Trendspotter: Do Doctors Treat Medicare Patients Differently?

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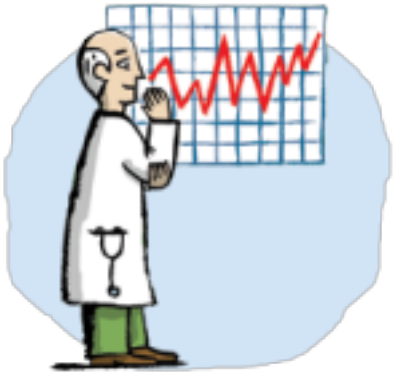
By Ken Terry [2]

Many doctors try to help out patients who can't afford to pay the full amount for an office visit or the copay for a pricey medication. Now along comes a study suggesting that physicians in one Texas community treat patients differently, depending on whether they are on Medicare or have private insurance. The study in Health Affairs re-examines the health cost data from McAllen, Texas.

Some years ago, I did a story for Medical Economics Magazine about whether doctors treat HMO patients differently. I discovered that, in fact, some physicians did differentiate between patients with different kinds of insurance. On the other side of the coin, many doctors try to help out patients who can't afford to pay the full amount for an office visit or the copay for a pricey medication. Now along comes a study suggesting that physicians in one Texas community treat patients differently, depending on whether they are on Medicare or have private insurance.



The study in Health Affairs re-examines the health cost data from McAllen, Texas, which surgeon Atul Gawande made famous by comparing McAllen's Medicare costs to the much lower spending of nearby El Paso, Texas. In a 2009 New Yorker article that was said to be required reading at the White House, Gawande made a compelling case that healthcare providers in McAllen ordered far more tests and performed more procedures than their El Paso counterparts because of the greater "entrepreneurial spirit" and "culture of money" in McAllen.

The new research doesn't debunk that notion, but puts it in a different perspective by comparing the health costs for members of Blue Cross and Blue Shield of Texas in McAllen and El Paso. Whereas price-adjusted Medicare spending per beneficiary was 86 percent higher in McAllen than in El Paso—and 75 percent above the national average—total spending for Blues members was 7 percent lower in McAllen than in El Paso. Inpatient and professional services costs were roughly similar in both cities for this commercial under-65 population, but McAllen spent 31 percent less on outpatient care than El Paso did.

Coauthors Luisa Franzini, Osama L. Mikhail, and Jonathan Skinner consider the possible explanations for the contrast between McAllen's high Medicare costs, relative to El Paso, and the spending on commercially insured patients. After discounting the impact of price, income and health in the two communities, they also dismiss the possibility that Blue Cross Blue Shield has greater market power in McAllen than in El Paso. (The company is the largest health insurer in Texas.) What they're left with is the suggestion that the Texas Blues has become adept at managing utilization of care in ways that Medicare has not attempted. Consequently, they theorize, McAllen doctors may take advantage of Medicare to order or perform services that the Blues might question. For example, the private insurer requires preauthorization of procedures and might not approve something that the diagnosis doesn't justify under evidence-based guidelines.

In addition, they point out, the Texas Blues has developed sophisticated case management and disease management programs that help patients manage their health and avoid hospitalization or readmissions.

One might think that Medicare would begin to adopt some of the same principles as private insurers to reduce waste and rein in spending. But a CMS demonstration project on disease management

yielded equivocal results a few years ago. Moreover, the Medicare fee-for-service program has historically paid for all medically necessary care—with doctors determining what that is. Medicare has clamped down on paying hospitals for “never events,” avoidable readmissions, and conditions present on admission; but it’s not clear that it has the authority to implement utilization management as it’s practiced by private insurers. So traditional Medicare (although not Medicare Advantage plans) will probably not impinge on doctors’ medical decisions any more than in the past. From physicians’ point of view, that’s a good thing. Yet, although the new study’s authors refused to draw this conclusion, it seems logical that what happens in McAllen occurs elsewhere, too. There must be communities all across the country where the same confluence of local culture and market dynamics leads some doctors to treat Medicare patients differently than other patients. (The same is probably true for Medicaid patients, too, although that would be grist for another column.)
Why is this important? I believe that’s a question that might cause some soul searching among physicians. If you believe that you have the same responsibility to every patient, regardless of their insurance status, you should treat them all the same. Of course, that’s not always easy, especially in small practices that are struggling to stay afloat in today’s economy. And it’s easy to talk yourself into believing that you are acting in patients’ interest by ordering more tests or procedures or putting them in the hospital. But in the end, the best care for a patient is the care he or she really needs.

Disclosures:

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