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Markets and Medicare

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Rarely in Washington does the president get to propose legislation that Congress is required to fast track. Such an opportunity exists right now, and it pertains to the most serious domestic policy problem this country faces: the rising costs of Medicare.

Under a 2003 law, the Medicare trustees have certified that the program's finances have deteriorated so much that they "trigger" a required presidential response. Sadly, Washington's response is not new. The White House proposed across-the-board cuts in payments to doctors and hospitals in the budget earlier this month. Such measures do not improve care, and have not worked to contain costs in the past.

More recently, Secretary of Health and Human Services Mike Leavitt has proposed measures to promote electronic medical records, price and quality transparency, limits on malpractice awards, and means-testing of Part D (drugs) premiums. While in some respects commendable, these proposals are far from adequate.

According to the trustees, Medicare's unfunded liability is $74 trillion -- five times that of Social Security. According to the Congressional Budget Office, health-care spending is on a course that could crowd out all other government programs. Clearly the time has come for fundamental reform.

How can we control the rising cost of Medicare? There are many examples of waste and inefficiency throughout our health-care system: diseases that we fail to prevent; chronic illnesses that progress to preventable complications that are treated with duplicative and ineffective services; and too-common medical errors. There is an enormous number of people who in theory could change these practices, including the 650,000 participating doctors, the 30,000 participating facilities, and especially the 44 million enrollees and their caregivers.

Perversely, however, people who try to improve Medicare are often financially penalized for doing so. This needs to change. Here's how:

- *Free the Doctors.* Doctors participating in Medicare must practice medicine under an outmoded, wasteful payment system. Typically, they receive no financial reward for talking to patients by telephone, communicating by e-mail, teaching patients how to manage their own care, or helping them be better consumers in the market for drugs. Medicare pays by task, and these are not reimbursable activities. So doctors who help patients in these ways are taking away from billable uses of their time.

In fact, physicians who help patients in these ways may end up with *less* payment from Medicare. To make matters worse, as Medicare suppresses reimbursement fees, they are increasingly unable to perform any task that is inadequately reimbursed. Other health-care providers face the same perverse incentives. All too often, high-cost, low-quality care is reimbursed at a higher rate than the alternative, and Medicare's payment rules get in the way of providers working together to improve health care.

We should be willing to reward doctors and other health-care providers who raise quality and lower costs -- including improving patient communication and access to care, and teaching patients how to be better managers of their own care.

Accordingly, providers 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) there is a mechanism for accountability, and a method of measuring and assuring that (1) and (2) have been satisfied.

Geisinger Health System in central Pennsylvania provides an example of what could be done. It offers a 90-day warranty on heart surgery, similar to the type of warranties found in consumer product markets. If the patient returns with complications in that period, Geisinger promises to attend to it without sending the patient or the insurer another bill.

The problem is that Geisinger doesn't get financial support from Medicare for this practice, even as it can save money for Medicare overall. This is because health-care organizations like Geisinger get paid more when patients have complications that lead to more visits, more tests and more readmissions. What is needed is a system willing to pay for such guarantees. Medicare should be willing to pay more for the initial surgery if taxpayers save money overall.

Another innovative example: Virginia Mason Medical Center in Seattle offers a new approach to the treatment of back pain, a source of considerable medical spending nationwide. Under the old system, a patient would often first receive an MRI scan or specialty consultation and other tests before referral to a physical therapist. Under the new system -- which cuts the cost of treatment in half -- patients are first seen by a physical therapist unless additional diagnostic measures are clearly indicated, and receive an MRI scan only if the therapy doesn't work and symptoms persist.

The new system improves efficiency and saves money for payers but leaves the providers financially worse off. As in the case of Geisinger, Medicare should permit a new payment arrangement -- one that is win-win for Medicare and Virginia Mason.

Once one hospital or doctor group implements an arrangement with better payment for better results, there will be competitive pressures on other providers to find new and innovative ways of raising quality and lowering costs. Plus, once Medicare takes these steps, private insurers can adopt similar payment systems more easily. Medicare and the private sector will be pushing in the same direction, for better care -- not just more services.

For reform to work, however, there must be accurate measurements of quality and cost, so that these transactions can be easy to negotiate and consummate. Another essential ingredient is to allow doctors and facilities to work together as a team -- making needed improvements and profiting from those improvements.

Similarly, regulations that prohibit profitable provider arrangements should be relaxed, when those arrangements are leading to documented improvements in care. There are many low-cost, high-quality pockets of excellence just waiting for the support they need to grow. Medicare has considerable authority to implement these changes now. If health-care providers accept more accountability for the results of their care, we can start seeing the benefits right away.

- *Free the Patients.* Patients also suffer when payments to doctors and hospitals do not reward prevention-focused, efficient care. Many patients have difficulty getting to see primary care physicians. When they do, all too often they get inadequate information about their overall health condition and the best ways to improve it.

Studies show that diabetics, asthmatics and other chronic patients can often manage their own care as well as, or better than, conventional physician care, and at lower costs, when given the support they need. Yet to do this patients need training, easier access to information, and the ability to purchase and use in-house monitors. One way to do this is by allowing patients (especially the chronically ill) to save money when they choose less costly, high-quality care. They should be able to use the savings to purchase services that are not paid for by traditional health insurance, including telephone and e-mail consultations and patient education services.

Almost all the states now have "Cash and Counsel" programs for homebound, disabled Medicaid patients -- allowing them to manage their own health-care dollars and hire and fire the people

who provide them services, instead of having these decisions made by an impersonal and outdated schedule of covered services and regulated prices. Patient satisfaction in these patient-controlled programs is almost 100%, according to government surveys. We need to build on this highly successful program by giving chronically ill Medicare patients some of the same opportunities.

Both within traditional Medicare and the Medicare private insurance plans (Medicare Advantage), this opportunity should include risk-adjusted deposits to the Health Savings Accounts (HSAs) of chronic patients. Unlike current law, these HSAs should be flexible -- allowing patients to exercise discretion where discretion is possible and desirable.

- *Free the Entrepreneurs.* While our health-care system has some of the most innovative treatments in the world, Medicare's payment system imposes many barriers to innovations in using those treatments efficiently and effectively. In normal markets, cost efficiencies and quality improvements mean larger net revenues when an entrepreneur finds a better way to provide products or services. By contrast, entrepreneurial efforts under Medicare all too often find their greatest reward when they exploit the system by finding ways to bill more for more services, rather than improve it. We should welcome and encourage better ways of meeting patient needs. For example, a medical practice that uses walk-in clinics and electronic prescribing to lower overall Medicare spending for the beneficiaries it serves should get higher payments.

These are just a few of the many things that can be done to control the rising costs of Medicare, while improving care and health at the same time. These steps will not be enough by themselves to put Medicare and our health- care system on a sustainable course, but timely action by the president and Congress can make a big difference.

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