reason.com
FREE MINDS AND FREE MARKETS

# Spend More, Save More

## Can Medicare save money by giving patients cash?

Peter Suderman | June 16, 2011

Medicare is on the path to bankruptcy. By 2024, the Congressional Budget Office estimates that the seniors health program will be insolvent. It's not just the program's fiscal health that's at stake either. In the long term, the program is the single biggest drive of the federal debt.

Yet reforming the program remains a dicey proposition. During the ObamaCare debates, Republicans latched onto the law's cuts to Medicare as their most effective messaging attack against it. In recent months, Democrats have responded in kind with similar attacks on Republican plans to overhaul the program.

With major changes to the program tied up in political gridlock, health wonks are on the hunt for innovative ways to lower spending. Lorens Helmchen, a professor at George Mason University's Department of Health Administration and Policy, has proposed a novel method of constraining the program's spending: He thinks the program may be able to save money by spending money—specifically by giving cash to patients who make more cost-effective choices.

The basic idea, dubbed cash-for-care, is as simple as a year-end performance bonus. When faced with two treatments of roughly equal efficacy but dramatically different cost, Medicare would pay patients a cash fee if they chose the less expensive option. The idea is a form of shared savings. But where most shared savings plans share exclusively with health care providers, Cash for Care shares it with patients.

In a coauthored working paper, Helmchen notes that end-of-life care currently accounts for a quarter of the Medicare's total spending. And much of that spending, in turn, is devoted to cancer treatment. But when it comes to cancer, cost-effectiveness varies wildly. Treatments for the same class of cancer can range in cost from as little as $1,300 a month to more than $7,000.

Greater utilization of lower-cost treatments could be a vehicle for savings. But many doctors are reticent to factor cost into their treatment decisions. And efforts to reorganize Medicare's payment system to give providers financial incentives to utilize more cost-effective care by paying single lump sums for entire treatment regimes run risks. So-called shared-savings programs give providers an incentive to provide less care overall, and to only steer patients toward the cheapest treatments. They also continue the longstanding pattern in American health care of insulating patients from patients, who may rebel against provider-side incentives out the belief that more expensive treatments are more effective.

There isn't much precedent for the specific approach in the U.S. Over email, Helmchen points to a Medicaid demonstration project labeled "Cash and Counseling" that gave patients the ability to manage their own individual Medicaid budget and retain the savings in cash, but that program paid mostly for counseling, not clinical services like cancer treatment.

But the underlying idea—giving patients financial incentives to make wise health care decisions—isn't new. According to Devon Herrick, a senior fellow and health care expert at the National Center for Policy Analysis, Cash for Care is "definitely trying to harness the same type of incentives as consumer-driven healthcare plans," which typically pair high-deductible insurance with health savings accounts. Under those plans, patients have a financial stake in their care decisions, and can save money depending on what sort of care they choose. The fundamental idea is to take bureaucrats out of the equation and put patients in charge. Cash for Care, Herrick says, is essentially "giving patients a bonus to ration their own care."

Critics argue that consumer-driven schemes encourage patients to skimp on necessary care. But Herrick points to the Rand Health Insurance Experiment, the most comprehensive study of its kind, which found that when insurers increased cost-sharing, individuals reduced their care consumption by about 30 percent. The vast majority, however, suffered no ill effects. Herrick notes that Cash for Counseling improved patient satisfaction and had no negative effects on the health of participants. "If anything," Helmchen says, "shared-savings supplements might encourage too many patients to seek a diagnosis because we're attaching a cash payment to the choice of the least costly care options."

What about savings? Multiple studies have reported that consumer-driven care plans produce substantial savings when compared with traditional health insurance plans, but Helmchen says he currently has no big-picture estimates of Cash for Care's potential savings. He expects, however, that the biggest savings would occur over time, "as shared-savings supplements stimulated the use of care that beneficiaries value most relative to its cost."

"I don't want to oversell the likely savings because at this point they are difficult to estimate," Helmchen cautions, but he and his fellow researchers would like to see the idea tested in a pilot program. That would allow them to estimate how many people would actually switch to lower-cost care, and thus to produce better cost estimates.

Medicare pilot programs designed to save the program money don't have a robust track record of success. But given the program's dire consequences, that doesn't mean they shouldn't be tried. Herrick, who describes himself as skeptical of the savings potential of many pilot programs, argues that even still, Medicare "needs to have more experiments in seeing what works and doesn't work."

Historically, though, what hasn't worked is a bureaucratic approach to pricing and paying for care. And that's the biggest potential problem for a program like Cash for Care: It still relies on experts and administrators to make decisions about which treatments to encourage, and which ones to discourage, and how much to pay for each.

Medicare's current payment system relies on bureaucratic price setting for more than 7,500 different treatments and procedures. Those prices are supposed to be designed in such a way that doctors don't make substantially more from one treatment versus its alternative. But price controllers sometimes get the details wrong. Somehow, the more profitable treatments end up prescribed at far higher rates.

Helmchen doesn't underplay the potential problem. "There is no evidence," he says, "that the demands on administrators would be less than under the current system." And that's the worry. Medicare has already tried setting prices. And according to Herrick, they're "not particularly good at it." Why should the program's administrators be any better at this? "It's not that the program shouldn't try to find better solutions," says Herrick. "It's just the convoluted way that Medicare works. You're unlikely to find those solutions in the bureaucratic system."