Backgrounder

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A "Demonstration Project" Equals No Medicare Reform

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> "Republicans are eager to win the support of Senator Edward M. Kennedy, Democrat of Massachusetts. But it is unclear whether they have made enough concessions to do so."
>
> —Robert Pear, *The New York Times*, November 12, 2003

The outline agreement reached this week by a House–Senate conference committee guts any serious long-term reform of the troubled Medicare program while proposing the single largest entitlement expansion in the program's history. Instead of enacting real reform at a date certain and in time to accommodate the retirement of the massive baby-boom generation, key congressional leaders are instead proposing that a "demonstration project," confined to only a few areas of the United States, be created to test serious Medicare reform.

Such a demonstration project, however, would not test reform; it would kill it. Previous experience with federal health care demonstration projects suggests strongly that political and special-interest opposition to competition would guarantee the failure of any new demonstration program.

Indeed, even before the ink on the Medicare conference agreement was dry, key Senators had already objected to the establishment of any demonstration project in their home states. Senators Gordon Smith (R–OR) and Arlen Specter (R–PA) want to "shelter" their states from any such "demonstration" program.[1]

Talking Points

- The latest congressional leadership proposal continues a tiresome pattern of bad federal health policy that undercuts the effectiveness of serious market-based health care reforms.
- Current and future taxpayers would be saddled with a universal drug entitlement of unknown cost as a permanent feature of the already ailing Medicare program, and a system of market-based competition would be reduced to a temporary and uncertain phenomenon, subject to relentless political attack over the next several years.
- Serious Medicare reform means one thing: creating a premium support financing system modeled on the superior Federal Employees Health Benefits Program.
- Contrary to the inaccurate claims routinely made by its opponents, the FEHBP, particularly when controlling for the value of benefits, is superior in controlling health care costs.

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In the first iteration of the "competitive demonstration" proposal, the House and Senate majority leadership reportedly favored scrapping the House-passed provisions in the Medicare drug bill to move toward national Medicare reform in 2010, substituting instead a time-limited demonstration program, beginning in 2008, in four metropolitan areas of the country and a geographic region, the geographic boundaries of which were undetermined.[2] In the final conference agreement, this was changed to demonstration projects in six metropolitan areas, including an area that crosses state lines. The Secretary of the Department of Health and Human Services would select the demonstration sites, and the projects would begin in 2010.[3]

In other words, current and future taxpayers would be saddled with a universal drug entitlement of unknown cost as a permanent feature of the already ailing Medicare program, and a system of market-based competition would be reduced to a temporary and uncertain phenomenon, subject to relentless political attack over the next several years.

Killing Serious Reform: The Tried and True Method

Members of Congress should be under no illusion about the record of similar Medicare "demonstration" projects enacted in previous Congresses. It has been amply documented that previous attempts to demonstrate some form of competitive pricing in Medicare were routinely undermined or destroyed.

Nonetheless, the latest congressional leadership proposal continues a tiresome pattern of bad federal health policy that undercuts the effectiveness of serious market-based health care reforms. Consider what happened in three cases:

- **The Medical Savings Account Demonstration Project of 1996**. The language of the Health Insurance Portability and Accountability Act of 1996 (the Kennedy–Kassebaum Bill) created a four-year demonstration project, setting a time limit on the market opportunities for developing and selling medical savings account (MSA) products. The bill also imposed a cap of 750,000 policies and limited the eligible population to firms with from two to 50 employees.

  What Happened. The demonstration project was hobbled by dozens of statutory and regulatory conditions. Not surprisingly, it was less than successful. Had the purpose of the project been to create a robust market for MSAs, it could not have been more poorly designed.

  Since the enactment of the badly designed MSA program, congressional champions of consumer choice and competition have had little chance to expand on the demonstration. Indeed, confronted by intense hostility in Congress, they have been forced to concentrate on trying to undo the restrictions on the MSA demonstration. With the current Medicare legislation, the congressional champions of consumer choice are expected to accept a massive Medicare drug entitlement as the price of liberalized MSA rules.

- **The Medicare+Choice Experiment of 1997.** As part of the Balanced Budget Act of 1997, Congress created the so-called Medicare+Choice program.

  What Happened. Although it was accompanied by free-market rhetoric of choice and competition, the Medicare+Choice program turned out to be a textbook example of political opposition and over-regulation, discouraging participation in health plans and so reducing the supply of plans and depriving seniors of promised choice.[4] Moreover, the problems associated with the administrative and congressionally imposed restrictions became a pretext for opponents of consumer choice and market-based competition to claim

1. Associated Press, "GOP Leaders Struggled to Clinch Medicare Deal," November 15, 2003.
2. Mark Sherman, "Congress Closer to Prescription Drug Bill," Associated Press, November 12, 2003.
3. Robert Pear, "Deal 'in Principle' for Medicare Plan to Cover Drug Costs," *The New York Times*, November 16, 2003.
4. For a brief assessment of the impact of the Medicare+Choice regulatory system, see Robert E. Moffit, "Regulated to Death: How Medicare's Bureaucracy Is Killing Seniors' Choices," Heritage Foundation *Executive Memorandum* No. 687, June 29, 2000. On the weaknesses of the Medicare+Choice system generally, see Sandra Mahkorn, M.D., "How Not to Reform Medicare: Lessons from the Medicare+Choice Experiment," Heritage Foundation *Backgrounder* No. 1319, September 15, 1999.

that choice and market competition are unworkable and undesirable.

- **The Medicare Competitive Pricing Demonstrations of the 1990s**. In the 1990s, four "competitive pricing" demonstration projects were established in the Medicare program to test a new form of private health care plan. The demonstrations were in Baltimore, Maryland; Denver, Colorado; Phoenix, Arizona; and Kansas City, Missouri.

  The most significant of these were the demonstration projects created in the Balanced Budget Act (BBA) of 1997 in Phoenix and Kansas City. Under the BBA arrangements, Congress set up a Competitive Pricing Advisory Committee, composed of private-sector experts, to oversee the creation of a system of competitive payments for the Medicare+Choice plans.

  What Happened. The aim of reformers was to create rational incentives and price competition in Medicare. But the plan payment system implemented in the Medicare+Choice program involved administrative pricing, under which prices were set by government rather than by the market.

  This turned out to be both inefficient and inequitable. As Urban Institute analysts Len M. Nichols and Robert Reischauer observed in 2000, "In the case of M+C plans, administrative pricing has both led to excessive Medicare spending and created significant inequities for beneficiaries."[5]

  All four of these projects were successfully undermined by political opposition and economic self-interest. The policy experience was well summarized in 2000 by the editors of *Health Affairs* in a special section on the demonstrations:

  > Recent demonstrations of the concept were fraught with operational obstacles, fierce industry opposition at the national and local levels, and congressional hostility. The upshot: The demonstrations never fully materialized, which suggests that such tests may not be feasible or even desirable.[6]

  Moreover, this successful opposition was neither as ideological nor as intense as that being directed against current efforts at Medicare reform.

Key Lessons from the Competitive Pricing Demonstrations

Based on the previous competitive pricing experiments alone, health policy analysts can point to a variety of painful lessons:

Lesson 1: There will be intense opposition from narrow special interests.

These interests include doctors, hospital officials, health plans, and other providers who have often resisted having to compete with each other on the basis of price.[7] According to Nichols and Reischauer:

> While it is common to talk about the Medicare program as health benefits for the elderly, it is also an important source of income for providers and plans. Competition and the efficiency it produces will inevitably hurt some local providers and plans.[8]

Lesson 2: Congressional delegations will obstruct the demonstrations.

Reflecting the strong self-interest of local providers, state and local congressional delegations frequently have lined up in opposition to Medicare competitive pricing demonstrations that threatened the status quo. Often, these delegations have been instrumental in enacting measures to block or

5. Len M. Nichols and Robert D. Reischauer, "Who Really Wants Price Competition in Medicare Managed Care," *Health Affairs*, Vol. 19, No. 5 (September/October 2000), p. 31.
6. "Special Section: Medicare's Experience With Competitive Pricing," *Health Affairs*, Vol. 19, No. 5 (September/October 2000), p. 8.
7. On this point, see Bryan Dowd, Robert Coulam, and Roger Feldman, "A Tale of Four Cities: Medicare Reform and Competitive Pricing," *Health Affairs*, Vol. 19, No 5 (September/October 2000), p. 24.
8. Nichols and Reischauer, "Who Really Wants Price Competition in Medicare Managed Care," p. 43.

impede the implementation of such demonstrations.

This was particularly the case with Medicare+Choice demonstration projects authorized under the Balanced Budget Act of 1997. As Nichols and Reischauer have explained:

> Congress as a whole did not kill the demonstrations it approved in the BBA. Rather, the leadership on both sides of the aisle and the White House allowed a few members to kill them, for reasons that had precious little to do with long run Medicare reform policy.[9]

Lesson 3: There will be destructive congressional micromanagement.

Even if Congress decides, as it did in 1997, to establish a semi-independent body to make key decisions governing the Medicare demonstration, it is unlikely that the demonstration will escape congressional micromanagement, an intervention invariably designed to make the process fail. "Over the history of the Medicare program," as prominent health policy analyst Bryan Dowd and his colleagues have noted, "Congress repeatedly has prevented HCFA [the Health Care Financing Administration, which was then running Medicare] from implementing efficient purchasing practices."[10]

Lesson 4: Demonstrations are not necessarily the easier road to reform.

Demonstrations are often portrayed as easier to enact and put into place than national reforms; but the curious feature of a limited Medicare demonstration project, such as that currently being proposed by the House and Senate leadership, is that the reverse often turns out to be true. Perhaps the best example of a sweeping national change is the comprehensive physician payment reform of 1989, which resulted in a complete overhaul of the method for paying all physicians, in every specialty, who treat Medicare patients.[11] Phased in nationally over five years, it changed the entire payment practice in Medicare in one step.

This lesson applies with special force to changing the system of payments to private plans through Medicare reform. As Dowd and his colleagues also note:

> Paradoxically, it may be politically easier, but riskier, to implement competitive pricing in Medicare as part of national reform with no demonstration. Demonstrations single out groups of beneficiaries and treat them differently from their peers. When the changes that are being tested have a significant and direct effect on all of the major stakeholders in a site, demonstrations may be impossible. At least, based on the record to date, Congress will defer to the complaints of sites that have been singled out.[12]

Reversing the Retreat from Serious Medicare Reform

Serious Medicare reform means one thing: creating a premium support financing system modeled on the superior Federal Employees Health Benefits Program (FEHBP) as recommended by the majority of the National Bipartisan Commission on the Future of Medicare and cited as a model for choice and competition by President George W. Bush. To this end, Section 241 of the House bill would set up an FEHBP-style competitive system starting in 2010 and then phase in the program over a period of five years. The Senate bill had no such provision.

However, although Section 241 of the House bill was a major improvement over the competitive features of the Senate bill, it would not have taken effect until 2010; and the first wave of the massive baby-boom generation becomes eligible for Medicare coverage in 2011. This would be a close call. Already, the House bill's reform timetable would pose a serious political risk to reform.

It would have been far wiser to give new retirees a chance to carry their private health plans into retirement as their primary coverage at an earlier date while creating an infrastructure of choice and com-

9. *Ibid.*, p. 42.

10. Dowd *et al.*, "A Tale of Four Cities," p. 26.

11. For an account of the Medicare physician fee schedule change, see Robert E. Moffit, "Comparable Worth for Doctors: A Severe Case of Government Malpractice," Heritage Foundation *Backgrounder* No. 855, September 23, 1991.

12. Dowd *et al.*, "A Tale of Four Cities," p. 25.

petition early enough to absorb the coming demographic shock of the baby-boom population. This would have given Congress and the Administration time to make the necessary adjustments well before the onset of the first wave of that huge generation's retirees.[13]

Moreover, by setting the date so far in the future, the House provision, while laudable in itself, would still have been vulnerable over the next several years to attempts by relentless congressional opponents of any serious change in Medicare—particularly those who champion a single-payer health care system for the United States—to undermine any such reform.

A Better Option. A better option would be to strengthen the competitive provisions of Section 241 of the House bill. This could be done by starting the process of serious reform earlier, in 2007 or 2008. At the same time, Congress could create the infrastructure of choice and competition administered by a market-friendly agency and could deem any private or public health plan covering new retirees, under existing rules, eligible for premium support for the primary coverage of retirees. FEHBP plans and state employee retiree plans, for example, would be deemed automatically eligible.

Moreover, a new competitive system should not be burdened by having to operate within rigid geographical service areas or by being forced to comply with comprehensive benefit standardization, both of which would inhibit plan participation, flexibility, and innovation.

Conclusion

A successful demonstration program of premium support has already been conducted. It is the Federal Employees Health Benefits Program, and it has been in operation for over 43 years. Predating Medicare itself, the FEHBP has covered millions of workers and retirees over that long period, including retirees who were never covered by Medicare. Indeed, from 1960 to 1983, federal retirees relied on the FEHBP's premium support system as their primary coverage; its use as supplementary coverage for federal retirees was not generally available until the enactment of amendments to the Social Security Act in 1983.

The FEHBP is superior to the Medicare program in every way: in the richness and variety of its health plans and benefits; in its administrative flexibility; in its rapid accession of new medical procedures, treatments, and technologies; and in the relatively low level of bureaucracy and regulation that governs the program. In addition—contrary to the inaccurate claims routinely made by its opponents—the FEHBP, particularly when controlling for the value of benefits, is superior to Medicare in controlling health care costs.[14]

Members of Congress know these facts about the FEHBP. That is why they have no excuse for retreating from a long-term reform of Medicare by enacting a demonstration program that is doomed to failure.

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13. For a description of how to accomplish this arrangement, see Walton J. Francis, "Using the Federal Employees' Model: Nine Tests for Rational Medicare Reform," Heritage Foundation *Backgrounder* No. 1675, August 7, 2003; for an excellent description of the functioning of the premium support model and how to organize such a system for future Medicare beneficiaries, see Jeff Lemieux, "Explaining Premium Support: How Medicare Reform Could Work," Centrists.Org, November 6, 2003, at *http://www.centrists.org/pages2003/10/26_lemieux_health.html*.

14. On this vital point, see Michael O'Grady, *Health Insurance Spending Growth: How Does Medicare Compare?* Joint Economic Committee, U.S. Congress, June 10, 2003; see also Walton Francis, "The FEHBP as a Model for Medicare Reform: Separating Fact from Fiction," Heritage Foundation *Backgrounder* No. 1674, August 7, 2003.