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# Reforming Medicare

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*How can we control the rising cost of Medicare? Fortunately, there are an enormous number of people who have answers. These include most of the 44 million enrollees, 650,000 doctors and 30,000 facilities participating in Medicare. In fact, almost everyone who has contact with the system can produce examples of waste and inefficiency that could be eliminated.*

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However, none of these people can do much to bring about the improvements needed. Perversely, people who try to improve the system are often financially penalized for doing so. This should change. Every doctor, patient and hospital administrator must be unleashed to use their intelligence and creativity to make the changes necessary to produce low-cost, high-quality health care.

## I. Free the Provider

Doctors participating in Medicare are forced to practice medicine under an outmoded, wasteful payment system designed for a different century. They should instead be allowed access to 21st century alternatives.

**Problem:** Typically, doctors receive no financial reward for talking to patients by telephone, communicating with them by e-mail, teaching them to manage their own care or helping them be better consumers in the market for drugs. In fact, doctors who help patients in these ways will end up with less take-home pay. To make matters worse, as Medicare suppresses reimbursement fees, doctors are increasingly unable to perform any task that is not reimbursed. Hospitals face the same perverse incentives. Facilities that figure out how to lower patient costs, raise quality and offer warranties and other guaranties are penalized for doing so. Unfortunately, high-cost, low-quality care is reimbursed at a higher rate than the alternative.

**Solution: New Payment Opportunities.** It should be as easy as possible for Medicare providers to get paid in better ways. What is needed is not pay-for-performance, but performance for pay — with ideas and proposals coming from the supply side of the market (which is more knowledgeable about potential improvements than the demand side).

Accordingly, any provider should be able to propose and obtain a different reimbursement arrangement, provided that (1) the total cost to government does not increase, (2) patient quality of care does not decrease and (3) the provider proposes a method of measuring and assuring that (1) and (2) have been satisfied.

**Case Study: Surgery with a Warranty in Pennsylvania.** According to a RAND Corporation study, patients receive recommended hospital care — such as an aspirin after a heart attack or antibiotics before hip surgery — only about half the time, on the average. There is also a lot of variation in quality. In Pennsylvania alone, the mortality rate for heart surgery among hospitals varies from zero to 10 percent. Even more surprising, hospitals usually profit from their mistakes: When patients have to be readmitted to deal with complications from the initial surgery,

the hospital can bill them again.

Geisinger Health System in central Pennsylvania has discovered a better way for patients and insurers. It offers a 90-day warranty, similar to the type of warranties found in consumer product markets. Specifically, Geisinger charges a flat fee for three months of follow-up treatment. If the patient returns with complications in that period, Geisinger promises not to send the patient or the insurer another bill.

The problem is that Geisinger would lose money on the proposition even as it saved money for Medicare and Medicaid — because those programs do not pay for such guarantees. Medicare should pay more to hospitals that save taxpayers money.

**Implementation: Streamline Approvals.** Paperwork and time delays are the enemy of entrepreneurship. Workable performance for pay reforms require transactions that are easy to negotiate and consummate. However, given a willing Medicare administration, the process of reform should not take long. There are already low-cost, high-quality pockets of excellence just waiting to be replicated.

**Implementation: Relax Stark Restrictions.** Another essential ingredient is allowing doctors and facilities to work together as a team — making needed improvements and profiting from them. To facilitate this change, regulations that prohibit profitable provider arrangements must be repealed or relaxed.

## II. Free the Patient

Patients also suffer when payments to doctors and hospitals are based on outmoded formulas. Whereas suppliers compete to meet customer needs in almost every other market, this rarely happens in health care.

**Problem:** Many patients have difficulty seeing primary care physicians. They often turn to hospital emergency rooms where there may be long waits and where the cost of care is much higher. When they do see doctors, patients often get inadequate information.

Studies show that diabetics, asthmatics and other chronic patients can manage their own care as well as or better than conventional physician care and at lower costs. Yet to do this patients need training, easier access to information and the ability to purchase and use in-home monitors. This is not happening under the current system.

**Solution: Patient Power.** New ways should be explored to empower patients — especially the chronically ill, allowing them to manage more of their own care and more of their own health care dollars.

For example, almost all the states have "Cash and Counsel" programs for homebound, disabled Medicaid patients — allowing them to manage their own health care dollars and hire and fire their caretakers, instead of having these decisions made by an impersonal bureaucracy. Patient satisfaction in these programs is almost 100 percent. Medicare should build on this highly successful program by giving chronically ill patients some of the same opportunities.

**Implementation: Flexible Health Savings Accounts.** Within both traditional Medicare and Medicare private insurance plans (Medicare Advantage), insurers should be able to make risk-adjusted deposits to the HSAs of chronic patients. Unlike the accounts under current law, these HSAs should be flexible — allowing patients to exercise discretion where it is possible and desirable.

## III. Free the Entrepreneur

In normal markets, entrepreneurs in search of profit often spur cost efficiencies and quality improvements. Under Medicare, by contrast, entrepreneurial efforts find their greatest reward when they exploit the system rather than improve it.

**Problem:** Entrepreneurs are creating new products to fill needs that traditional health insurance does not meet. For example, people can purchase blood tests via the Internet and get results in 24 hours. They can get low-cost care with very little waiting at walk-in clinics in shopping malls. Yet these services are often hampered by outmoded, unnecessary government regulations. Amazingly, doctors are prohibited from owning and operating walk-in clinics that refer patients to their regular practices!

**Solution: Deregulate the Supply Side.** As a regulator of care, government has erected many obstacles. For example it is illegal for a doctor practicing on the Texas side of Texarkana to treat a patient by phone on the Arkansas side of the same city. It is illegal for a doctor practicing in East St. Louis (Illinois side) to interpret x-rays taken for a patient treated in west St. Louis (Missouri side). Unless these relics of misguided regulatory excess are repealed, the services accessible to each of us will be limited by the borders of the state in which we live.

**Implementation: Override State Laws.** Although the federal government should move cautiously in overriding state regulatory barriers to efficiency, the case for change is strong. A national market for provider services should be established quickly.

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