HealthAffairs Blog

A Better Way To Approach Medicare's Impossible Task

By Thomas Saving and John Goodman **November 15th, 2011**

As Congress faces mounting pressure to rein in Medicare spending, two sides seem to be squaring off. The don't-touch-a-thing-other-than-squeezing-provider-fees position seems to appeal to mainly Democrats, while eat-your-spinach reforms, including more cost sharing and higher premiums, seem to appeal mainly to Republicans. Neither position is very appealing to voters, however, nor should they be.

Is there a third way? Is there a way to get the job done and appeal to voters – young and old – at the same time? We think there is. To see how it might work, we first have to understand that what Medicare is currently trying to do is virtually impossible.

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

Still, Medicare is potentially setting about 6 billion prices at any one time all over the United States of America, as well as in Guam, Puerto Rico, the Mariana Islands, American Samoa and the Virgin Islands.

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

Let's say that the 50 million or so Medicare enrollees average about 10 doctor visits per year and let's conservatively assume that each visit gives rise to only one procedure. Then considering all of the ways a procedure can be correctly and incorrectly coded, Medicare is regulating 3 quadrillion potential transactions over the course of a year! (A quadrillion is a 1 followed by 15 zeroes.)

Is there any chance that Medicare can make the right decisions for all these transactions? Not likely.

What does it mean when Medicare makes the wrong decisions? It often means that doctors face perverse incentives to provide care that is too costly, too risky and less appropriate than the care

they should be providing. It also means that the skill set of our entire supply of doctors will become misallocated, as medical students and even practicing doctors respond to the fact that Medicare is over-paying for some skills and under-paying for others.

To pick one example, a post at *Health Affairs* Blog [1] compared a 25 minute office visit with a primary care physician to a 10-15 minute cataract removal by an ophthalmologist. The authors note that in examining such symptoms 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 in focused factories designed to maximize their income.

Medicare this year is paying $111.36 for the PCP visit while the ophthalmologist is raking in $836.36 (including the patient copayment). Basically, Medicare is paying 7.5 times more for cataract removal than for primary care. Per time spent to earn the fee, Medicare is paying the specialist 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?

Unfortunately, the authors of the *Health Affairs* piece think the solution is for Medicare to do a better job of setting the 6 billion prices. But, if Medicare's 20-year-old experiment in price setting has worked so poorly in the past, why would anyone expect it to work any better in the future?

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.

In trying to do that, we face two problems. First, we have completely suppressed normal market forces in medical care for many years. How can you have market prices where no real market exists? Second, many people believe that Medicare is using monopsony (single buyer) power to push provide fees below market levels. However, economic theory predicts that monopsony not only results in lower input prices, it also results in less output. In this case, that means less medical care.

Without government acting as a monopsony buyer, patients might end up paying more for the services they currently get, but they would also get more care or their access to care would improve. Would they be better off as a result? That's hard to say. The monopsony owners, taxpayers presumably, benefit with monopsony profits, while the monosony customers lose with higher total market prices, in this case waiting time and service availability.

We believe there are at least nine important policy changes that can circumvent these two problems and free the marketplace in the process.

Retail outlets. All over the country there are retail establishments that are offer primary care services to cash-paying patients. Because these services arose outside of the third-party payment system, their prices are free market prices. Walk-in clinics, doc-in-the-box clinics and free-standing emergency care clinics post prices and usually deliver high quality care. Many follow evidence-based protocols, keep records electronically and order prescriptions electronically.

Medicare should immediately allow enrollees to obtain care at almost all of these places — paying posted, market prices, not Medicare's prices. And since these fees are way below what Medicare would have paid at a physician's office or hospital emergency room, this reform would lower Medicare's costs, even as it makes primary care more accessible.

Note: Medicare can always reverse this decision in isolated cases where the provider fees turn out not to be competitive, although if Medicare is using its monopsony power, prices and output are already non-competitive.

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

Concierge doctors. Medicare should encourage physicians to repackage and re-price their services in ways that are good for the doctor, good for the patient and good for Medicare. For example, Medicare should encourage — rather than discourage — the emergence of concierge doctor arrangements.

A typical concierge doctor charges about $1,500 per patient per year. In return, patients get telephone and email consultations, same-day or next-day appointments, electronic medical records, electronic prescribing, etc. and an agent to help them solve problems in dealing with the rest of the health care system.

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 medical marketplace handle everything else.

Billing by time, rather than task. Most professionals are not paid by task – the way doctors are paid. They are paid by the time it takes to deliver their services. When we pay doctors by task, we will always omit valuable services from the price list, no matter how long the list. In the current system, doctors get no compensation (or woefully inadequate compensation) for talking to patients by telephone and email, for patient education, for helping patients become smart shoppers for drugs and diagnostic tests and for dozens of other things.

As an alternative, we should allow doctors to change the mix of services they offer, and pay them for their time. If the change in practice is substantial enough, we should allow patient copayments and let them be determined in the marketplace. The test of whether the new set of services has added value is whether seniors are willing to pay more out of pocket to get them.

Paramedical personnel. One way to expand the supply of low-cost medical care is through the increased use of nurses and physician assistants to perform tasks that do not require a physician's level of expertise. The current system discourages the creative use of paramedical personnel, however. The reason: when a task is performed by a nurse rather than a physician, Medicare automatically reduces its fee. (See the example here [2].)

A better approach would be to allow doctors to profit when they find ways of reducing the cost to the payer. This is the natural outcome in a free market, where firms that reduce customer cost benefit both themselves and the customers. Absent a free market, rules that allow innovators to benefit when they reduce the cost to taxpayer's should be encouraged. Doctors who want to practice medicine in a different way and be paid in a different way should be allowed to do so long as the cost to Medicare goes down and the quality of care patients receive does not suffer. The principle: doctors should be encouraged to earn more income by saving Medicare money.

Bundling. One of the obstacles to offering patients a package surgery price, covering all services, is that surgery typically involves several entities who are financially independent. For example, the hospital, the surgeon, the anesthetist, etc. In a normal market, independent entities come together all the time, jointly produce a good or service, and agree on how to divide the revenue from the exercise. This would be naturally happening in medicine as well, were it not for the Stark amendment – making such arrangements illegal.

Clearly this impediment to efficiency must be removed. Providers should be encouraged to offer package prices for bundled services and Medicare should be willing to pay the package price wherever it is expected to be less than what taxpayers would otherwise have paid. Patients should share in the savings as well – in order to encourage them to patronize lower-cost, higher-quality provision.

Medical tourism. You don't have to go to India, Thailand or Singapore these days to find high-quality, low-cost medical care. Medical tourism is coming much closer to our shores. For example, a renowned Indian heart surgeon is building a medical tourist facility in the Cayman Islands. Others will surely follow suit. Since the international medical tourism market is a real market where providers routinely compete for patients based on price and quality, Medicare should take advantage of it.

Further, if a patient saves money for Medicare by traveling, the patient should share in the savings. As in the case of doctors, patients should be encouraged to make money by saving Medicare money.

You don't actually have to go off shore to participate in the market for medical tourism. There is a flourishing market for it on shore. The only problem: it's generally not available to Americans. Canadians, for example, routinely come to the United States for surgical procedures and they usually face a package price for all services agreed to in advance. The general rule: hospitals only step outside the system and charge package prices to people who travel (thus, they are a marginal customer) and who pay out of pocket (thus, the hospital has to compete on price.)

Seniors too could be in this market, and they would be if Medicare allowed seniors to share in the savings created by traveling to a higher-quality, lower-cost facility.

Selective relaxation of price controls. There is substantial evidence that Medicare fees are well below normal fees paid by the private sector. There is very little evidence to show us what difference this makes, however. Are we substituting rationing by waiting for rationing by price? Are seniors getting lower quality care? Are they being deprived of amenities? One way to seek answers to these questions is to let a few doctors in a given area – but not most – charge anything they like for Medicare covered services. Medicare would continue to pay its list price, but the patient would have to pay any remaining extra charge out of pocket.

Patients then would have a choice. They could go to doctors who charge the regulated Medicare fee. Or they could go to doctors who charge a market-determined fee. Here's the test: can doctors who are free to do so attract patients even though those patients have to pay more than they would pay elsewhere? If so, that means that Medicare patients under the current system are being denied convenience, amenities and perhaps quality and that they are willing to pay for in the market. In the face of such evidence, Medicare should then be willing to allow even more doctors the same option.

Health care stamps. The efficiency of markets vis-à-vis centralized control is well documented wherever centralized control has been tried. But how do we transition from the current centrally controlled Medicare system to individual control. Perhaps we can learn something from how the food industry is treated. Supermarkets contain thousands of individual products all with prices attached. Since food consumption is a necessity, just as health care, how do we insure that food is available to all? Rather than having Foodcare, we subsidize low income individuals by selling them "dollar value food stamps" at discounted prices. These stamps are real money to the grocery stores and to the recipients. Since individuals consume more than their food stamp limit, on the margin they are spending a dollar for a dollar. However, if they choose to buy pricey steak instead of hamburger using food stamps dollars, they will have less to spend on other products.

Competition for food stamp dollars forces stores to compete on price and, unlike health care, the prices are transparent. Every paper contains full page ads in which price plays a dominant role.. This proposal would be especially ideal for the dual eligible population (qualifying for both Medicare and Medicaid) because this population has first dollar coverage anyway. A combination of the Clinton Commission's "premium support" and health care stamps would

result in controlling the federal contribution to the cost of Medicare for this group and letting the elderly consume whatever level of health care they desire.

We should make certain that the poor have the wherewithal to pay for their health care not by forcing them to wait or take poorer quality, but with health care dollars. These health care dollars would be full dollars to providers, insuring that the poor can complete for resources with all other buyers of care.

In each of these cases, and in others we could think of, the principle is the same: let markets do what only markets can do well. Essentially we let the market replace the gigantic Medicare regulatory apparatus.