THE WALL STREET JOURNAL.

Three Simple Ways Medicare Can Save Money

Price fixing can be costly. The government should embrace alternatives like concierge physician arrangements.

By JOHN C. GOODMAN **August 11, 2011**

The most significant reason for our out-of-control deficit spending is health care. And the biggest federal health-care program is Medicare. That's why almost everybody—on the right and the left— agrees that Medicare must be reformed. A good place to start is recognizing that what Medicare is trying to do is impossible.

Medicare has a list of some 7,500 separate tasks it pays physicians to perform. For each task there is a price that varies according to location and other factors. Of the 800,000 practicing physicians in this country, not all are in Medicare and no doctor is going to perform every task on Medicare's list.

Yet Medicare is potentially setting about six billion prices across the country at any one time.

Each price Medicare pays is tied to a patient with a condition. And with the 7,500 things doctors could possibly do to treat a given condition, Medicare has to be just as diligent in not paying for inappropriate care as it is in paying for procedures that should be done. So, in fact, Medicare isn't just setting prices. It is regulating whole transactions.

Is there any chance that Medicare can set prices and approve transactions in a way that does not cause serious problems? Not likely.

What happens when Medicare gets it wrong? One result is that doctors face perverse incentives to provide care that is costlier and less appropriate than the care they should be providing. Another result is that the skill set of our nation's doctors becomes misallocated, as medical students and practicing doctors respond to the fact that Medicare is overpaying for some skills and underpaying for others.

Consider the following example. A post at the Health Affairs blog compares a 25-minute office visit with a primary care physician (PCP) to a 10-15 minute cataract removal by an ophthalmologist. The authors note that in examining symptoms such as a persistent cough, the PCP must draw on the whole of medicine in order to diagnose the condition and treat the patient.

By contrast, cataract removal is a 50-year-old procedure, and many of the doctors who do it operate in assembly-line fashion designed to maximize their income.

This year, Medicare is paying $111.36 for the PCP visit. The ophthalmologist, meanwhile, is raking in $836.36 (including the patient copayment). Medicare is paying 7.5 times more for cataract removal than for a primary care visit. If we measure according to the time spent to earn the fee, Medicare is paying the ophthalmologist 15 times what it pays the PCP.

Is there any wonder why the shortage of primary care is reaching crisis proportions in many parts of the country, while cataract removal is available at the drop of a hat?

A more sensible approach is to quit asking for the impossible. Instead, let's begin the process of allowing medical fees to be determined the way prices are determined everywhere else in our economy—in the marketplace. Here are three ways to start:

First, all over the country there are walk-in, free-standing emergency-care clinics that post prices and usually deliver high-quality care. Because these services arose for cash-paying patients outside of the health-insurance system, their prices are free-market prices. Many follow evidence-based protocols, keep records electronically, and order prescriptions electronically. These methods tend to either cut costs or raise the quality of care.

Medicare should allow enrollees to obtain care at almost all of these places, and it should pay the posted prices. Since these fees are well below what Medicare would have paid at a physician's office or hospital emergency room, this reform would lower Medicare's overall costs.

Second, Medicare should allow enrollees to take advantage of commercial telephone and email services. TelaDoc offers telephone consultations with physicians at a price that is probably lower than the same service delivered by a nurse at a walk-in clinic. Where appropriate, its services are more accessible than those of the walk-in clinic. Also, TelaDoc doctors use electronic medical records and prescribe electronically. Again, it is important to pay the market price, not Medicare's price, although Medicare patients should probably pay a good portion of the cost of each phone call out of pocket.

Finally, Medicare should encourage physicians to repackage and reprice their services in ways that are good for the doctor, good for the patient, and good for Medicare. For example, Medicare should encourage concierge doctor arrangements.

A typical concierge doctor charges about $1,500 per patient per year. In return, patients get telephone and email consultations, same- or next-day appointments, electronic medical records, and electronic prescribing. If patients and doctors are willing, Medicare should be willing to throw its 7,500-item price list away, pay some portion of the concierge fee, and let the marketplace handle everything else.

In each of these cases, the principle is the same: Let markets do what only markets can do well.

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