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Medicare Competitive Pricing: Lessons Being Learned in Phoenix and Kansas City

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A discussion featuring

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Medicare Competitive Pricing

Many lawmakers have embraced the idea of bringing more competition to the Medicare program as a way to achieve greater cost efficiency and provide more choice for beneficiaries. Advocates of this strategy believe Medicare should move away from its historical administrative pricing approach toward a competitive bidding process similar to those used by many private purchasers. Both President Clinton's Medicare reform proposal and the one developed by Sen. John Breaux (D-La.) and Rep. Bill Thomas (R-Calif.) would rely on a form of competitive pricing to achieve their objectives.

The idea is that the government will no longer tell health plans how much it will pay to provide care, but rather the plans will tell the government how much care will cost by submitting bids. The Health Care Financing Administration (HCFA), or another entity as proposed by Breaux-Thomas, would then use those bids—not administrative calculations—to establish payment rates.

Yet, despite support for the concept, every effort to test it in the marketplace has been met with strong opposition. Proposed demonstrations launched by HCFA in Baltimore and Denver collapsed after local and state officials mounted campaigns against each of the projects and ultimately succeeded in bringing them to a halt.

Congress then mandated the Medicare Prepaid Competitive Pricing Demonstration as part of the Balanced Budget Act of 1997 (BBA). To address some of the concerns raised in Baltimore and Denver, the BBA established two types of advisory committees to assist—and in some ways wrest control from—HCFA in its efforts to conduct a competitive pricing demonstration. First, the BBA created a Competitive Pricing Advisory Committee (CPAC), a national committee of independent experts that represent beneficiaries, health plans, providers, purchasers, and other technical experts, to make design recommendations and select up to seven sites for the demonstration. Second, the BBA called for an area advisory committee (AAC) at each demonstration site to assist in implementing the demonstration and adapting the overall design to local circumstances and concerns.

In January 1999, CPAC selected Maricopa County, Arizona, and the Kansas City metropolitan statistical area (straddling the Kansas-Missouri border) as the first two sites for the demonstration. Under the BBA, the first two demonstrations were to have been implemented on January 1, 1999, but CPAC—realizing that this date was not feasible—voted at one of its first meetings to delay implementation to January 1, 2000. On July 22, 1999, CPAC voted to delay implementation another year until January 1, 2001, based on input from the local AACs.

Meanwhile, political opponents of the demonstration—led by health plans and providers from the local communities—worked against moving the project forward. A provision to prohibit implementation of the project in any area until January 1, 2001, and in Phoenix and Kansas City ever, was passed by the Senate as Title IX of the Patient's Bill of Rights (S. 1344). Similar language that would effectively kill the demonstration was included as part of the Labor-Health and Human Services appropriations bill (S. 1650) passed by the Senate on October 8. While earlier versions of a House managed care reform bill (H.R. 2824) contained a similar provision, the final bill did not, and it was ultimately defeated on October 7. As of this writing, no other House vehicles were evident.

While the fate of the experiment is still uncertain, it is clear that those participating in Phoenix and Kansas City—notably private purchasers, consumers, and health plans as well as HCFA—have already learned a great deal about the types of issues that must be considered if Medicare is truly to pay health plans in a competitive

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manner. In addition, they have learned much more about the nature of the products being offered in those markets and the competitive and political forces now at work.

This Forum meeting will explore the lessons that have been learned so far in Kansas City and Phoenix. It will look at the process CPAC has used to select sites and receive input from the local communities, areas of agreement and disagreement between CPAC and the local AACs, and problems that have arisen, including design considerations, timing issues, and statutory limits. The meeting will also explore the reasons for opposition to the project. Are the objections simply a case of "not in my backyard" syndrome or are there more fundamental design flaws that render the project unworkable? Finally, the session will examine the relationship of this demonstration to broader efforts to reform the Medicare program.

OVERVIEW

In the past, government payments to health plans participating in the Medicare program have been set by administrative pricing methods, designed to pay 95 percent of estimated fee-for-service costs in a given geographic area. This payment system—based on the adjusted average per capita cost, or AAPCC—has been widely criticized as uneven and inefficient. Some areas receive high payments that enable health plans to offer extra benefits at little or no added cost to Medicare enrollees. But in low-payment areas enrollees have had to pay substantial out-of-pocket costs for benefits beyond the Medicare entitlement, even though all beneficiaries pay the same Part B premium, regardless of where they live. To address these inequities, the BBA substantially restructured the system for setting the rates that Medicare pays health plans (see NHPF Issue Brief No. 730, "Medicare Pullouts: What Do They Portend for the Future of Medicare+Choice?" for more information). In addition, the BBA created the Medicare Prepaid Competitive Pricing Demonstration to test an approach under which payments to Medicare+Choice plans in designated areas would be determined based on competitive pricing methodology.

This statutory mandate follows earlier efforts by HCFA to implement competitive pricing demonstrations for Medicare-risk health maintenance organizations (HMOs) in Baltimore (1996) and Denver (1997). Both of these demonstrations were suspended prior to implementation because of opposition by health plans and political pressure at the state and national level. The American Association of Health Plans (AAHP) filed a lawsuit against the Denver demonstration and won a temporary restraining order. The demonstration was eventually killed by congressional action in an appropriations bill.

CPAC, the independent authority Congress established in the wake of the concerns voiced in Baltimore and Denver, is intended to "bring the experience and judgment of a panel of national experts to the task of designing a competitive pricing demonstration for Medicare health plans."[1] The BBA required that CPAC include "independent actuaries, individuals with expertise in competitive health plan pricing, and an employee of the Office of Personnel Management with expertise in the administration of the Federal Employees Health Benefit Program."[2]

The members of CPAC are James Cubbin (chairman), executive director, General Motors Health Care Initiatives; Robert Berenson, M.D. (co-chairman), director, Center for Health Plans and Providers, HCFA; John Bertko, chief executive officer and senior actuary, PM Squared Inc.; Dave Durenberger, senior health policy fellow, University of St. Thomas, and founder, Public Policy Partners; Gary Goldstein, M.D., chief executive officer, the Oschner Clinic; Samuel Havens, health care consultant and chairman, Health Scope/United; Margaret Jordan, health care consultant and chief executive officer, the Margaret Jordan Group; Chip Kahn, chief executive officer, Health Insurance Association of America; Cleve Killingsworth, president, Health Alliance Plan; Nancy Kichak, director, Office of Actuaries, Office of Personnel Management; Len Nichols, principal research associate, the Urban Institute; Robert Reischauer, senior fellow, the Brookings Institution; John Rother, director, Legislation and Public Policy, American Association of Retired Persons; Andrew Stern, president, Service Employees International Union, AFL-CIO; Jay Wolfson, director, the Florida Information Center, University of South Florida.

To govern the committee's deliberations, CPAC translated the BBA statutory requirements for the demonstration into five objectives:[3]

- To make the pricing methodology fair, balancing concerns of cost, access, and quality.
- To use the demonstration to reform HCFA's pricing methodology by (*a*) reducing overall costs to Medicare and (*b*) increasing the number of beneficiaries who are satisfied with Medicare+Choice.
- To set market rules and to determine what should govern a health plan marketplace.

- To show that competition can work based on performance, rather than risk selection.
- To enhance consumer choice through educational information.

One of the chief criticisms of the Denver demonstration was the lack of input from the local community. Thus, to complement CPAC, the BBA provided for local advisory groups—the AACs—in each demonstration site. The secretary of health and human services appointed the members of each AAC, which were required to consist of representatives of health plans, providers, and Medicare beneficiaries. The AACs will operate for the duration of the demonstration in their respective locations. The purpose of the AACs, as stated in the BBA legislation (Section 4012(b)), is to "advise the Secretary concerning how the project will be implemented in the area . . . [including] advice concerning the marketing and pricing of plans in the area and other salient factors."

SITE SELECTION

Considering site selection to be one of its more important tasks, CPAC devoted extensive attention to this issue. After considering different models for sites, CPAC ultimately settled on three models:

- Model 1: Sites that have high AAPCC rates and *low* HMO market penetration and that meet certain other market and beneficiary constraints
- Model 2: Sites that have high AAPCC rates and *high* HMO market penetration and that meet certain other market and beneficiary constraints
- Model 3: Sites that have low AAPCC rates and two or more HMOs and that meet certain other market and beneficiary constraints

CPAC used data from the 319 metropolitan statistical areas (MSAs) nationwide to systematically pare down the number of sites in a series of steps. (See Figure 1 below for a detailed flowchart description of the steps followed by CPAC to select sites.) Information on all 319 sites was derived from national sources —such as census data, Medicare plan data, and the industry-oriented Interstudy market report—on the following variables: market characteristics, beneficiary and other population characteristics, and health system characteristics. As the process continued, CPAC considered increasingly detailed information about each site under consideration. HCFA regional offices collected qualitative and other information, including size of market, proximity to other health MSAs, number of plans, market concentration of two largest plans, new entry of plans, HMO nonrenewal/service reductions, physician networks, employer considerations, Medicaid issues, and the presence of hospital-medical school influence.

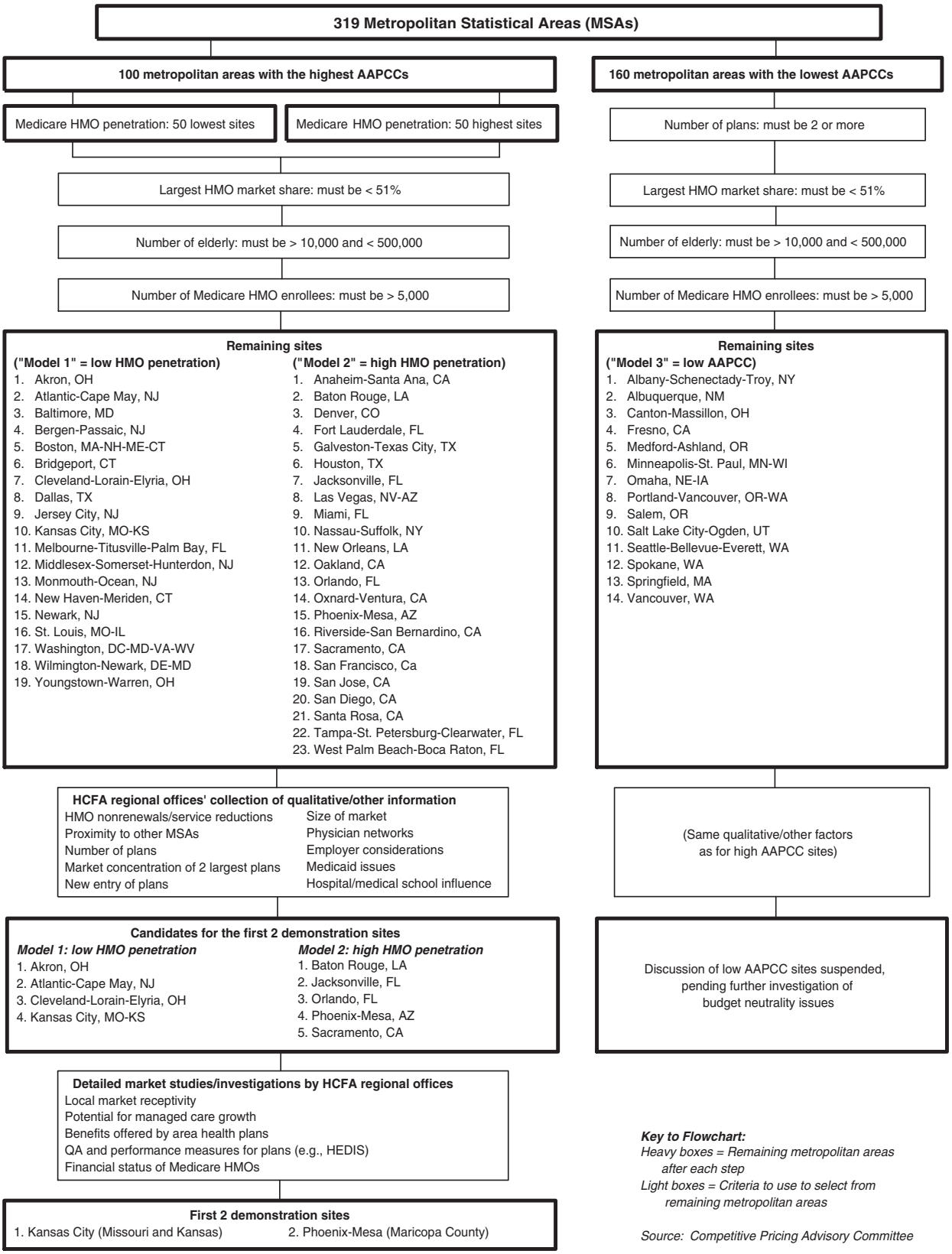
Because of budget neutrality constraints placed on the demonstration (discussed further below), CPAC suspended consideration of low AAPCC sites, pending further review. Ultimately, the committee narrowed the list down in three steps, from 319 MSAs to 56, then to 9, then to 2. As the number of sites was reduced, CPAC considered finer-grained data on the smaller number of remaining sites. From this process, two sites emerged as the most highly ranked: one Model 1 site (Kansas City) and one Model 2 site (Phoenix-Maricopa). CPAC considers the process it used to be "an orderly and systematic method for selecting the first sites" and believes it resulted in two sites that "should be strong settings for testing and evaluating the effects of competitive pricing."[4]

The two sites were selected in January 1999, after which the Department of Health and Human Services selected AACs in each site. The Kansas City AAC met for the first time on March 22, 1999; the Phoenix AAC met for the first time on March 31, 1999.

Despite the methodical process, the selection of Phoenix met with strong opposition. In an April 2 letter to HCFA Administrator Nancy-Ann DeParle, the entire Arizona congressional delegation said Maricopa County did not meet the criteria for an effective demonstration.[5] "Implementing this experiment in Phoenix would only disrupt a market in which competition is already vigorous, costs are low, and participation is high," said the letter signed by Republican Sens. Jon Kyl and John McCain and by the six House members who represent the state.

Opposition in Kansas City came a bit later in the process and reportedly was led by the physician community. By July, all four senators from Missouri and Kansas were opposed to moving the project forward. A July 1 letter to DeParle signed by Missouri Sens. John Ashcroft (R) and Christopher S. Bond (R) and Kansas Sens. Sam Brownback (R) and Pat Roberts (R) stated that "halting this project is necessary to protect the health care of senior citizens and to assure that Medicare beneficiaries continue to have access to excellent health care at prices they can afford."[6] They went on to assert that Kansas City is "not an appropriate choice for this demonstration."

Figure 1
Steps Followed by CPAC to Select Sites



Source: Competitive Pricing Advisory Committee

DESIGN RECOMMENDATIONS

Fulfilling its additional mandate of developing recommendations for the basic demonstration design, CPAC produced a design comprising four major components. These concerned (*a*) which plans can and which plans must participate, (*b*) the benefit package, (*c*) the bidding process, and (*d*) the government contribution to premiums.

Each local AAC was asked to provide recommendations regarding (*a*) specification of the "market norm" standard benefit package in each site, (*b*) choice of the median or weighted average bid as the government contribution rule, (*c*) an option to delay the new risk adjustment system in the first year of the demonstration (when the demonstration was to begin in 2000), and (*d*) the question of whether plans should submit separate bids on each county in the demonstration area or bid on a "reference" county with payments to other counties determined by payment ratios under the current system.[7]

Plan Eligibility and Participation

CPAC determined that all Medicare+Choice plans are eligible to participate in the demonstration, with one exception: medical savings accounts. The benefit structures of medical savings accounts were thought to be incompatible with other health plan types in a competitive pricing demonstration.

CPAC also discussed the inclusion of the traditional fee-for-service coverage in the demonstration. HCFA advised the committee that it was the intent of the demonstration to develop a pricing methodology for Medicare+Choice plans only. (This issue is discussed further below.)

Whether or not plans should be *required* to participate in the demonstration was another key question. In other words, would there be an alternative payment system available for plans that choose not to submit a bid? The AAHP and others have argued that plan participation should be voluntary. CPAC recommended that all eligible plans not otherwise exempted be required to participate in the demonstration, in order to participate in Medicare. In an August 3 letter, CPAC Chairman James Cubbin and Co-Chairman Robert Berenson reinforced CPAC's decision to make participation mandatory stating that "we would not be able to have true competitive bidding if some competitors could opt out of the bidding and not be affected by the bidding results."[8]

Benefit Package

The question of whether or not benefits should be standardized has often stymied health reform efforts in the past. This issue was a major point of contention in discussions among the Bipartisan Commission on the Future of Medicare. Some argued that standardization inhibits innovation and forces a "one-size-fits-all" package on all beneficiaries, regardless of their personal needs or circumstances; others argued that standardization is crucial in a national entitlement for equity reasons. In principle, CPAC agreed that health plans should be allowed to submit bids for any package of benefits of their own design that meets statutory requirements.[9] Ultimately, however, it decided it was essential that plans submit bids on a standard benefit package. The need for the government to assess bids across plans and its desire to provide beneficiaries with comparative information on managed care alternatives outweighed other concerns in CPAC's estimation.

Because most Medicare+Choice plans currently offer benefits beyond the Medicare statutory entitlement, CPAC decided that the standard benefit in the demonstration should be enhanced beyond the entitlement. Specifically, there should be a national minimum standard package composed of the basic Medicare benefit package with a limited drug benefit ($500) with cost sharing. CPAC determined that enhancements beyond the national minimum should be determined according to a local standard and should be set by the AACs, in consultation with HCFA. One of the chief concerns in the Baltimore and Denver experiences was that beneficiaries would receive fewer benefits under the demonstration. Moreover, plans were concerned that they did not have enough opportunity for dialogue concerning the overall design of the benefit package.[10] Under the new demonstration, plans will also be allowed to offer additional benefits beyond the local standard, as long they reveal the prices of each of their supplemental packages separately from their standard bid.

Both AACs set about this task by comparing the current benefit packages being offering by Medicare+Choice plans in their respective areas. Both AACs reported that current packages varied widely and that plans do not currently use standardized definitions, even though they use the same terminology (for example, ambulance services), making it difficult to compare benefits. CPAC and the AACs found the drug benefits to be especially confusing for plan comparison purposes because plans compute them differently. For example, although each plan might have a $1,000 cap on brand-name products, some use the average wholesale price to

reach the cap, others use a discounted plan price, and still others count Medicare-covered drugs in computing the cap.[11] In the end, both AACs came up with standard benefit packages that were somewhat more generous than the average plan offering in their areas.

In Kansas City, the standard benefit package currently includes limited coverage for routine hearing and vision services. It does not include coverage of dental services. Copays for primary-care physician visits were set at $12, visits to specialists at $17. Kansas City expanded the prescription drug coverage beyond the national minimum to cover up to $1,000 per year. Now that the demonstration has been delayed, the Kansas City AAC will rework its benefit package to reflect changes in the market norm. Because plans in Kansas City scaled back their benefits and/or raised their premiums for 2000, the new benefit package will be less favorable to beneficiaries than originally conceived.

The Phoenix standard benefit package is more generous than that in Kansas City, which is not surprising because the AAPCC is higher in Phoenix and has typically allowed plans to offer more extra benefits. Among the benefits in Phoenix's package are $10 copayments to primary-care physicians, specialists and other outpatient services; $8 copayments for generic drugs; and $18 copayments for brand-name drugs. The prescription drug benefit will cover up to $2,000 in brand-name drug costs; generics are not subject to the limit. The package also will cover dental services, in addition to limited hearing and vision services. It also expands Medicare's outpatient mental health benefit to include alcohol and chemical dependency.

As the differences in these benefit packages demonstrate, there is considerable diversity today, in terms of prices and coverage of extra benefits that beneficiaries receive from Medicare HMOs within and across markets. While standardization for local bidding processes can make benefits more comparable within markets, more market competition could make geographic diversity greater and more visible over time, which in turn, could raise difficult political questions.[12]

The Bidding Process

CPAC also had to consider how the bidding process should be structured and organized to provide HCFA, the plans, and other stakeholders with the needed framework to obtain market-like processes. CPAC determined that bidding cycles should be one year and that they should match the schedule followed by other Medicare+Choice plans as much as possible.

In its design report, CPAC notes that competitive pricing programs in the public and private sectors have different ways of processing the bids received from managed care plans. "The public programs tend toward formal processes with fewer opportunities for one-on-one negotiation and exercises of buyer discretion, as that is practiced in the private sector."[13]

CPAC recommended that HCFA should determine the results of bidding (*a*) from formal bids, rather than negotiations, and (*b*) from the first round of bidding. If the bids are unacceptable after the first round, HCFA can request a second round of bids.

The Phoenix demonstration will involve 150,000 Medicare beneficiaries enrolled in 11 plans. Beneficiaries in Maricopa county number 355,000.[14] The Kansas City demonstration will involve six plans in 12 counties that currently enroll 23 percent of the 230,000 area beneficiaries.

Government Contribution to Premiums

Perhaps one of the most challenging issues facing CPAC was how to set the government contribution level. One view among economists would encourage setting a defined contribution at the level of the lowest bid to gain maximum efficiency. But CPAC chose a middle ground based on several considerations. In a soon-to-be published paper,[15] CPAC member and economist Len Nichols describes why the committee decided not to go with the lowest bidder:

> First, the lowest bidders may not have enough capacity to handle their new demand, and this could force some beneficiaries to pay extra out-of-pocket payments for plans that were not their first choice. Second, this kind of contribution policy could lead low income beneficiaries to congregate in low bidding plans while higher income beneficiaries gravitate toward higher cost plans. This raises the specter of a two-tiered Medicare program which has been largely avoided to date, by design. Finally, and pragmatically, the reality is that many Medicare+Choice beneficiaries today have access to zero premium plans that provide benefits beyond the statutory package. Moving to an efficient pricing strategy precipitously would mean that most current managed care enrollees would experience competitive bidding first as a premium increase for the same or lower benefits than they get now.

Ultimately, CPAC recommended that HCFA set the government contribution to premiums as either (*a*) the median bid (adjusted to reflect available capacity in low-bid plans) or (*b*) the enrollment weighted average bid. Both the Phoenix and Kansas City AACs asked CPAC to set its contribution at the higher of the two.

Plans that bid higher than the government contribution will have to charge the excess to beneficiaries in the form of a premium. Plans that bid lower will be allowed to retain the difference or (subject to HCFA review) add benefits worth the difference. Some analysts have argued that the demonstration design removes the incentive for plans to bid low. If even one large-enrollment plans bids high, than all government payments will be increased. Also, under the demonstration, plans can only add benefits if they bid low. Therefore, the profit maximizing/risk-reducing strategy is to bid at the expected weighted average premium.

Recently, some CPAC members have suggested allowing plans that bid below the government contribution to provide premium rebates to beneficiaries. Both Clinton's Medicare proposal and the Breaux-Thomas proposal would allow beneficiaries to pay less than the Part B premium if they choose a lower cost plan. Advocates of this approach believe they could have a powerful effect on beneficiary choice of health plans and thus could provide a strong incentive for low bids.

Both AACs opted to delay any change in risk adjustment in year one, keeping the old, demographic-based system of risk adjustment at the start. Both AACs have criticized HCFA's proposed approach to risk adjustment and have indicated that they will present alternative approaches for consideration. Originally, CPAC allowed sites to consider delaying risk adjustment as a way to mitigate change resulting from the demonstration project. However, given the delay in starting the demonstration, HCFA will be implementing risk adjustment on schedule in the two sites. At the CPAC meeting on September 16, CPAC said it did not make sense to offer the sites the option to delay risk adjustment and amended its design to include only the option for sites to identify an alternative risk methodology.

Finally, several CPAC members have expressed a strong interest in linking financial incentives to the quality of care provided by health plans. A subcommittee has been formed to explore the feasibility of creating an incentive pool for high-quality plans. The incentive pool would be created by withholding a percentage of savings and distributing it later among plans, based on the achievement of quality goals. For the early years of the demonstration, CPAC recommended that HCFA rely on the current plan qualification process and market competition to ensure quality. However, the one-year delay in the implementation process has led some CPAC members to believe the extra time may allow quality performance rewards to be implemented soon.

Comparisons to AHCCCS

It is important to remember that the Phoenix community comes to this demonstration project after 17 years of experience operating the Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid managed care program. The AHCCCS program has often been touted as a model for the nation as an effective competitive pricing program. Not surprisingly, Phoenix AAC members look to the AHCCCS model for potential solutions to the questions raised by the Medicare competitive pricing demonstration. Indeed, the AAC chairman, Joe Anderson, was an early deputy director of the AHCCCS program, credited with many of the program's successful administrative features.

Of course, one of the most critical differences between the proposed demonstration and the AHCCCS program is the fact that Arizona requires mandatory enrollment in AHCCCS plans for its Medicaid population, with no fee-for-service option. The entire AHCCCS program is conducted through contracts with managed care organizations, providing a measure of stability to predicted enrollment. On the contrary, the Medicare demonstration allows beneficiaries to select fee-for-service, which exacerbates HMO enrollment unpredictability. However, it ultimately gives beneficiaries more choice. In addition, according to HCFA officials, the exclusion of fee-for-service provides a safety valve and relieves problems with access or quality that were seen in earlier AHCCCS days.

The Phoenix AAC's regulatory subcommittee has asked whether CPAC and HCFA should consider an alternative process that does not rely on competitive bids to establish a standard government contribution. Under the AHCCCS model, the government agency establishes the acceptable range for bids through extensive actuarial evaluations from experts in the field. Plans are not told the range in advance, but those that come in below or above the range are asked to resubmit and reconsider their projections. AHCCCS does not accept bids that come in below or above the range.

In addition, AHCCCS limits the number of contracts available. For example, in a certain area, only two contracts may be awarded to the top two plans; in more populated areas, additional plans are allowed to participate. As a result, plans can build their rates more effectively based on a predictable enrollment level. While this definitely creates winners and losers, AHCCCS officials say that, because their bidding process is well communicated through bidders' conference and other means, the state has prevailed in all of the bid protests.

Under the Medicare demonstration project, all plans submitting a bid will be able to provide services under Medicare. CPAC decided to allow all plans that meet basic qualification standards to offer their products to Medicare beneficiaries, regardless of price or recent quality performance, in order to maximize plan participation. AHCCCS, on the other hand, attributes much of its success to the ability to penalize or deny participation to plans with poor performance. AHCCCS evaluators believe a critical element in the bid evaluation "is the assessment of how each health plan will meet all financial and operational requirements, ensure quality in the delivery of services, and provide a sufficient provider network to meet provider accessibility requirements."[16] Cost is just one of the evaluation criteria.

The Phoenix AAC's regulatory subcommittee recently criticized HCFA's lack of integrated financial oversight, stating that

> compared to the AHCCCS program, the Medicare demonstration creates potentially more financial volatility for the participating health plans, but fails to include adequate financial safeguards and oversight appropriately integrated with the bidding and contract performance.[17]

In addition, under AHCCCS, health plan contracts have historically been awarded for a three-year period subject to annual review and renewal as opposed to the demonstration project's one-year bidding cycles.

CONCERNS

Several criticisms have been leveled at the demonstration project from the local communities, interest groups, and CPAC members themselves. The key concerns relate to the exclusion of fee-for-service, budget neutrality, and timing.

Exclusion of Fee-for-Service

Since CPAC's inception, several of its members have expressed concern that the exclusion of fee-for-service will reduce the usefulness of the demonstration's findings because there is not a "level playing field." Some members worry that it might "jeopardize the acceptance of the demonstration by Medicare+Choice plans and limit HCFA's ability to (1) measure the impact of competitive pricing and (2) generalize demonstration results to the entire Medicare program."[18]

Many health plans and some members of Congress believe the exclusion of fee-for-service is a fatal flaw that makes the demonstration project inherently unfair. In a recent *New York Times* article, AAHP President Karen Ignagni said that leaving the fee-for-service program out of the demonstration "means that private plans will be paid less than the Government plan, forcing the private plans to crimp benefits while the Government plan goes unscathed."[19] Health plans believe the exclusion of fee-for-service could undermine the goal of fostering the availability of health plan options to Medicare beneficiaries.

On the other hand, some members of CPAC, especially those from the private purchaser community, question the feasibility of including fee-for-service in the demonstration. Private purchasers are able to deliver a large number of enrollees to the plan with the winning bid. In Medicare, the beneficiary maintains control of where he or she goes. In addition, the technical complexities of adding fee-for-service to the demonstration would be "mind-boggling," according to CPAC member Chip Kahn.

Political issues would be heightened as well. CPAC member Len Nichols states that if fee-for-service Medicare was forced to bid against HMOs at the present time, without sufficient risk adjusters,

> its premium would have to be high to cover the higher (and unadjusted) costs of its relatively sicker enrollees. This would mean that people would likely have to pay an extra premium out-of-pocket (beyond the current Medicare Part B premium) to remain in FFS [fee-for-service] Medicare, which would drive the healthiest out of FFS and into HMOs and exacerbate the adverse selection which FFS Medicare continues to labor under.[20]

Budget Neutrality

The BBA requires that the competitive pricing demonstration be "budget neutral" (that is, payments to health plans in each site cannot increase during the demonstration). Because CPAC has recommended that health plans in all demonstration sites bid on a minimum standard benefit package that is more generous than the standard Medicare entitlement, the budget neutrality provision "virtually precludes conducting the demonstration in a site that currently features low payments to private health plans."[21]

CPAC members—by a unanimous vote—believe that

> permitting budget neutrality over the entire demonstration (cross-site), rather than requiring each site to have budget-neutral results (within-site) would provide a more robust demonstration by providing a new approach to redistribute the current skewed payment levels.[22]

However, others have noted that the political ramifications of transferring funds from savings in Phoenix, for example, to a low-cost area such as Minneapolis seem particularly troublesome.

In an analysis of the competitive bidding process under Arizona's AHCCCS program, Diane Hillman and Jon Christianson found that competitive bidding, as implemented in practice, is in general likely to have less than ideal incentives for cost containment. They pointed out that

> for standard bidding processes to generate effective price competition, public officials must be willing to fund their programs at the level of submitted bids, even if the required expenditures exceed budget estimates. . . . Program implementors must accept the outcomes of the bidding process as having greater validity than their budget projections. This requires sacrificing the appearance of budget control, and the favorable media coverage associated with negotiated "savings," in favor of an uncertain and less visible reduction in costs over a longer period of time, a trade-off which most politicians are uncomfortable in making.[23]

Moreover, because one of the stated objectives of the demonstration project is to reduce overall costs to Medicare, most health plans assume they will get less from Medicare under a competitive bidding process than they currently do. Thus, it is no wonder they have not embraced this concept. Because this project is inherently risky—with plans, providers, and beneficiaries fearful that they will get less—some have suggested that extra funding be added to permit plans, providers, and beneficiaries to be held harmless from the negative consequences of this demonstration. "Hold harmless" clauses were reportedly part of the demonstration project in New Jersey that first tested the diagnostic-related groups for use in paying hospitals prospectively.

Timing

Timing has turned out to be one of the major objections to the demonstration project on two fronts: first, the current turmoil in the Medicare HMO market which has seen numerous plan withdrawals and service area reductions throughout the country and, second, the deadlines and timeframes included in the BBA.

Over the past two years, several Medicare+Choice plans have decided to withdraw from the program or reduce their service areas.[24] Although only 5 to 6 percent of Medicare beneficiaries have been affected by the withdrawals, the HMO exodus has been widely publicized and has created disruption in the marketplace and anxiety for beneficiaries. In addition, according to HCFA's latest status report, many plans have restructured their benefits in ways that increase enrollee out-of-pocket costs and limit plan coverage, especially drug benefits. Moreover, for the Medicare+Choice program overall, monthly premiums paid by beneficiaries will increase.[25]

Health plans have warned that the demonstration project will only make matters worse and would end up undermining the very system Congress is trying to foster. Plans are concerned the demonstration will force changes in enrollees' benefits, premiums, or relationships with physicians during a time when the market is already unstable.[26] Physician groups have also expressed strong opposition. According to the American Medical Association, doctors in both communities have expressed fear that the project would ultimately result in fewer extra benefits and higher premiums for seniors in their areas. They believe it would create "tremendous pressure [on seniors] to change plans on a regular basis, disrupting the continuity of care and patient-physician relationships."[27] A minority of CPAC members also supported delay of implementation because of events occurring in the managed care sector. But the majority of CPAC members supported proceeding with the planning and implementation of the demonstration because the "problems experienced by some plans are likely caused by the problems with the current payment system."[28] Thus, the demonstration could provide the opportunity to try new payment methods that might be more effective.

Finally, the local communities urged delay of the demonstration largely on the grounds that more time was needed for effective implementation. At its very first meeting, the Phoenix AAC voted almost unanimously to recommend a year-long delay in implementation. AAC members expressed concern that the time frames set out by the BBA were far too aggressive and impossible to achieve. While the Kansas City AAC reported that it was on track to meet its requirements, the Phoenix AAC said they needed more time to develop a benefits package and conduct outreach to beneficiaries. When it became clear Phoenix would likely be granted a one-year extension, Kansas City AAC members voted on July 22 by a small majority to request a one-year delay as well. The same day CPAC granted these requests for delay, pushing the project start date back to January 1, 2001. But committee members also "unanimously reaffirmed the selection of Kansas City and Phoenix as correct and sound."

THE FORUM SESSION

The focus of this session will be the lessons being learned in Phoenix and Kansas City regarding competitive pricing and the implications for broader Medicare reform. A secondary intent is to help participants in the Forum's upcoming Phoenix site visit become familiar with the competitive environment and current issues facing Arizona health plans.

Key Questions

- What have been the chief stumbling blocks to getting the project off the ground (statutory limits, political opposition, design flaws)?
- What are the key differences between this demonstration and earlier efforts in Denver and Baltimore? What are the similarities?
- What have been the key lessons learned so far in both sites? What are the differences between the Phoenix and Kansas City experiences?
- What might be learned if the demonstration moves forward? What's at risk?
- Will the one-year implementation delay allow the demonstration to be more successful, or is it merely a stalling technique?
- If efforts to stop the demonstration are successful, what are the implications for future competitive pricing demonstration projects? What are the implications for broader Medicare reform proposals based on a competitive model?

Speakers

James Cubbin, CPAC chairman and executive director, Health Care Initiatives, General Motors Corporation, will provide an overview of the demonstration project and the site selection process. He will discuss the key lessons learned so far from his perspective as a private purchaser, focusing on the way this demonstration replicates the private-sector experience and the ways it differs. As executive director for General Motors (GM), he is responsible for all activities related to the company's health care initiatives, legislative analysis, and cost and quality improvements. Cubbin joined GM in 1963 and has held a series of engineering and legal positions, including general counsel for Saturn Corporation and the Buick-Olds-Cadillac Group. He presently serves as a member of the Board of Directors of the National Committee for Quality Assurance.

Robert Berenson, M.D., CPAC co-chairman and director of HCFA's Center for Health Plans and Providers, will review the lessons HCFA has learned so far regarding this demonstration and will consider the implications for Medicare competitive pricing in the future. He will also report on the current status of the Medicare+Choice program in terms of beneficiary enrollment, health plan participation, and changes in premiums and extra benefits offered. Before joining HCFA, Berenson served as vice president of the Lewin Group and for ten years as a founder and medical director of the National Capital Preferred Provider Organization. He also practiced medicine for 12 years in a Washington, D.C., group practice.

E. J. Holland, Jr., chairman, Kansas City AAC, and assistant vice president, Corporate Benefits, Sprint Corporation, will provide an overview of the Kansas City experience to date and reflect on future directions. In his role at Sprint, Holland is responsible for the company's retirement and welfare benefits, including purchasing health care for Sprint's 70,000 employees and 13,000 retirees nationwide. Prior to joining Sprint, he was senior vice president, chief administrative officer, and corporate secretary for Payless Cashways, Inc., the Kansas City–based building materials retailer. Before that, he had been managing partner and co-chairman of the health law practice group of the Kansas City law firm of Spencer Fane Britt & Browne, where he spent almost 24 years representing employers, particularly health care providers, in labor and employee relations matters.

Joseph P. Anderson, chairman, Phoenix-Maricopa AAC, and president and chief executive officer of Schaller Anderson Incorporated (SAI), will provide the Phoenix perspective and the key lessons learned there so far. Through an SAI management contract, he served from 1989 to 1997 as president and chief executive officer of Arizona Physicians IPA, Inc., Arizona's largest Medicaid managed care plan. Currently, he provides oversight to the health plans managed by SAI in California, Oklahoma, Maryland, and Missouri. He is a former chairman of HCFA's Medicaid Managed Care Industry Group, which is aimed at promoting Medicaid managed care programs. Prior to forming SAI with Donald Schaller, M.D., in 1986, Anderson was deputy director of Arizona's AHCCCS program.

Robert D. Reischauer, Ph.D., member of CPAC and a senior fellow at the Brookings Institution, will discuss the implications of the demonstration project for broader Medicare reform. From 1989 to 1995, Reischauer served as the director of the Congressional

Budget Office. He is an economist who has written extensively on federal budget policy, Congress, health and social welfare issues, poverty, and state and local fiscal problems.

ENDNOTES

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21. CPAC, "Report to the Secretary," 27.

22. CPAC, "Report to the Secretary," 27.

23. Diane G. Hillman and Jon B. Christianson, University of Arizona, "Competitive Bidding as a Cost-Containment Strategy for Indigent Medical Care: The Implementation Experience in Arizona," *Journal of Health Politics, Policy and Law,* 9, no. 3 (Fall 1984): 447.

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