Medicare Private Plans Under Pressure to Improve

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WASHINGTON — If competition drives prices down, why does the government pay private insurers more per patient than the Medicare program spends on an average beneficiary?

That was the question from a growing number of people, said panelists at a press briefing on health care costs sponsored by the Center for Studying Health System Change. "A lot of folks are suffering from amnesia about this whole issue. In 2003, we passed something called the Medicare Modernization Act.. . . It was about how are we going to solve the baby boomer problem, how are we going to bring Medicare costs under control," said Robert Laszewski, president of a health policy and marketplace consulting firm in Alexandria, Va.

At the time, the Republican-led Congress decided that the best way to bring costs under control was to encourage more Medicare beneficiaries to join private plans. So, depending upon which type of plan they offer, managed care companies receive 10%-20% above what Medicare spends on the average beneficiary in the fee-for-service system. This induces private insurers to offer managed Medicare products and enable them to offer more benefits to attract beneficiaries into the private plans, according to the philosophy behind the legislation.

It's 4 years later, and some are wondering what they are buying with the millions of extra dollars flowing to private insurers. Physicians on the government's Medicare Physician Advisory Commission (MedPAC) have called on Congress to redirect those funds toward other priorities, such as fixing the sustainable growth rate formula.

However, it may be too early to pull the plug on this experiment, said Christine Arnold, a managing director at Morgan Stanley who covers the managed care industry. "The managed care companies that I speak to say that they can reduce medical costs 10% for a managed product versus an unmanaged product, but it takes 2-4 years."

It is not just in the Medicare program that cost-saving techniques are being questioned. Health savings accounts and other consumer-driven approaches are losing favor with the public. The number of U.S. workers who enrolled in consumer-directed plans grew by a meager 300,000 between 2005 and 2006, according to the Kaiser Family Foundation's annual survey of employer benefits.

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A survey by America's Health Insurance Plans, a trade organization, confirms that trend. After a few years in which enrollment in health savings account–affiliated, high-deductible plans doubled and then tripled, last year the number of people in the plans grew by less than a third.

Consumer-directed plans may be a good idea, but they're based on the false assumption that patients have the resources to make the right choices, said Douglas Simpson, the senior managed care analyst at Merrill Lynch & Co.

"We're incentivizing them with the benefit structure, but then we're really not giving them the tools to make better decisions. It's sort of like giving somebody $100 to go out to dinner and then not putting the prices on the menu," Mr. Simpson said.

The cyclical nature of health care reform also is becoming more apparent, said Joshua Raskin, who covers the managed care industry as a senior vice president at Lehman Brothers Inc.

During the late 1980s and early 1990s, health care premiums grew by double digits, resulting in political backlash. Hillary Clinton's universal care plan further popularized health maintenance organizations. "HMOs had this huge period of proliferation and you got the cost trending down in the mid-1990s to. . . really low single digits," said Mr. Raskin. Then, the economy picked back up—along with medical costs—and double-digit growth returned. Now, the discussion is again focusing on "more government intervention. It's 2007 and 2008, and guess what: Hillary Clinton is back and so is universal health care." ■