

# Competitive Implications of Health Plan Pricing Rules in Medicare Reform Proposals

## Testimony before the Senate Committee on Finance

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I am honored to come before you today to discuss proposals that could enhance the role of competition in Medicare. I should like to begin by applauding you, Mr. Chairman, and the members of your committee for holding this set of hearings so early in this congressional session and election year. Your continued bipartisan leadership will be essential if we are indeed to successfully reform and strengthen the Medicare program.

I was asked to analyze the competitive implications of the health plan pricing arrangements in the two current Medicare reform proposals—which I shall call the Breaux-Frist plan<sup>1</sup> and the President Clinton plan<sup>2</sup>, respectively—by drawing upon my research as a health economist and policy analyst at the Urban Institute, as well as upon my experiences as a member of the Competitive Pricing Advisory Commission (CPAC). As you know, the CPAC was created by the Balanced Budget Act of 1997 and empowered to design and implement demonstration projects that would test crucial elements of competitive pricing mechanisms for Medicare + Choice plans.<sup>3</sup> As you also know, the competitive bidding demonstration's implementation schedule was thwarted by a last minute amendment to the Comprehensive Appropriations Act last November,<sup>4</sup> but with your help and continued support we may yet help the Medicare program learn to use market forces to serve both beneficiaries and taxpayers more effectively. I would be glad to explain more about the CPAC experience and answer any questions you or other members of the committee may have about it at any time.

Both proposals before us today are commendable. They are comprehensive, logically cohesive, and share three key features: (1) recognition of the centrality of prescription drug coverage for modern clinical practice and for modernizing the Medicare benefit package; (2) price incentives for both health plans and beneficiaries that would encourage greater efficiency; and (3) equity protections for beneficiaries with low incomes, poor health status, or who happen to live in areas with high health care costs. Combining some elements of both plans could get us very close to significant and desirable reform.

### The goals of reform

Before getting into details, it is often useful to begin with a simple question: what do we want a reformed Medicare health plan pricing system to accomplish? I would offer five primary objectives and note that most serious proposals share them: (1) reveal the real costs of delivering high quality care in an efficient manner; (2) provide incentives for health plans to become efficient providers of high quality care; (3) provide incentives for beneficiaries to select efficient, high quality plans; (4) protect beneficiaries from the possibly harsh consequences of geographic, income, and health status differences over which they have little or no control; and (5) provide for a relatively smooth transition from the current system to the new, more efficient one. After discussing why each goal is important, I will analyze each reform proposal's likelihood of achieving these goals. I will organize that discussion around the three key elements of any pricing reform plan: benefit package and bidding process, beneficiary payment rules, and government payment rules.

A good pricing system will discover and reveal the real costs of efficiently delivered high quality care. To accomplish this, prices must be based on specific offers or bids by willing sellers in competitive markets. Administered prices, in our democracy, inevitably end up being too high because all providers would much rather be overpaid on average than forced to compete for correct prices at the margin. With the inaccurate signals of today's administered pricing system, even as reformed by the BBA, it is difficult to tell if Medicare is

paying too little. Thus, to safely maintain access, Medicare tends to err on the side of paying too much. The proof of this for Medicare + Choice health plans is the fact that the vast majority still offered beneficiaries zero premium drug benefits in 1999, even after the BBA had started to reduce payment growth for most plans.<sup>2</sup> These drug benefits and other supplemental services that health plans offer can only be financed out of excess government payments for the statutory benefit package.

This is not to deny that in some areas of the country Medicare still pays health plans too little to make it worthwhile for them to enter into Medicare contracts. Overpayment on average and in some places coexists with underpayment in other areas, and this coexistence is an unfortunate fact of life under administered pricing systems. The art of health policy leadership lies in restructuring the pricing system to force providers and health plans to willingly compete for Medicare business like they do for private sector business. In the private sector, competitive bidding, voluntary market negotiations, and performance (accountability) determine prices, not formulae based on government estimates of relative costs. Only when we know true costs of delivering high quality care services in each area of the country can we have a meaningful policy discussion about which services we are willing to pay for collectively.

Market-based Medicare reform will require private health plans to play major roles in reorganizing care delivery patterns and improving provider accountability. For this to occur, both beneficiaries and profits will have to flow to plans or care-giving arrangements that provide high quality care. A pricing system with improved incentives will enable these flows to occur, but to be fully successful, a system of information flows about quality of care that plans believe in and can react to will have to be created and maintained. A new Medicare health plan pricing system that ignores quality and plan plus provider accountability will never engender the high quality care delivery that Medicare beneficiaries deserve.

If efficient care delivery plans are to flourish in a reformed Medicare system, beneficiaries must also have incentives to choose them over inefficient ones. Again, both price incentives and quality information are absolutely imperative if Medicare is to reform itself. Information flows about quality of care that beneficiaries and their families come to rely upon will also have to be created and maintained. A new Medicare beneficiary pricing system that ignores quality and plan plus provider accountability will never earn or maintain the support of the American people.

Providing price incentives to beneficiaries can sometimes conflict with equity goals that must then be balanced like any policy tradeoff. Preserving equitable access to care for beneficiaries regardless of where they live, their current health status, or their income level has always been a goal of the Medicare program. This requires special subsidies for low income individuals, as well as payment rules which insulate all beneficiaries from the financial consequences of bad health status or high health service costs where they happen to live. Payments to plans, however, must be adjusted to reflect the relative health status of their enrollees and real cost differences of delivering care in different parts of the country.

Finally, good proposals for reform not only outline the new system but lay down a clear and practical path from the current one. Medicare is not starting anew, and the transition to reform must be mindful of the high level of confidence that beneficiaries have in the current Medicare program, along with the anomalies, inequities, and inefficiencies that do indeed cry out for reform. One obvious way to maintain support for reform—since over 80% of Medicare beneficiaries are still in FFS today—would be to enable traditional fee-for-service (FFS) Medicare to become more efficient while minimizing the financial penalty for remaining in the traditional program during the transition to a more competitive system. There will likely always be a role, perhaps a major role, for FFS providers in any health insurance program for the elderly and disabled.

### **Achieving the goals of reforms through real proposals**

These goals are, of course, related to each other, and more than one is sometimes affected by particular policy provisions. Nevertheless I discuss them separately as much as possible in order to help clarify the similarities and differences between the Breaux-Frist and Clinton plans.

*Goal #1: Reveal the real cost of delivering high quality care efficiently.* Both proposals are based on competitive bidding by health plans, an essential first step toward cost revelation and a major improvement over today's administered formula system. However, both plans have features which would limit Medicare's ability to elicit prices that were no higher than the true cost of efficiently delivered benefit packages.

Contrary to managed competition theory and practice in the private sector, Breaux-Frist does not require health plans to bid on standardized benefit packages. It does specify a minimum actuarial value drug benefit and maximum cost sharing (stop-loss) amounts for its "high option" plans, but it allows variation in each locale above those specifications. The purpose of standard packages is to facilitate comparison shopping and to eliminate risk selection by benefit design. The Medicare Board would have the power to disapprove a benefit package that was "designed" to bring about favorable selection, but it would be much simpler for beneficiaries and the Board if all plans had to submit bids based on the same set of benefits. Standard packages also help compensate for the absence of perfect risk adjustment, which will be the reality for at least a few more years.

The national weighted average (NWA) premium under Breaux-Frist depends only on the premium required for the "core" package of benefits. This is quite similar to the concept of a price for an efficient plan. One complexity in the Breaux-Frist bidding process, however, is that if an insurer wishes to offer only the "high option" plan, as most Medicare + Choice plans do today, then the Board must determine the "core" premium for that plan. This seems to substitute bureaucratic judgment—just as HCFA does today in the ACR (adjusted community rate) process—for market signals. This "core" price is key since it helps determine the NWA. At a minimum, the combination of flexible benefits for the "high option" plan and the Board-determined "core"

premium introduces noise into the market signals coming out of the bidding process. On balance, Breaux-Frist's bidding mechanism represents major progress over today's system, to be sure, but not as clean an efficiency revelation mechanism as one can imagine, either.

The Clinton plan has (almost) standard packages with its completely specified drug benefit for its high option (Part D) plan ("almost" because Clinton does allow cost sharing to be reduced as long as the additional actuarial value is less than 10% of the basic package). However, the main difficulty the Clinton plan would have eliciting the true cost of efficient plans stems from the potentially quite high reference premium in high cost areas. Since Clinton fully adjusts for geographic cost differences—including input prices *and* all utilization differences— in essence Clinton pegs the benchmark government payment at 96% of the current local fee for service cost level. This feature has a number of implications that will be discussed below, but for now just focus on the first goal. Clinton allows beneficiaries to pay a zero premium if the health plan they choose bids about 20% below the local FFS cost level. There are areas of this country with utilization more than 20% higher than the national average. Thus, in those areas, the beneficiaries' premium cannot possibly be reduced enough to fully reflect a plans' low cost from reducing excess utilization to zero. Therefore it is unlikely that local health plans in high cost areas—precisely where potential savings from competition are the greatest—would bid as low as their costs unless and until FFS costs fell there as well.

Both proposals treat the high option plan—with prescription drug coverage, and also stop-loss protection in the case of Breaux-Frist—as optional. This complicates comparison shopping for beneficiaries as well as the clear price signals we are trying to elicit. Both could make the "high option" plan the standard—perhaps raising the base beneficiary premium to compensate partially for the higher cost—and still allow more generous drug coverage or other benefits to be added if plans want. The key is to force plans to bid on the same standard package, and then to reveal the true marginal cost of any extra benefits they might want to also offer. The point of adding drugs and stop loss provisions to the basic benefit package is to move beyond inefficient benefit competition and move toward price competition.

By the way, the competitive advantages from real price competition reducing the rate of growth of Medicare costs may very well help pay for the extra benefits in the long run. The rate of growth of Medicare costs is much more important to long run solvency than one year's level of average costs. Another way of illustrating this is to note that the drug benefits in both plans would add about 15% to the actuarial cost of the Medicare package. Fifteen percent represents about three years of the 25-year average in growth in real costs per beneficiary of 5% per year. If real competition could reduce 2 percentage points off that long run growth rate, it would "pay" for the drug benefit in a little over 7 years.

The general point is that one can have the competitive benefits of standardized packages without dictating every jot and tittle from Washington or Baltimore. For example, in the Breaux-Frist framework, Congress could specify the actuarial value of the "standard" drug benefit and let local area stakeholders—health plans, beneficiary representatives, providers—work out the details of *their* standard drug benefit. This was the approach taken by the CPAC, which let the local area advisory committees work out the details of the standard drug benefit to be offered by all local plans. Local feedback suggested this was one of the most popular and productive elements of the entire competitive bidding demonstration process, for beneficiaries and plans alike came to appreciate just how confusing and heterogeneous their current drug benefits were, and correspondingly, to appreciate the virtues of benefit package clarity and simplicity. It also has the advantage of preserving continuity with the kind of drug benefit most plans had been offering in a given area.

*Goal #2: Provide incentives for health plans to become efficient providers of high quality care.* This is accomplished through payment rules, where there are two general tools, carrots (advantages from low prices) and sticks (disadvantages from high prices). Breaux-Frist uses both tools, whereas Clinton uses only carrots.

The Breaux-Frist reference price—the national weighted average premium—is likely to be considerably below the current average cost of FFS Medicare in high cost areas and above the current average cost of FFS Medicare in low cost areas. Since Medicare + Choice payments under the BBA and BBRA are still tied to local FFS costs, this means that the Breaux-Frist plan would exert much greater pressure on health plans to become efficient than would the Clinton proposal. Part of the extra competitive pressure stems from their different approaches to geographic adjustment. Breaux-Frist proposes to adjust across areas for input price differences only, whereas Clinton would effectively adjust for both input prices and utilization differences. Breaux-Frist would have the additional advantage of possibly encouraging entry of managed care plans into currently low cost areas, since the NWA is likely to be higher than their current Medicare + Choice payment rates.

Clinton's higher reference price and geographic adjusters would minimize competitive pressure on private plans in high cost areas. They could gain enrollment from lowering prices, but carrots are rarely as effective as carrots plus sticks. The historical experience of private employers suggests that managed care plans will not be able to "shadow price" more expensive FFS forever, but they still might be able to for quite a while. In some very high cost areas, beneficiary premiums under Clinton would reach zero before all of the current utilization difference is eliminated. This would attenuate the incentives for plans in these areas to become as efficient as possible, unless FFS costs here declined as well. The good news is the Clinton plan includes provisions to make FFS Medicare more like a PPO, which could move it toward efficiency eventually through selective provider contracting. The bad news is there is no price pressure on FFS Medicare to become more efficient, yet its level of efficiency is the benchmark against which managed care plans would be judged.

*Goal #3: Provide incentives for beneficiaries to choose efficient providers of high quality care.* Again, Breaux-Frist scores higher on these incentives as well since it uses both carrots and sticks, while the Clinton plan always holds harmless any beneficiaries who prefer FFS Medicare. That is, it is possible that Breaux-Frist

could raise premiums for FFS beneficiaries in high cost areas, thus giving them strong incentives to seek out efficient private plans. Plus, the Clinton plan only gives beneficiaries 75 cents for each dollar below the FFS benchmark cost that the private health plan bids, whereas Breaux-Frist gives beneficiaries at least 80 cents and up to the full dollar depending on the level of the plan's bid *vis a vis* the NWA.

*Goal #4: Protect beneficiaries from the consequences of geographic, income, and health status differences.* Both plans take important steps to achieve these goals. On risk adjustment, I will assume for the purposes of this testimony that they are virtually identical, since the Breaux-Frist mechanism is unspecified but the Board would be free to choose the method just developed and currently being implemented by HCFA. If a better method becomes known in the future it seems likely to be adopted by either HCFA or the Medicare Board.

Breaux-Frist has stronger protections for the lowest income beneficiaries. As long as a high option plan is available, any person with income below 135% of poverty could enroll in the lowest cost high option plan at zero cost. And beneficiaries with incomes between 135% and 150% of poverty would get a subsidy for the drug benefit between 25-50%. Above 150% of poverty, Breaux-Frist provides a 25% subsidy for prescription drugs in the high option plan chosen. Clinton subsidizes all beneficiaries for 50% of the drug benefit, and preserves current law for dual eligibles, qualified Medicare beneficiaries (QMBs), special low income beneficiaries (SLMBs), and other low income individuals. Thus, Clinton's drug benefit is more generous for most beneficiaries, but the President's plan has no analogue to the "free" high option plan for those between state-determined Medicaid eligibility thresholds and 135% of poverty.

As discussed earlier, geographic adjustment is among the larger conceptual differences in the two approaches, since Clinton's adjustment is "full" and Breaux-Frist only adjusts for differences in input prices. In a way, Breaux-Frist reflects what might be called a Wennberg-esque view of clinical practice,<sup>6</sup> i.e., there is one efficient standard of care, and the government should not subsidize excess utilization with no demonstrable clinical value. Clinton's approach is more agnostic about the efficient standard of care, and his structure implicitly expects any real inefficiencies in use patterns to be eroded by competitive pricing's carrots over time, but maybe not to zero.

Breaux-Frist requires HCFA to bid the same amount for the FFS plan everywhere, and since the reference price is a national weighted average, beneficiaries in low use areas would pay less, on average, than beneficiaries in high use areas. By doing "full cost" geographic adjustment, Clinton in essence lets FFS Medicare "bid" based on local costs while charging beneficiaries who choose FFS the same amount everywhere, based on national average FFS cost.

A simple way to describe the differences between the plans is that Clinton balances competing objectives (incentives and equity) toward the equity end of the spectrum, while Breaux-Frist puts a larger relative weight on efficiency. Given its Wennberg-esque view of current utilization patterns, Breaux-Frist implicitly believes that real geographic differences in care delivery patterns are not more complicated than risk adjustment can account for. Breaux-Frist may be right as an analytic matter in the long run, but it could make beneficiaries, providers, and health plans in high cost areas rather unhappy to learn so very quickly. Which gets us to the last goal, a smooth transition.

*Goal #5: Provide for a relatively smooth transition from the current system to the new, more efficient one.* This is the dimension where the Clinton plan shines, for it is in many ways itself a perfect transition plan, since it holds FFS beneficiaries harmless while imparting gentle but real incentives for plans to become more efficient. In essence, Breaux-Frist is less patient, and the first year's NWA could introduce quite a price shock to the high cost areas of the country, which would indeed impart strong incentives but at some cost to beneficiary and plan stability in those areas. At the same time, Breaux-Frist seems more likely to improve the health plan options in low cost areas. Breaux-Frist would be less risky in the short run if risk adjustment were already perfect. Since it is not perfect yet (but it is getting better), it is probably safer for Medicare to slide toward stronger incentives over time.

Perhaps a reasonable way to proceed is to start with Clinton and then reduce the degree of geographic utilization adjustment while lowering the percentage of FFS costs that the reference price is pegged to over time. Alternatively, if Breaux-Frist is the chosen framework, a transition plan could phase in the use of the benchmark NWA in increments, like the BBA does in gradually increasing the relative weight attached to the national risk-adjusted capitation rate in the new "blended" payment methodology for Medicare + Choice plans. Ideally in the long run under either plan, FFS would be self-sustaining and there would be no statutory link between FFS and managed care prices. However, given imperfect risk adjustment and the strong preference for FFS on the part of many current beneficiaries, it is probably wise to move slowly to such a potentially efficient system. Nevertheless I do encourage you to continue to work on ways to move toward it and past the Clinton plan's clever but too modest incentives (in the long run).

### **Concluding remarks**

This statement has focused on pricing incentives because that is the core analytic issue in the proposals at hand, but as I stated in the beginning, virtually all policy observers today agree that Medicare reform cannot ignore quality. I encourage you to investigate the innovations being put in place by, e.g., General Motors and the Buyers Health Care Action Group in Minnesota. These employers are structuring price incentives for employees that are based on health plan quality performance as well as total premium and price offers from insurers and providers. Medicare can learn a great deal from cutting edge private sector employers, as the CPAC did when designing its competitive pricing demonstration projects.

Finally, it seems worth reminding ourselves that competition is not a panacea or an end in itself. Competition in any health insurance market—especially one for some of our most vulnerable citizens—must be very

carefully structured, and the competing objectives of efficiency and equity must be balanced by any public program like Medicare. Still, I believe a properly structured competitive health plan market can be the Medicare program's best long run friend, serving both beneficiaries and taxpayers quite well. I applaud your quest for that balanced structure, and would be glad to answer any questions that my testimony may have provoked.

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## Notes

1. S. 1895, as introduced on 11/9/99.
2. "The President's Plan to Modernize and Strengthen Medicare for the 21st Century," National Economic Council and Domestic Policy Council, 7/2/99.
3. The CPAC web page which describes the committee and its work is <http://www.hcfa.gov/medicare/cpacpage.htm>. The report which was distributed to all members of Congress is "Report to the Secretary of the Department of Health and Human Services from the Competitive Pricing Advisory Committee," March 31, 1999.
4. The Consolidated Appropriations Act passed both houses and was signed into law at the same time as the Balanced Budget Refinement Act last November.
5. Gold, Marsha, et al. "Medicare Managed Care: Preliminary Analysis of Trends in Benefits and Premiums, 1997-1999," Mathematica Policy Institute, June 1999.
6. John E. Wennberg is the physician who discovered how practice patterns vary across locales for ostensibly the same set of medical conditions. A recent paper summarizes lessons learned from his and related research. Wennberg, John E. "On the Appropriateness of Small-Area Analysis for Cost Containment," *Health Affairs* v. 15 # 4 (Winter 1996) pp. 164-67.

## Other Publications by the Authors

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