Medicare Private Plans Are Urged to Prove Their Worth

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WASHINGTON — If competition drives prices down, then why does the government pay private insurers more per patient than the Medicare program spends on the average beneficiary? This is the question on the minds of a growing number of people, said panelists at a press briefing on health care costs sponsored by the Center for Studying Health System Change.

"In 2003, we passed the Medicare Modernization Act.... It was about how [we are] going to solve the baby boomer problem ... [and] 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 the best way to bring costs under control was to encourage more Medicare beneficiaries to join private plans. So, depending on which type of plan they offer, managed care companies receive 10%-20% above what Medicare spends on the average beneficiary in the government-run, fee-for-service system.

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

But Christine Arnold, a managing director at Morgan Stanley, where she covers the managed care industry, said it may be too early to pull the plug on using private insurers to control costs. "The companies I speak to say 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 the cost-saving techniques of managed care companies are being questioned.

Health savings accounts and other consumer-driven approaches are beginning to lose 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.

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

Consumer-directed plans may be a good idea, but they're based on a 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 we're not giving them the tools to make better decisions. It's like giving somebody $100 for dinner, then not putting the prices on the menu."

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 were growing by double digits, resulting in a political backlash in the form of Hillary Clinton's universal care plan further popularizing health maintenance organizations, he said. Costs in the mid-1990s to slipped to the low single digits, then the economy picked up again and so did medical cost trends. Now, the discussion is back to focusing on more government intervention. ■

Most Medicare Part D Plans Cover a Brand-Name in Each Treatment Class

Although formularies under Medicare Part D plans vary widely, nearly all plans cover at least one brand-name drug in many commonly prescribed treatment classes, according to data from a study in California.

The researchers studied eight treatment classes, including angiotensin-converting enzyme inhibitors, angiotensin II receptor blockers, β-blockers, calcium channel blockers, loop diuretics, selective serotonin reuptake inhibitors, statins, and thiazide diuretics.

They noted how often drugs were included in at least 90% of formularies at copayments of $35 or less without prior authorization.

"Providers can have a difficult time knowing which drug is paid for by Medicare Part D because there are over 1,800 plans and there's a great deal of variation among these formularies," Dr. Chien-Wen Tseng, of the University of Hawaii and the Pacific Health Research Institute, said in an interview. "[But] despite the large number of plans and variation among their formularies, for most of the treatment classes we examined, we found one or more drugs that were covered by nearly 100% of Part D formularies."

Nearly all of these widely covered drugs are generics, and the drugs covered by Part D formularies are likely to change as generics become available and as new clinical data are released (JAMA 2007;297:2596-602).

Dr. Tseng said that a Web site that tracks the list of widely covered drugs could help physicians determine which drugs are most likely to be covered and therefore more affordable for patients.

In addition to the inconvenience for doctors, the variations also pose a health problem for patients "because they may not get the drug they need if it's not covered or too expensive."

—Jane Anderson

POLICY & PRACTICE

E-Prescribing Called 'Win-Win'

Electronic prescribing could prevent nearly 2 million medication errors and save the federal government $26 billion over the next decade—even after providing funds for equipment, training, and support—if physicians were required to use the technology for their Medicare patients, according to a study released by the Pharmaceutical Care Management Association. The study found that when physicians use e-prescribing to learn their patients' medication history and prescription choices, both patient safety and savings improve dramatically. However, fewer than one in 10 physicians actually use e-prescribing, according to PCMA. The group, which represents pharmacy benefit managers, is pushing the Centers for Medicare and Medicaid Services to require e-prescribing for all Medicare Part D prescriptions by 2010, while providing incentive payments for physicians that would offset their costs for equipment, training and support.

Feds Release Medicaid Drug Rule

CMS has unveiled a new method of setting limits on what the federal government will reimburse state Medicaid agencies for prescription drug payments. As part of the new regulation, states will be required to collect information from physicians about prescription drugs administered in their offices so that the state can collect any rebates offered by drug manufacturers on those products. The final rule, which will take effect Oct. 1, is aimed at reining in inflated drug product payments, CMS said. The regulation is expected to save states and the federal government $8.4 billion over the next 5 years, but even with the change, the Medicaid program still is expected to spend $140 billion for drugs over the same time period. The change is in part a reaction to a series of reports showing that Medicaid payments to pharmacies for generic drugs were much higher than what pharmacies actually were paying for the drugs.

N.Y. AG Fights Rankings

New York's attorney general has asked insurer UnitedHealthcare to halt the introduction of a program that would rank physicians in the state according to quality of care and cost of service. United was slated to release its New York physician rankings next month, and State Attorney General Andrew Cuomo's staff said they feared that consumers would be steered to physicians based on faulty data and criteria. In addition, the letter from Linda Lacewell, the attorney general's counsel for economic and social justice, said that consumers may be encouraged through the program to "choose doctors because they are cheap rather than because they are good." Ms. Lacewell wrote, "UnitedHealthcare's profit motive may affect the accuracy of its quality ratings because high-quality doctors may cost UnitedHealthcare more money."

APhA Urges Delay in Rx Rule

The American Pharmacists Association and three lawmakers have urged CMS to delay implementation of a new federal mandate requiring the use of tamper-resistant prescription pads for all Medicaid prescriptions beginning Oct. 1. The mandate, included in recently approved legislation to fund the war in Iraq, requires that all Medicaid prescriptions be written on "tamper-resistant" paper to be eligible for federal reimbursement. But even though many states have similar requirements, it will take much longer than 3 months to roll out such a program across the country, said APhA executive vice president and CEO John Gans in a statement. The three lawmakers—Rep. Charlie Wilson (D-Ohio), Rep. Marion Berry (D-Ark.), and Rep. Mike Ross (D-Ark.)—say that most physicians do not currently use these types of pads, nor are supplies readily available. "The tamper-proof pad law was designed to prevent Medicaid fraud," the legislators said in a statement. "However, the timeline for implementation could result in patients being turned away from their pharmacies as of Oct. 1, 2007, if doctors fail to write prescriptions on 'tamper-resistant' paper." The congressmen have introduced a bill that would require only prescriptions for Class II narcotics to be written on the tamper-proof prescription pads.

Army to Educate on Mental Health

The U.S. Army is beginning a program to have all soldiers—and their families—learn the symptoms of traumatic brain injury and posttraumatic stress disorder and to help service personnel seek treatment. The goal is for all active-duty and reserve military personnel to receive training by mid-October. The Army will use what it calls a "chain-teaching" method, with education coming down the chain of command. Leaders can retrieve materials—consisting of a 35-page guide and video and slide shows—at www.army.mil. The aim is to remove the stigma of seeking help, according to the Army.

New Orleans MD Charges Dropped

A grand jury refused to indict Dr. Anna Pou, the New Orleans surgeon who was accused of murder in the wake of Hurricane Katrina. The decision by the Orleans Parish grand jury came just days after Dr. Pou sued the state attorney general over the case, and ends the year-long criminal investigation into Dr. Pou's performance at Memorial Medical Center immediately after the hurricane. Dr. Pou had been accused of giving four patients a "lethal cocktail" of painkillers and sedatives shortly before the sweltering hospital was evacuated. Dr. Pou's suit against State Attorney General Charles Foti accuses the attorney general of using the murder case against her to fuel his reelection campaign. The lawsuit, filed in state district court in Baton Rouge, also asks the court to force the state to defend Dr. Pou against wrongful death lawsuits filed by family members of three of the patients who died at Memorial.

—Jane Anderson