds of disingenuousness. Another illustration of the tendency of participants in the policy process to not always say exactly what they mean is provided by the role of HCFA-bashing in 1999 congressional discussions.

Obviously, both of us are prejudiced in our views about HCFA, although neither of us would argue that it is without considerable flaws and shortcomings, some of its own making. But the actual narratives of both papers, which largely support most of the decisions HCFA made in attempting to conduct demonstrations of competitive pricing, stand in striking contrast to the report that HCFA’s reputation in the Congress is so poor that its identification with the demonstrations is itself a liability, unless one tries to draw a connection between those two themes.

It might be suggested, in that regard, that a sizable number of members of Congress (and the interests that support them), having been frustrated in the mid-1990s in their efforts to convert Medicare into a defined-contribution program, adopted the strategy of villainizing the administrative agency as a way of discrediting the program when they knew that the political costs of direct attacks on the program would be too high. Many of the same people succeeded with a near-identical strategy relative to the Internal Revenue Service just a few years earlier.

It is especially clear that many of the attacks on HCFA over the past couple of years are tied to the failure of the BBA’s managed care provisions to produce the results that were widely promised. Yet, while HCFA has often been considerably less agile and less adept at public relations than one might wish, it is difficult to argue that HCFA’s implementation of the law has been inconsistent with the statute’s exceedingly complex, often self-contradictory requirements. Members of Congress, fueled by well-compensated advocates, are furious at HCFA because they were sold a bill of goods by various interest groups and policy entrepreneurs about what the BBA would accomplish.

Nothing in the Constitution keeps Congress from attacking an executive agency for doing what Congress told it to do but failing to produce the expected results. Indeed, the Madisonian system almost demands such a process. But it is disappointing when independent analysts fail to acknowledge the underlying dynamic. Such a failure is especially troublesome in light of the current congressional popularity of proposals to turn administration of the managed care parts of Medicare over to an independent board separate from HCFA. Such a proposal makes no administrative sense, and is probably unconstitutional to boot, but it is entirely consistent with the logic that holds that applying (some of) the principles of the market to Medicare must certainly produce benefits to the government and beneficiaries alike, so that if such benefits do not emerge, it must be the result of an administrative problem rather than any flaw in the theory.

**Lesson 3: Medicare Is A Provider-Entitlement Program**

Congress also expects HCFA to be as parsimonious as possible with taxpayers’ dollars while protecting the financial security of every provider in each member’s district. Most of us think of Medicare as an entitlement program for seniors and disabled per-
sons. People contribute to a trust fund all of their working lives, and when they turn sixty-five or reach a threshold of disability, they are entitled to health insurance. For some of us, that is the magic and glory of social insurance, and we seek to maintain or even expand it. For others of us, entitlements are budget-busting headaches, and we form task forces to address the “problem.” But all of this has been in the context of beneficiary entitlement. The failed competitive-pricing demonstrations have in fact demonstrated, once again, that Congress tends to treat Medicare as an entitlement to providers and health plans.

It is hard to see how demonstrations such as this can ever be successful without having at least a dampening effect on the rates that plans pay to hospitals, physicians, and other providers. So it is not surprising that providers worked with the plans to kill the demonstrations. (If nothing else, the effort brought these usually warring factions together.) Faced with a conflict between the abstract principles of competition and the short-term fiscal concerns of providers in their own states and districts, members of Congress responded as they usually do.

In setting up the Kansas City and Phoenix sites, CPAC decided to allow all plans to participate. As Nichols and Reischauer point out, “Medicare, being a government program, had never restricted qualified providers from participating. To do so in the demonstration would only have increased opposition to the experiment” (page 35). Of course, there is no logical reason why Medicare should not be able to contract selectively, but if the politics of Medicare as a provider entitlement make doing so too difficult, then the plausibility of related competitive schemes must be called into question.

Perhaps most telling about who is “entitled” to Medicare relates to CPAC’s pledge to the plans to consider constructing the demonstrations so that all of the money that otherwise would have flowed to plans in their community would continue to do so. No such pledge was made to beneficiaries to let them keep all of their benefits.

The demonstration experience is symptomatic of the larger issue. Many U.S. hospitals now receive adjustments in their Medicare prospective payment formulas based on a legislative reassignment to areas with higher wage rates, and the recently enacted Balance Budget Refinement Act (BBRA) increased that number just as the competitive-pricing demonstrations were being put on indefinite hold. Of course, some geographic reclassifications are justified by the need to permit providers to remain financially viable, so that rural beneficiaries are not harmed if the providers fail. But no one, to our knowledge, has proposed “reclassifying” beneficiaries to higher adjusted average per capita cost (AAPCC) counties so that they might receive the same supplemental benefits as their counterparts who actually reside in those counties.

**Lesson 4: Everyone Wants Market Competition Until They Don’t Like The Results**

Real markets have losers. Without them, it is difficult to achieve much efficiency. In a democratic political system, losers, potential losers, and even those who feel that they might someday be losers often seek redress from their elected officials.

If Medicare expenditures are to be reduced, but there are to be no losers among the providers, then there are only two possible ways out. Either the miracle of competition must somehow induce the system to operate much more efficiently, with none of the participants collecting any excess rents in the process, or the buck has to be passed to someone else. That is precisely what converting Medicare into a defined-contribution program—or a quasi-defined-contribution program under a “premium-support” approach—would do: make beneficiaries the losers if marketplace competition did not increase efficiency.

Only in the context of an implicit agenda to promote conversion of Medicare to defined contributions does the notion, supported by CPAC and memorialized by Congress, that competitive-pricing demonstrations should “include” FFS Medicare make any sense.
Capitated plans exist to take risk for services to their enrollees in exchange for a fixed price; in an FFS insurance plan, risk is borne by the insurer—in this case, Medicare—not an intermediary. That is exactly what some people object to in today’s Medicare structure, although given the state of the art in risk adjustment technology, it is hard to argue that either beneficiaries or plans should bear full risk. There is simply no logical way to “include” the FFS program in a Medicare competitive-pricing demonstration for capitated plans without transferring risk to beneficiaries—unless one is talking about including the market for Medicare supplemental plans in the same bidding and selection process, a proposal that Congress rejected during the BBA legislative process.

Recognition that it is hard to enforce marketplace discipline in the U.S. political environment is also often adduced as the rationale for creating a separate, independent administrative structure for Medicare, like the board proposed in the Breux-Frist bill or similar arrangements. The theory seems to be that such an arrangement, by insulating the administrative organization from politics, will allow for marketplace losers and thus promote greater efficiency in the system as a whole. There is, in fact, a long history in this country of efforts to use similar mechanisms to insulate markets from too much political meddling; the honor roll of such entities includes the Interstate Commerce Commission, the Federal Power Commission, and the Civil Aeronautics Board. In those instances and many others, the prevailing professional and academic consensus was that “capture” of the regulatory agencies by producer interests left consumers, over time, considerably worse off. The fact that deregulation of railroads, electric utilities, and airlines has produced losers as well as winners is apparently unworthy of serious discussion in elite circles these days. The relevant point here is that “insulating” a program with major economic implications from politics by creating an independent agency does not work.

Lesson 5: The Dog Didn’t Bark

One could question whether competitive pricing for capitated plans will, over time, produce either considerable savings for Medicare or continued high levels of participation in Medicare by the managed care industry. However, the case for competitive bidding for some of the other things Medicare buys appears to be much simpler and more straightforward. Medicare spends hundreds of millions of dollars a year, for example, on certain items of durable medical equipment (DME), which are exceedingly well defined, highly standardized, uniformly available throughout the country, in more than abundant supply, and produced at costs that are a mere fraction of Medicare’s prices. Medicare’s overpayment for clinical laboratory services, in a national industry with chronic excess capacity, involves even more dollars. Yet, as Dowd and colleagues note, a decade of effort has produced only one small demonstration for four DME items in one county in Florida.

May be we should stop kidding ourselves. A federal program that pays more than $220 billion a year to close to one million suppliers in every congressional district in the United States is going to end up with administered prices, whether that is a theoretically elegant phenomenon or not. We have thirty-five years of extensive and relatively sophisticated trial-and-error experience in trying to improve the fairness, rationality, and incentives in Medicare-administered prices, and maybe we just need to suck it up and get back to the hard work that entails.

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