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Critics Say Proposal for Medicare Could Increase Costs

By ROBERT PEAR

WASHINGTON, May 5 — Congressional efforts to revamp Medicare by expanding the role of private health plans have been immensely complicated by new data suggesting that such plans would not save money and could substantially increase Medicare costs.

Republicans in Congress said last week that they had accepted President Bush's proposal to encourage the development of private health plans known as preferred provider organizations, which steer patients to certain doctors and hospitals. Competition among private plans can slow the growth of Medicare, they said.

But, federal officials and health policy experts say, new evidence shows that the private plans pay doctors and hospitals more than Medicare pays, so they would probably not save money any time soon.

Influential lawmakers are starting to sift through the evidence, which has the potential to reshape the debate over the future of Medicare.

The Medicare Payment Advisory Commission, a nonpartisan federal advisory panel, recently had a study done comparing fees paid by Medicare and private health plans. Zachary Dyckman, the economist who did the study, collected data from 33 health plans of 31 million people.

In an interview today, Mr. Dyckman said he had found that "private health plan fees are about 15 percent higher than Medicare fees."

Paul B. Ginsburg, president of the Center for Studying Health System Change, a private group that monitors trends in health care markets around the country, found the same pattern, and he said it was becoming more prevalent.

"In most areas of the country payment rates for hospitals and physicians that are negotiated by private plans are higher than those paid by the Medicare fee-for-service program," Mr. Ginsburg said.

Despite such findings, Bush administration officials and Republican members of Congress said the private plans could improve the quality of care.

Representative Nancy L. Johnson, Republican of Connecticut, said Republicans had decided to give private plans a major role, not just in administering pharmaceutical benefits under Medicare, but in coordinating care for those with chronic conditions like asthma, diabetes and heart disease.

"I am extremely interested in chronic care, chronic disease management, enabling seniors to have more access to coordinated care," said Mrs. Johnson, chairwoman of the Ways and Means Subcommittee on Health. "A prescription drug bill will result in overmedication of seniors, at great cost physically and

monetarily, if we don't coordinate care for people with multiple chronic conditions. That's why we've decided to include preferred provider organizations. They're much more capable of managing care than a fee-for-service plan."

Preferred provider organizations have become popular in the commercial market. They serve 52 percent of workers with private health insurance, up from 38 percent in 1999.

A preferred provider organization typically has a network of doctors. Patients can visit any doctors in the network, usually without seeing a primary care doctor, or gatekeeper, and for an extra charge they may see doctors outside the network.

Mr. Dyckman said that such private plans usually had to pay doctors more than Medicare to get enough physicians to participate in their networks.

Alissa Fox, policy director for the Blue Cross and Blue Shield Association, agreed. "Medicare payments are lower than what we generally pay in our private business," Ms. Fox said. Blue Cross and Blue Shield plans provide coverage to 85 million Americans.

The federal government sets the level of Medicare payments to doctors and hospitals by statutes and regulations. By contrast, private plans set rates through negotiations with health care providers.

Hospital mergers have enhanced the bargaining power of many hospitals, just as doctors have increased their leverage by joining in large groups. Hospitals with reputations for excellence and medical groups representing many doctors in a specialty have successfully demanded higher payments, even as consumers and purchasers of care have demanded access to such providers.

"Boston, Cleveland, Greenville, S.C., Little Rock, Ark., and Seattle have private rates that are much higher than Medicare rates," Mr. Ginsburg said. "Private payments range from 120 percent to 180 percent of Medicare physician payments in Little Rock, and from 100 percent to 150 percent in Boston."

In rural areas, Mr. Ginsburg added, private health plans often pay far more than Medicare. In many of those areas, he said, there is little competition among health care providers, so private plans have difficulty obtaining discounts.

Administration officials often complain that under Medicare, the government sets prices for thousands of goods and services, ranging from wheelchairs to cardiac bypass surgery. Several Senate Republicans said they wanted to give private health plans a larger role in Medicare, but feared that this approach could lead to higher costs.

To hold down costs, Senate Republicans said, they are considering legislation to authorize private health plans to follow fee schedules used in the traditional Medicare program. The maximum prices paid by private health plans would be determined not by market forces, but by federal rules, at least for several years.

Unveiling his "framework to modernize and improve Medicare" in March, President Bush said he wanted to "introduce private-sector innovation and competition to the Medicare system, to help keep costs reasonable" and to ensure high-quality care. But Mr. Dyckman and Mr. Ginsburg said they doubted that the private plans would save much money because such plans paid higher rates to doctors and hospitals than Medicare pays in most markets.

In June 2000 and again in June 2002, the House of Representatives passed Republican bills to add prescription drug benefits to Medicare, the federal program for 40 million people who are elderly or disabled.

Under the legislation, Medicare would pay subsidies to insurance companies to induce them to sell a product that does not now exist: insurance covering prescription drug costs and nothing else.

Bush administration officials said they now wanted more fundamental changes in the structure of Medicare. Stand-alone drug coverage "does not exist in nature" and would probably not work in practice, said Thomas A. Scully, administrator of the federal Centers for Medicare and Medicaid Services.

House Republican leaders said they had tentatively decided to combine their Medicare legislation with a separate bill limiting the damages that could be awarded in medical malpractice lawsuits.

The Congressional Budget Office estimated that the malpractice bill would save the federal government \$14.9 billion over 10 years, mainly by reducing what Medicare and Medicaid spend on malpractice insurance premiums for doctors and hospitals.

The American Medical Association and some House Republicans said the savings could be used to pay higher fees to doctors treating Medicare patients. Medicare officials said that if Congress took no action, doctors' Medicare fees would be automatically cut about 4 percent next year, under a statutory formula.