The Need For Demonstrations To Test New Ideas

In addition to determining payments, demonstrations can produce valuable information about how to structure new programs.

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The two papers on Medicare’s competitive-pricing demonstrations support the case for moving the Medicare+Choice (M+C) program to market-based pricing. The problem is that while the cognoscenti in the health policy community all agree on this proposition, we are preaching to the choir. Everyone else potentially affected—managed care plans, durable medical equipment (DME) suppliers and other providers, and beneficiaries—is either actively hostile to the idea or susceptible to being scared into opposing it.

We know that market-based pricing works. A competitive-bidding demonstration for equipment and supplies, which was successfully implemented in Polk County, Florida, resulted in aggregate savings of 17 percent, without a reduction in access to high-quality supplies or services. We are beginning to implement a similar demonstration in San Antonio, Texas, that also will use competitive forces to develop prices.

One need look no further than the current volatility in the M+C program to understand why we need to test something other than the current methodology of applying a national payment formula to set prices. The Health Care Financing Administration (HCFA) does not underpay plans in the aggregate for the statutory benefits that plans must provide to beneficiaries. Since payment rates are based upon the historical spending patterns of fee-for-service (FFS) Medicare providers, health plans in areas with inefficient provider practice patterns are able to offer generous additional benefits, while plans in low-payment areas cannot. Yet managed care organizations (MCOs) in areas with the highest payments actually are better positioned to manage costs because these areas tend to have the greatest excess of hospital beds and physicians. This places MCOs in a position to negotiate healthy price discounts. Further, high-payment areas tend to be the ones with extravagant practice styles that should be amenable to straightforward medical management approaches that do not compromise quality.¹

No administered-pricing formula can appropriately account for the myriad local factors that determine a plan’s cost of providing care; nor can administered pricing account for strategic business decisions that determine how an MCO can price a product. In short, MCOs are better able to determine their best price than Congress in a statutorily set formula.

The competitive-pricing demonstrations were not only about achieving more appropriate payment rates, however. We also need information about the administrative resources required to implement change, HCFA’s capacity to manage operational details on the local level, how beneficiaries respond to different marginal financial contributions, and...
how best to educate beneficiaries. The demonstrations would have allowed us to test plans’ ability to serve a logical service area that reflects community patterns of care, rather than having to tolerate continued segmentation of service areas as permitted under the current rules related to administered pricing.

Even during the brief duration of the Phoenix and Kansas City demonstrations, we learned that some plans were not actually offering full Medicare benefits because they did not understand the precise coverage requirements. We also learned how ostensibly similar benefits are implemented differently by different plans, resulting in significant variations in actual services received by beneficiaries.

Both papers argue that the demonstrations should not have had to achieve budget-neutrality. We agree. Most of the demonstration objectives could have been met without regard to budgetary savings. It makes more sense to test whether competitive pricing, if applied broadly, could protect taxpayers and the trust funds, not whether funding would be reduced to the Phoenix and Kansas City communities. Indeed, HCFA and the Competitive Pricing Advisory Committee (CPAC) recommended that expected savings from competitive pricing be retained in the demonstration sites and be redistributed to plans and providers that achieved the best quality outcome and beneficiary satisfaction scores.

**What did we learn?** Now a few observations on the “lessons learned.” First, after four failures to implement this demonstration model, it is difficult to believe that it could ever be successful. Bob Reischauer predicted as much when we asked him to serve on CPAC; he did not believe that we could overcome the “not in my backyard” (NIMBY) problem in Congress. He was right. We note, however, that the demonstration almost went forward in Kansas City and probably would have been implemented had it not been for the dynamic of Phoenix. Various distortions in Phoenix helped to mobilize opposition long before HCFA and CPAC could develop a presence and correct the record. Indeed, in Phoenix the opposition incorrectly kept describing the demonstration as HCFA’s last-ditch attempt to do in Phoenix what it had been prevented from doing in Baltimore and Denver. As Bryan Dowd and colleagues point out, the Kansas City advisory committee did not want to be “chumps.” Yet HCFA went out of its way to work within the structure set out by Congress. Even though the law did not require it, we deferred to CPAC on all decisions, not just site selection.

HCFA has been criticized for not conducting an aggressive public relations campaign or actively seeking congressional support for the demonstration. In fact, HCFA conducted beneficiary focus groups, met with media, and provided regular and timely updates to Congress. We did not lobby Congress and did not engage in an active public relations campaign to garner beneficiary or other stakeholder support, because it would not have been appropriate, nor would it have been tolerated by Congress. The opponents of the demonstration were not so constrained.

Finally, the timing of the demonstrations in Phoenix and Kansas City proved unfortunate, coming in the midst of significant pull-outs from the M+C program in other parts of the country. Even though Phoenix and Kansas City are high-payment areas, the overall M+C instability contributed to a view that the demonstrations should be deferred.

Nichols and Reischauer’s lesson, “don’t let HCFA be your face on the Hill,” struck us as naïve and off-base. We believe that the authors became too involved in tactical issues and miss the larger point: Without broad political support by members of Congress, a project like this cannot overcome the NIMBY reflexes of affected politicians. There is no reason to believe that CPAC would have been
any more successful had it played a more visible role. CPAC itself came under the same kind of criticism that HCFA had faced in the various demonstration sites. Indeed, by the middle of 1999 the local communities knew that CPAC, not HCFA, was the entity calling the shots. Opponents then began demonizing CPAC for elitism and policy experimentation at the expense of local beneficiaries. In response, CPAC made a number of concessions in the hopes of keeping the demonstration alive.

This is an important lesson to those who argue that an “independent” board will allow Medicare greater flexibility and engender reform in the future. CPAC experts designed this demonstration and selected the sites. CPAC, and HCFA, gave great deference to the local communities’ concerns. Yet the outcome was no different than in the previous attempts to implement a competitive managed care pricing demonstration. CPAC was Congress’s creation; yet, in the end, Congress denied paternity.

We know that it is difficult to change Medicare, but it is worse to do so without testing new ideas. We see this whenever we change a pricing system, even if every comma and decimal point in the new system was authorized by Congress. By not testing competition on a small scale before imposing a new competitive approach nationally, we will miss the opportunity to gauge the unintended consequences and the market area-sensitive effects that could result. In general, new approaches must be tested if Medicare is to evolve and continue to meet the changing needs of Medicare beneficiaries. The failure of the competitive-pricing demonstrations—not once, but four times—does not bode well for our ability to develop new market-based approaches to Medicare.

The authors thank Sharon Arnold, Ron Deacon, Peter Ashkenaz, and Laurie McWright, who contributed to this response.