The Century Foundation

The AGENDA

# Getting Better Value from Medicare

By Maggie Mahar

## Introduction

*At some point we as a nation will have to decide whether we wish to design our health care system primarily to satisfy those who profit from it or to protect the health and welfare of all Americans.*

—David Mechanic, *The Truth about Health Care* [1]

## I. The Problem

In January, a new president will have little choice: Medicare will be on his agenda. Whether or not this new president is willing or able to move on national health insurance, Medicare reform cannot wait.

Medicare's financing is unraveling. In its March 2008 report, the independent Medicare Payment Advisory Commission (MedPac)[2] warned that the amount that Medicare's Hospital Insurance (HI) trust fund lays out for inpatient stays and other post-acute care began to outstrip its annual income from taxes in 2004. By 2019, MedPac explained, "Income from payroll taxes . . . would cover 79 percent of projected benefit expenditures."[3] And each year after 2019, the shortfall will widen.

Medicare's financial woes mirror problems in the health care system as a whole. The United States spends more than twice as much as the average developed nation on health care, yet the quality of care that U.S. patients receive has failed to keep pace with spiraling costs. On this point, MedPac cites a shocking statistic from the National Scorecard on U.S. Health System Performance.[4] When nineteen industrialized nations were ranked on how many of their citizens died before age seventy-five "from conditions that are at least partially preventable or modifiable with timely and effective healthcare," the United States placed fifteenth.

Too often, in the laissez faire chaos that we call a health care "system," no one is accountable for ensuring that the patients' needs come first. For example, the researchers from the Commonwealth Fund who compiled the National Scorecard found that U.S. patients discharged from the hospital with congestive heart failure receive written discharge instructions—a measure of well-coordinated care—only 50 percent of the time. This helps explain high rates of re-admission even at some of the nation's most prestigious hospitals. Overall, the authors concluded: the United States "stands out" both for "inefficient care" and an unnerving number of medical "errors."[5]



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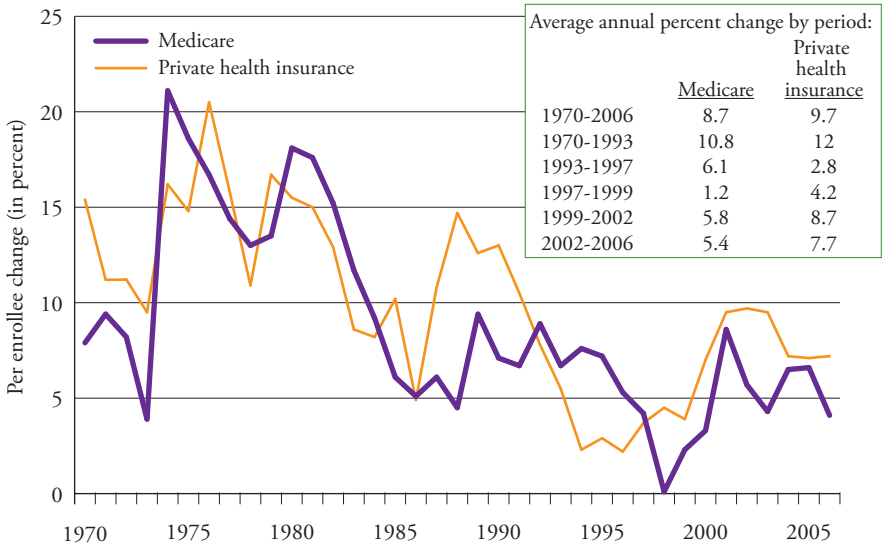
Conservative critics of the public sector often insinuate that Medicare provides yet another example of an inefficient government program spending hand-over-fist without caring whether it is getting value for taxpayers' dollars. But the truth is that health care prices have been climbing, without a concomitant improvement in outcomes, in the private sector as well.

As Figure 1 illustrates, Medicare spending has grown faster in some years, while in other years, outlays by private insurers skyrocketed. Over the long term (1970 to 2006), insurers were slightly more extravagant—their reimbursements for care climbed by an average of 9.7 percent a year, while Medicare spending rose by 8.7 percent. But what is most important is that neither the public sector nor the private sector has found a way to rein in health care inflation.[6] Thanks to the nightmare of compounding, health care is becoming less and less affordable. As health care inflation outstrips GDP growth, the nation's medical bill threatens to crowd out other national priorities such as education, national security, and the environment.

**Figure 1. Changes in Spending per Enrollee for Medicare and Private Health Insurance, 1969–2006**




Average annual percent change by period:

| | Medicare | Private health insurance |
|---|---|---|
| 1970-2006 | 8.7 | 9.7 |
| 1970-1993 | 10.8 | 12 |
| 1993-1997 | 6.1 | 2.8 |
| 1997-1999 | 1.2 | 4.2 |
| 1999-2002 | 5.8 | 8.7 |
| 2002-2006 | 5.4 | 7.7 |

*Source:* Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, 2007, available online at http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf.

The most common solutions proposed for containing Medicare's costs are ideas that have been tried again and again but have never worked: putting a cap on physicians' fees, for example, or requiring beneficiaries to pay more for their care. What is really needed is a much more fundamental set of reforms that would not only save money but also improve the quality of care beneficiaries receive. Those changes include:

- Establishing a Comparative Effectiveness Agency that would provide unbiased, empirically based information about the effectiveness of new drugs, devices, and procedures for a particular set of patients, comparing these new treatments to the alternatives they are trying to replace.
- Allowing Medicare to negotiate for discounts on drugs and devices.
- Eliminating the $16 billion windfall bonus to Medicare Advantage Insurers.
- Boosting payments for primary care—and paying some specialists as well as primary care physicians extra if they can meet the requirements for establishing a "medical home" for their patients.

- Trimming fees for some procedures, based on how much they do or do not benefit the patient.
- "Bundling" payments to doctors and hospitals to reward them for the quality rather than the volume of care that they provide.

### *Why Blindly Slashing Physicians' Fees Is Not the Answer*

Legislators understand that Medicare must find a way to contain costs. This is why members of Congress flirted with political suicide earlier this year by nearly allowing a drastic 10.6 percent across-the-board cut in the fees Medicare pays physicians. The American Medical Association (AMA) howled. The American Association of Retired Persons (AARP) organized. Doctors threatened to close their doors to Medicare patients. At the eleventh hour, legislators stepped back from the edge of the cliff, and left Medicare's fee schedule untouched.

Members of Congress know that they will be compelled to revisit the issue of Medicare spending early in 2009—if not sooner. Physicians' fees are once again scheduled to be slashed on January 1.

As legislators realize, cutting doctors' fees across the board is a crude solution. Medicare pays primary care physicians too little, which is why 30 percent of Medicare patients looking for a new medical home report difficulty finding one.[7] At the same time, Medicare pays specialists too much for certain procedures. The fee schedule must be adjusted with a scalpel, not an axe.

Most importantly Medicare cannot contain healthcare inflation by focusing solely on doctors' fees. The program overpays drug-makers; it overpays device-makers; it overpays private insurers who offer Medicare Advantage. Too often, it squanders dollars on unnecessary hospitalizations.

How can Medicare reduce spending without undermining patient benefits? In its March 2007 report, MedPac floated a new way of thinking about Medicare's payment system, noting that "Some Commissioners have argued that" how much Medicare pays for a service "should be at least partly based on a service's value to Medicare."[8] The report offered an example: "if analysis of clinical effectiveness for a given condition were to show that one service were superior to an alternative service for a given condition, then [the amount Medicare pays] might reflect that."[9] In medicine, this is a novel idea. But in other sectors of the economy, we do this all of the time: it is called "paying for value." And as MedPac describes "the value of a service to Medicare," it becomes clear that this is synonymous with the value of the treatment to the patient.

Today, Medicare's fee schedule is based solely on how much it costs the doctor to provide the service. Payments for specific procedures represent an estimate of the how much time it will take the physician to perform the procedure as well as the amount of training, mental effort, judgment, technical skill, physical effort, and stress involved.[10] But the likely benefit to the patient does not figure into the calculation.

Meanwhile, drug-makers and device-makers argue that they, too, should be paid based on what it costs them to develop their products. But some MedPac Commissioners are suggesting that we might also ask: How much are new drugs, devices, and procedures worth to the patient? How effective are they?

Medicare needs to distribute healthcare dollars more "efficiently," in this sense of the word: it needs to allocate its dollars a way that puts patients first. Otherwise, Congress will have to choose among three equally unpalatable alternatives: reduce benefits for America's seniors, hike payroll taxes, or ask elderly patients to pay higher co-pays and deductibles.

### *Should Medicare Beneficiaries Share More of the Costs?*

Some conservatives argue that making the elderly pay more of the costs of their health care is not such a bitter choice. Beneficiaries *should* have "more skin in the game," they argue. But the government

already has asked seniors to contribute more: "Between 2000 and 2007 Medicare beneficiaries faced average annual increases in the Part B premium of nearly 11 percent," MedPac reports. "Meanwhile, Social Security benefits, which averaged around $900 per month in 2005, grew by about 3 percent annually over the same period."[11]

Conceivably, one could raise co-pays and deductibles for the wealthiest. But what makes Medicare special—and so popular—is that it treats all Americans equally. With Medicare, the United States has achieved something that often seems just out of reach in our society: solidarity. Democrats recognized that this was one of the great virtues of the program when it created Medicare in 1965. At the time, some in Congress argued that more affluent Americans should not be eligible, but the program's supporters resisted this idea. They did not want Medicare to become "a poor program for the poor."[12]

Conservatives do not understand this. Or perhaps they do. In 2003, as part of a veiled campaign to eliminate Medicare as a public program, the Bush administration opened the door to means-testing, hiking premiums for seniors with incomes over $80,000 [13]—and raising concerns that wealthier Americans might begin dropping out of the optional Part B of the program, which covers outpatient treatment and doctors' visits. Without their premiums, Medicare could quickly become a "poor program for the middle-class."

The majority of U.S seniors cannot afford higher deductibles. As MedPac observed in 2007, the latest data available revealed that about half of Medicare's beneficiaries lived on incomes of $20,000 or less. Eighteen percent were scraping along somewhere below the poverty line ($9,060 for those living alone, and $11,430 for married couples).[14] Note that "income" includes every dollar that comes into the home, including Social Security, dividends, capital gains, food stamps, and income from part-time jobs.

### *What Drives Medicare Inflation? (It Is Not an Aging Population)*

Many people assume that medical needs propel spending, that we are laying out more and more each year because the baby-boomers are aging. In fact, we have a younger population than many developed countries, including Germany, Italy, and Japan.[15] Yet, we spend close to $7,000 per person each year on health care while Japan spends only about $2,500.[16]

The median age in the United States will rise just three years, to thirty-nine, over the next quarter century—and only then will the aging of America begin to accelerate.[17] Even then, the boomers will age, just as they were born, over a period of decades. We are not going to be suddenly overwhelmed by a tsunami of greedy geezers.

Princeton health care economist Uwe Reinhardt made this clear in March of 2008 at the World Healthcare Congress Europe when he demonstrated that a senescent citizenry is playing only a minor role in the ongoing climb in the nation's health care bill—from $585 billion (the sum we laid out in 1990) to over $14 trillion (the amount we are projected to spend in 2030, assuming we continue in our profligate ways). (See Figure 2.)[18]

What, then, is the biggest factor pushing the tab so much higher? "Innovation," says Reinhardt. "The healthcare industry will continue developing new stuff for every age group," Reinhardt explains. Will that "new stuff"—in the form of new drugs, devices, tests, and procedures—be worth it? Some of it will be, and some of it will not.

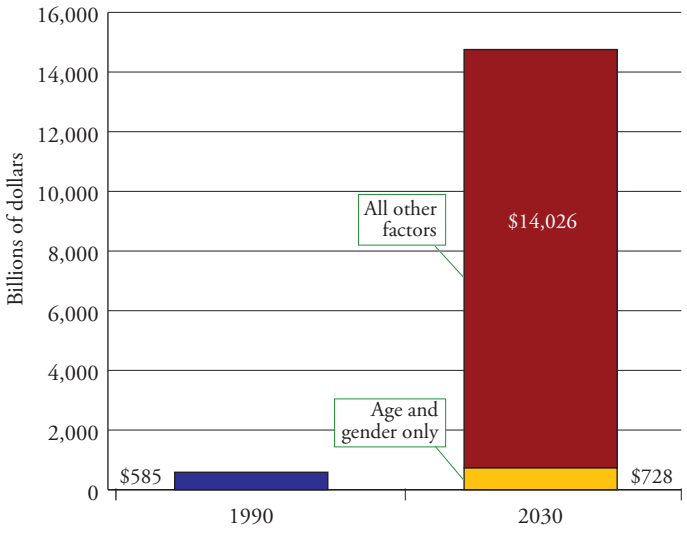
As medical technology advances—and becomes more expensive—it does not necessarily become more effective. A 2006 study in *Health Affairs* reveals that over the preceding decade, while spending on new technologies designed to treat heart disease climbed, the share of patients who survived flattened out.[19] In many areas, we seem to have reached a point of diminishing returns. Spending rises, but outcomes are no

better. This also is true in the drug industry, where most new entries are "me-too drugs"—little different from older, less expensive products.

Nevertheless, Reinhardt fully expects that healthcare spending will continue to levitate in the years ahead: "But," he emphasizes, "what will drive costs in coming years, will come, not from the demand side of the equation, but from the supply side." Suppliers will continue to invent new products, charging us more and selling us more—using whatever methods it takes, from direct-to-consumer advertising to promises of near immortality and perpetual youth.

Our for-profit health care industry is always selling—and selling hard. Granted, other nations also wrestle with health care inflation. But in the United States from 1970 to 2002, "the increase in healthcare costs exceeded annual growth in GDP by 2 percent a year." Over the same span, in other OECD nations spending outstripped GDP growth by only 1.1 percent.[20]

**Figure 2. Projected U.S. Health Spending 1990–2030**




*Source:* S. T. Bruner, D. R. Waldo, D. R. McKusick, "National Health Expenditures Projections through 2030," *Health Care Financing Review* 14, no. 1 (Fall 1992): 1–29.

The difference may not sound great, but compounded, year after year, health care inflation amounts to billions of dollars—and explains why Medicare is running out of funds. At the same time, as Urban Institute senior fellow Robert Berenson points out, in order to stave off a financing crisis, "we only have to flatten the growth curve by 1 percent to 2 percent."[21] Those who would like to privatize Medicare sometimes scoff that the government program simply is not sustainable. But it would take only a modicum of political will and common sense to bring spending back in line with GDP.

The cost of care climbs faster in the United States because we are the only nation in the developed world that has chosen to turn health care into a largely unregulated for-profit enterprise. As a result, corporate shareholders have come to expect that health care will be a "growth" industry. And CEOs hooked on growth do their best to ramp up earnings, quarter after quarter, year after year. This is their job.

But corporate goals conflict with society's need to make health care affordable. Former *New England Journal of Medicine* editor Marcia Angell makes the point: within the for-profit industry "the pressure is to increase total health-care expenditures, not to reduce them. Presumably, as a nation, we want to constrain the growth of health costs." Angell adds, "But that's simply not what health-care businesses do. Like all businesses, they want more, not fewer, customers."[22]

This does not mean that we should call a halt to medical progress. But we should be wary of blindly embracing every new invention that comes to market. It is only reasonable to insist on unbiased evidence that the new product or service works.

### *Assessing New Products*

Imagine a society that lets its automakers oversee crash tests on new models, allowing the industry to report results, as it sees fit, to government and consumers. Sometimes, an automaker might not reveal the outcome of a test that turned out badly, deciding that the dummies in the vehicle had been too short—no wonder their chests were crushed. In other cases, a company might postpone reporting on crash test results for a year or two, hoping that later trials will turn out better. In these cases, dozens of trials might be required in order to achieve the desired outcome. The car maker would, of course, pass the additional costs along, in the form of higher sticker prices.

In such a society, crash tests are not run and paid for by an independent entity like our National Highway Traffic Safety Administration (funded by taxpayers) or the Insurance Institute for Highway Safety (funded by insurers). Instead, the auto industry itself finances and controls the trials. Automakers also provide most of the funding for the government agency that rules on car safety. Finally, under this system, head-to-head comparisons of cars in a similar weight class are frowned upon. Such trials would create winners and losers—and who wants to be a loser? Instead, each company tests its own cars, and when outcomes finally are published, they tend to be excellent.

If this all sounds fantastic, consider this: the system sketched above comes pretty close to describing how we try to assure the safety of the prescription drugs and medical devices sold in the United States. We may be the only country in the developed world that allows the companies that manufacture these devices to control both what doctors and what patients know about them.

The pharmaceutical industry also provides much of the funding for the Food and Drug Administration (FDA), the agency responsible for weighing the risks and benefits of these products. No wonder the FDA does not require manufacturers to test their products against similar, less expensive products already on the market. Instead, the FDA asks only that the sponsor test its new entry against a placebo—demonstrating that it is "better than nothing."

Manufacturers run the trials, and as MedPac notes, "researchers have shown that bias in industry-sponsored trials is common."[23] Because we lack disinterested, "evidence-based" information about new products, "we do not know which treatments are necessary for which types of patients. Guidelines do not exist . . . to delineate how much care is typically needed . . . and when patients are unlikely to improve with additional treatment."[24]

### *The Brighter Side of the Problem: "Hazardous Waste"*

Runaway health care inflation is only one of two formidable challenges that the Medicare program faces. The second is that the system is clogged with waste.

One out of three of our health care dollars is squandered on ineffective, sometimes unwanted procedures, unnecessary hospitalizations, and over-priced drugs and devices that are no better than the less expensive products that they are meant to replace. This may seem a stunning—even outrageous—statement, but nearly three decades of research done by researchers at Dartmouth' Medical School confirms the promiscuous use of medical technologies. Their findings are now widely accepted both by the cognoscenti of the medical world and by the mainstream press.[25]

We now know that "more care"—in the form of more aggressive, more expensive, high tech care—is not necessarily better care. Sometimes it is worse. "What is so profound, and so scary, is that the data is so

powerful, and it doesn't change," observes Dr. Christine Cassel, president of the American Board of Internal Medicine. "There is a stark correlation between reduced utilization and better outcomes."[26]

The irony is that this is the good news. Because there is so much unnecessary and ineffective care, if we make a commitment to Medicare reform, we will not need to hike Medicare payroll taxes, or ration care. We can raise the quality of care under Medicare—and put it on a solid financial footing—by squeezing the "hazardous waste" out of the system.[27] This, in turn, could serve as a demonstration project for national health care reform.

It also is critical to recognize that the billions of dollars we pour into ineffective or unnecessary treatment is not simply a waste of resources. Any medical treatment, no matter how simple, carries some risk. Whenever a patient undergoes an unnecessary procedure, he is, by definition, exposed to risk without benefit. In the worst-case scenario, an unnecessary hospitalization can result in a fatal medication mix-up or a gruesome surgical site infection. Every year, an estimated 30,000 Americans are killed by what doctors call "iatrogenic disease" caused, inadvertently, by medical care.[28] Thousands more are seriously injured.

When Dartmouth's research on medical waste was first published in the 1980s, it was not warmly received. "This is so antithetical to the dominant ideology that many can't bear to talk about it," says Dr. Jack Wennberg, who pioneered what has become known simply as "the Dartmouth Research."[29] That he speaks in the present tense suggests that the "dominant ideology" lingers still. What exactly is that ideology?

"Manifest efficacy," Wennberg says, smiling. "Everything we do [in medicine] is effective." His smile is not smug; it is rueful. "It's not just doctors," he adds. "Patients also want to believe in manifest efficacy. It places medicine closer to a religion than a science."

Today, "such manifest confidence is grounded in a fervent belief in medical technology," Wennberg adds. "In the past, this wasn't so important. And it didn't cost so much. But now it's expensive. It's costly not just in dollars, but in the cost for patients."

When Jack Wennberg began his work in the 1970s, the human cost of over-treatment was becoming apparent. At the time, twenty-five percent of the nation's children underwent tonsillectomies, almost as a matter of course. Most did not need the procedure. Some suffered complications. A few died.

In 1973, Wennberg reported that, over the previous four years, tonsillectomies in just two small states—Maine and Vermont—led to the deaths of three children. "For so costly a procedure, ambiguity concerning its value will likely become increasingly intolerable," he wrote.[30]

Yet today, we continue to subject patients to what Wennberg calls "uncontrolled experiments," administering risky treatments without any medical proof of benefit. For example, many doctors routinely send men over age fifty-five for a prostate-specific antigen (PSA) test to check for signs of early stage prostate cancer. If a test and a subsequent biopsy prove positive, the doctor may recommend radiation or surgery, even though these procedures can lead to life-changing side effects—incontinence and/or impotence.

The alternative is "watchful waiting"—keeping an eye on the cancer to see if it progresses. Since this is a slow-growing cancer—seventeen out of twenty patients who have been diagnosed with early stage prostate cancer will die of something else, in most cases long before experiencing symptoms of the cancer—diagnosis does not mandate immediate action.[31]

Meanwhile, we do not have medical evidence that any of the treatments currently available for early stage prostate cancer save lives, or even lengthen life by a single day. As the National Cancer Institute (NCI) warns, "screening tests are able to detect prostate cancer at an early stage, but it is not clear whether this earlier detection and consequent earlier treatment leads to any change in the natural history and outcome of the disease."[32] This is just one of many "gray areas" in American medicine where disinterested research and guidelines are needed.

## II. Recommendations

### *Establish a Comparative Effectiveness Agency*

In its June 2008 report, MedPac casts a cold eye on just how quickly we adopt bleeding-edge medical products and procedures to treat "most common clinical conditions" without "credible, empirically based information" to tell us "whether they outperform existing treatments and to what extent."[33]

In the 1990s, for instance 23,000 to 40,000 breast cancer patients underwent futile bone marrow transplants at a cost of $1.8 to $3.2 billion. And that was just the cost in dollars. "You can't raise your head, you are so sick, and it's so horrible and so hard, and you don't have time to say goodbye to the people you love," recalls an attorney who helped women sue their HMOs in order to receive the treatment.[34] When she realized that these women survived no longer than those who received less-aggressive treatments, she stopped taking the cases. For a decade, both the oncology establishment and the media had promoted the transplants—despite the dearth of evidence on their effectiveness.

To avoid such needless suffering, MedPac recommends that we set up an institute that compares the relative effectiveness of various products and procedures, noting that "other developed countries . . . already have established clinical agencies to conduct [such] research."[35] In the United Kingdom, for example, the National Institute for Health and Clinical Excellence (NICE) reviews medical research, consults with doctors, patients, manufacturers, and their rivals, and then recommends the best treatment for patients who fit a particular profile.[36]

The British National Health Service must cover whatever NICE recommends. Doctors, however, are not required to follow NICE's guidelines. In individual cases, they have the leeway to use their best judgment. Nevertheless, in 89 percent of all cases, providers do follow NICE's recommendations.

It is important to note a key difference between the United Kingdom and the United States. Because the United Kingdom has a much smaller health care budget, NICE must consider the "cost-effectiveness" of services: is a drug that promises another nine months of life worth the price? By contrast, MedPac suggests that Medicare focus only on the "clinical-effectiveness" of two treatments, choosing the one that provides the greatest benefit, regardless of cost. MedPac is not recommending that Medicare "ration" care based on price.

One might wonder why we do not already test new products and procedures against existing treatments. The answer is that lobbyists representing those who profit from new products and procedures adamantly object to head-to-head comparisons.

Reformers should gird themselves for a battle. Lobbyists will fight any attempt at disinterested comparisons tooth and nail. But, as David Mechanic stresses, ultimately, we "will have to decide whether we wish to design our health care system primarily to satisfy those who profit from it or to protect the health and welfare of all Americans."[37]

Moreover, despite the opposition, when it comes to Medicare, reformers have a compelling argument: the elderly should not become guinea pigs for unproven treatments. And the taxpayers who support Medicare cannot afford to squander health care dollars on inferior products and procedures.[38]

Any Comparative Effectiveness Institute will have to be insulated from both Congress and the lobbyists. Congressional Budget Office (CBO) director Peter Orszag has suggested that board members might be shielded by giving them

> long terms of service—on the order of a decade or more—as are governors of the Federal Reserve. Further, appointments could be such that members could be removed only "for

> cause," [as members of the FED and the Federal Trade Commission are] rather than serving at the will of the President. . . . Legislation could also establish an independent source of funding, so that the board would not have to go back to Congress each year for funding.[39]

Ultimately, Medicare could use the information that the Comparative Effectiveness Institute generates to decide how much it is willing to pay for new drugs and devices as well as certain procedures.

Today, thanks to the Medicare Modernization Act of 2003, Medicare is specifically prohibited from using its size to negotiate for discounts on prescription drugs—despite the fact that virtually every other developed nation negotiates, looking at the effectiveness of a new product when deciding how much it is willing to pay. In the United States, only the Veterans' Administration (VA) is allowed to haggle. As it result, the VA pays 50 percent less for ten of the twenty drugs most popular among Medicare patients—proof that government negotiators can be effective.

### *Eliminate the Bonus to Medicare Advantage Insurers*

There is a second plank in the Medicare Modernization Act that should be repealed: the $16 billion bonus to Medicare Advantage insurers.

When Congress created Medicare Advantage, the program that allows private insurers to offer Medicare to seniors, it agreed to pay for-profit insurers about 12 percent more per patient than traditional Medicare would spend if it were covering those patients directly. Add up those extra payments and they amount to a $16-billion-a-year subsidy for the health insurance industry.

Why the sweetener? Lobbyists argued that the government would have to pay more to persuade for-profit insurers to join the Medicare Advantage program. Moreover, they promised that the insurers would use the $16 billion to offer patients extra benefits such as acupuncture and eye exams. And Congress agreed.

Now, think about this for a minute: legislators agreed to use our tax dollars to help for-profit insurers draw customers away from a government program that most people liked—and that cost taxpayers less. This is not about saving money by transferring Medicare to the supposedly more efficient private sector. This is about the conservative agenda: some politicians are determined to try to outsource government to for-profit corporations.

Meanwhile, many Medicare Advantage insurers have been quietly shifting costs to seniors, while pocketing the bonus. For example, 86 percent of Medicare Advantage plans now require whopping co-pays for the most expensive "tier 4" drugs use to treat diseases such as multiple sclerosis, hepatitis C, and some cancers. Rather than charging a flat co-pay of, say, $25, seniors must pay as much as 33 percent of the cost of a $100,000 cancer drug.[40]

Protests from patients, physicians, unions, and the Government Accounting Office have been mounting.[41] Even the insurers know that Medicare cannot afford the giveaway. The days of the Medicare Advantage bonus are numbered.[42]

### *Boost Payments for Primary Care and Medical Homes*

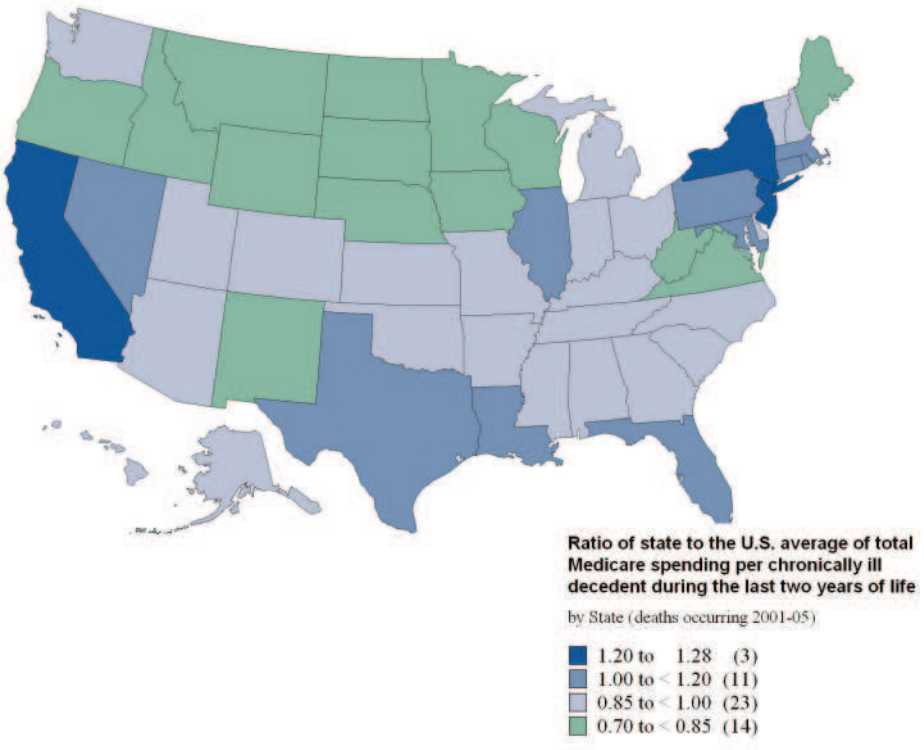
While stripping waste out of the system, Medicare needs to spend more on preventive care. Today, MedPac observes, "primary care services are undervalued," which helps explain why "the share of U.S. medical school graduates entering primary care residency programs has declined" sharply over the past decade.[43]

Recent figures reveal that internists and family doctors can expect to start out earning $120,000 to $135,000 a year, and over time, can hope to average $160,000 to $175,000.[44] For a thirty-two-year-old student who emerges from medical school with $150,000 to $200,000 in debt, at a time of life when he or she might want to buy a home or start a family, these are hardly enticing numbers.

Before reviewing how MedPac proposes to raise fees, it is important to understand why Medicare should promote primary care. This is not merely about saving money. The startling truth is that in regions of the country where Americans receive more specialized, intensive care, they do not enjoy "higher quality, better outcomes, or greater patient satisfaction." Again, this is something MedPac has learned from the Dartmouth research.

While investigating medical waste, Wennberg and colleague Dr. Elliott Fisher found staggering differences in how much Medicare spends on patients in different cities. In Manhattan, Los Angeles, and Miami, for instance, odds are much higher that Medicare patients will see ten or more specialists during their final six months of life. Overall, patients suffering from chronic diseases such as congestive heart failure will receive more aggressive and expensive care than very similar patients in Salt Lake City or Des Moines. (See Figure 3.)

Figure 3. Total Medicare Spending during the Last Two Years of Life for Patients with at Least One of Nine Chronic Conditions, by State (Deaths Occurring 2001–05)




*Source*: John E. Wennberg, Elliott S. Fisher, David C. Goodman, and Jonathan S. Skinner, "Tracking the Care of Patients with Sever Chronic Illness," Executive Summary, *The Dartmouth Atlas of Health Care* 2008, The Dartmouth Institute for Health Policy and Clinical Practice, June 2008, Map 1, p. 5, available online at http://www.dartmouthatlas.org/atlases/2008_Atlas_Exec_Summ.pdf.

Yet here is the stunner: chronically ill patients who receive the most intensive and costly treatments fare no better than those who receive more conservative care. A study of nearly one million patients sums up the findings: "higher spending did not result in higher quality care, lower mortality, better function outcomes, or greater patient satisfaction." Quite often, outcomes were worse.[45] How could this be? "Probably mortalities are higher because of medical errors associated with increased use of acute-care hospitals," the researchers explain.[46] As Fisher puts it, "Hospitals are dangerous places—especially if you don't need to be there."[47] Since 75 percent of our health care dollars are spent on the chronically ill, this is critical information.

In the past, critics suggested that patients in New Jersey and Florida are simply sicker than the hearty citizens of Minnesota—and therefore need more aggressive care. Dartmouth's researchers had considered that possibility: over the decades, they have bent over backwards to adjust for differences in race, age, sex, and the overall health of each community. They acknowledge, for instance, that salubrious conditions in Grand Junction, Colorado, imply that Medicare outlays there should be about 20 percent below the national average, while spending in Birmingham, Alabama, should be about 25 percent above average. Even so, researchers found the underlying health of the population accounts for only one-quarter of enormous disparities in spending.[48]

Meanwhile, the citizens Minnesota, a state with lower health care costs, contribute the same share of their paychecks to Medicare as do workers in California. Yet Medicare spends far more per beneficiary in Southern California. "And as long as the number of representatives in Congress coming from high-cost states [such as New York and California] exceeds the number of representatives coming from low-cost states [such as Utah and Minnesota], this will continue to be the case," says Dr. George Isham, medical director of HealthPartners of Minnesota.[49]

Some observers suggest that patients in Manhattan and Miami are simply more demanding. But it is hard to imagine that a two-fold difference in health care spending can be explained by widespread regional character flaws—especially when high-spending states include Texas and Louisiana, cultural milieus that bear little resemblance to Miami or Manhattan.

What, then, do the high-spending regions have in common? More specialists and more hospital beds. Supply, not demand, drives higher bills.

Let me be clear: the Dartmouth team does not believe that specialists in high-treatment areas count the beds in their region and then, with an eye to boosting their income, grimly set out to fill them. As Wennberg explains, the number of beds plays a subconscious role in physicians' decision-making. "While physicians don't really know how many beds are available," supply has a "subliminal influence on utilization. If there's a bed available, naturally you'll use it."[50] When it comes to deciding whether or not to hospitalize a chronically ill patient, there is no rule book. When should a sixty-five-year-old patient suffering from congestive heart failure be admitted to the hospital? When would she be better off at home? There are no guidelines.

Convenience often influences the decision. It is often easier to manage care in an inpatient setting. But hospitalization also lowers the threshold for further intervention: it is now easier to order tests, perform minor discretionary surgeries, or consult with other specialists, who in turn order their own tests and treatments. One thing leads to another.

As to how often a patient sees a specialist, the uncertainties of medical science again come into play. How frequently should a doctor see that patient suffering from congestive heart failure?

"The doctor will sort it out based on how sick the individual patient is and how many openings he has in his schedule," Wennberg explains. "Specialists tend to fill their appointment books to capacity."[51] So it is easy to see how doubling the supply of cardiologists in a particular town means that patients there will see their doctors twice as often.

But rather than seeing ten doctors, what many patients need most is one doctor who coordinates their care. Unnecessary hospitalizations also could be avoided if patients received more preventive care. Thus MedPac suggests creating a pilot program that pays both primary care doctors and specialists who focus on chronic diseases (such as diabetes) extra if they provide a "medical home" for their patients, using electronic medical records to track who they are seeing and what medications they are taking.[52] At the same time, MedPac recommends that some specialists' fees should be trimmed. Today, the commission points out, Medicare's physician fee schedule favors specialists who perform the most aggressive procedures. This is in part because the little-known panel that updates Medicare fees is dominated by specialists.[53] No surprise then that a specialist's time is usually deemed to be worth considerably more than an internist's.

Testifying before the House Ways and Means Committee's Subcommittee on Health last year, MedPac chairman Glenn Hackbarth recommended that Medicare establish a separate group of experts, not to replace the panel that updates the fee schedule, but to augment it. The new group should include members "who do not directly benefit from changes to Medicare's [fee-for-service] payment rates, such as physicians who are salaried."[54] But this would be only a temporary fix. Ultimately, MedPac argues, Medicare should move away from fee-for-service payments.

### *"Bundle" Payments to Pay for Quality, Not Volume*

When we reimburse physicians "fee-for-service," we are paying piecemeal for the quantity of care they provide. Instead of rewarding doctors for "doing more," MedPac argues that we should pay for quality by offering bonuses for better outcomes. But it is extremely difficult to measure the quality of care that a single doctor or small group practice offers. Just a few non-compliant patients can skew the results. Moreover, these days, outcomes are rarely determined by single doctor; many caregivers are involved.

MedPac urges experimenting with "bundling" payments to all doctors and hospitals that are involved in a single episode of care, rewarding the group for lifting quality while reducing costs. Providers who agreed to participate would be eligible for sharing in the bonus when they divvied up the lump sum.

Bundling payments encourages closer collaboration between doctors and hospital, and Pennsylvania's Geisinger Health system has shown that it works. Geisinger's program combines all payments for coronary artery bypass graft surgery, including all doctors who provide care thirty days before and ninety days after the surgery. What is the result? Providers are more likely to follow "best practice" guidelines. Outcomes are better, and both lengths of stay and thirty-day readmission rates have declined. [55]

The idea of bundling payments to providers is appealing because hospitals vary so widely both in how efficiently they use their resources and in the quality of care they provide. Table 1 highlights what Dartmouth researchers describe as the "remarkable differences" in the intensity and the cost of the care that very similar patients receive at prestigious medical centers."[56]

**Table 1. Spending, Resource Use, and Utilization of Services among Medicare Beneficiaries with Chronic Illness Cared For at Five "Honor Roll" Academic Medical Centers (Deaths Occurring 2001–05)**

| | UCLA Medical Center | Johns Hopkins Hospital | Massachusetts General Hospital | Cleveland Clinic Foundation | Mayo Clinic (St. Mary's Hospital) |
|---|---|---|---|---|---|
| **Medicare spending per patient during last two years of life** | | | | | |
| Total Medicare spending | $93,842 | $85,729 | $78,666 | $55,333 | $53,432 |
| Inpatient site of care | $63,900 | $63,079 | $43,058 | $34,437 | $34,372 |
| Outpatient site of care | $14,125 | $13,404 | $11,509 | $8,906 | $7,557 |
| Skilled nursing/long-term care facility | $6,891 | $3,287 | $15,149 | $5,101 | $7,114 |
| Other sectors of care | $8,926 | $5,959 | $8,951 | $6,889 | $4,389 |
| **Resource inputs per 1,000 patients during last two years of life** | | | | | |
| Hospital beds | 85.8 | 78.2 | 79.2 | 65.5 | 58.2 |
| Intensive care (ICU) beds | 38.1 | 20.0 | 16.0 | 19.2 | 18.4 |
| FTE physician labor | | | | | |
| *All physicians* | 38.5 | 25.7 | 29.5 | 26.1 | 20.3 |
| *Primary care physicians* | 9.6 | 10.0 | 11.5 | 8.8 | 6.8 |
| *Medical specialists* | 21.2 | 8.9 | 11.7 | 10.6 | 8.9 |
| **Care during last six months of life** | | | | | |
| Hospital days per patient | 18.5 | 16.5 | 17.3 | 14.8 | 12.0 |
| Physician visits per patient | 52.8 | 28.9 | 39.5 | 33.1 | 23.9 |
| **Terminal care** | | | | | |
| Percent of deaths associated with ICU admission | 37.9 | 23.2 | 22.5 | 23.1 | 21.8 |
| Percent admitted to hospice | 28.8 | 35.2 | 23.8 | 36.6 | 29.1 |
| **Average estimated co-payments per patient for physician services and durable medical equipment during the last two years of life** | $4,835 | $3,390 | $3,409 | $3,045 | $2,439 |

*Source:* John E. Wennberg, Elliott S. Fisher, David C. Goodman, and Jonathan S. Skinner, "Tracking the Care of Patients with Sever Chronic Illness," Executive Summary, *The Dartmouth Atlas of Health Care* 2008, The Dartmouth Institute for Health Policy and Clinical Practice, June 2008, Table 2, p. 8, available online at http://www.dartmouthatlas.org/atlases/2008_Atlas_Exec_Summ.pdf.

Take a close look at the table. What is astounding is that Medicare spends nearly 50 percent less if a patient receives care at the Mayo Clinic, in Rochester, Minnesota, rather than at UCLA Medical Center (see the top line, left-hand column and far-right–hand column). Yet, as one might assume, outcomes are better and both patient and doctor satisfaction higher at Mayo.

The bottom two-thirds of the table explains why Mayo is significantly less expensive than UCLA, Johns Hopkins, and Mass General. The other hospitals use more hospital beds and more physicians to care

for the same number of patients during the last two years of life. This means that patients spend more time in the hospital, and, at UCLA in particular, they see many more specialists. They also are more likely to die in an intensive care unit. Yet, these patients fare no better.

This will seem counterintuitive, but the truth is that when it comes to health care, higher quality and lower spending often go hand in hand. At Mayo, where doctors are working together, on salary, care is coordinated, and so physicians are likely to arrive at the right diagnosis early on in the process. At another hospital, while ten specialists who are in private practice may "consult" on the same patient, they may not consult with each other.

The Dartmouth research shows that Mayo is not the only medical center that provides higher-quality care while using fewer resources. At these "benchmark" hospitals, where Medicare bills are lower, patients spend fewer days in the hospital in part because there are fewer errors, fewer hospital-acquired infections and fewer re-admissions. This, of course, means less revenue for the hospital, but a better experience for the patient.

These efficient medical centers prove that there is enough money in the system to provide superior care for everyone—but only if Medicare resists the lobbyists who would design a health care system that serves their interests. Too often, those who profit from our health care system seem to be setting the priorities. Medicare should set the terms for a patient-centered health care system—one that insists on the greatest value for the patient. If done right, Medicare reform could pave the way for meaningful national health care reform.

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1 David Mechanic, *The Truth about Health Care: Why Reform Is Not Working in America* (New Brunswick, N.J.: Rutgers University Press, 2006), p. 240.

2 The Medicare Payment Advisory Commission, which advises Congress on Medicare, is comprised of seventeen members who bring diverse expertise in the financing and delivery of health care services. Commissioners are appointed to three-year terms (subject to renewal) by the comptroller general and serve part time. Appointments are staggered; the terms of five or six commissioners expire each year. The commission is supported by an executive director and a staff of analysts, who typically have backgrounds in economics, health policy, and public health.

3 MedPac, "Report to the Congress: Medicare Payment Policy," March 2008, p. 9.

4 Ibid., p. 18. Here, MedPac cites C. Schoen, K. Davis, S. How, et al., "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusives, 2006, available online at http://content.healthaffairs.org/cgi/content/ full/25/6/w457?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=Schoen&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT.

5 C. Schoen et al., "Taking the Pulse of the Health Care Systems: Experiences of Patients with Health Problems in Six Countries," *Health Affairs* 3, November 2005, available online at http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.5 09v3?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=Schoen+&fulltext=%22stands+out%22&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT.

6 M. V. Pauly, "What If Technology Never Stops Improving? Medicare's Future under Continuous Cost Increases," *Washington & Lee Law Revie*w 60, no. 4 (2003): 1233–1250.

7 Medpac, "Report to Congress: Reforming the Delivery System," June 2008, p. 31.

8 MedPac, "Assessing Alternatives to the Sustainable Growth Rate System," March 2007, p. 46.

9 Ibid.

10 For a description of how Medicare's fee schedule was created, see Maggie Mahar, "Today We Pay For How Much It Costs a Physician To Provide a Service," HealthBeat, August 18, 2008, available online at http://www.healthbeatblog.org/2008/08/today-we-pay-fo.html.

11 MedPac, "Report to the Congress: Medicare Payment Policy," p. 13.

12 At one point in the 1965 debate, Republicans argued that the whole program should be means-tested so that middle-12 At one

point in the 1965 debate, Republicans argued that the whole program should be means-tested so that middle income and upper-middle-income individuals would not qualify. Democrats understood that if this happened, Medicare would become, in their words, "a poor program for the poor." This proposal missed passing of the powerful Ways and Means Committee by one vote. Carol S. Weissert and William G. Weissert, *Governing Health: The Politics of Health Policy,* 2d ed. (Baltimore: The Johns Hopkins University Press, 2002), p. 291.

13 Under the Bush administration' Medicare Modernization Act of 2003, Americans with an income over $80,000 ($160,000 for couples) pay larger Part B Medicare premiums and receive a lower prescription drug benefit. Presidential candidate Senator John McCain proposes a substantial increase in what they pay for prescription coverage.

14 MedPac, "Report to the Congress: Medicare Payment Policy," p. 11. MedPac took the income data from the Henry J. Kaiser Foundation, *Medicare Chartbook*, 3d ed., Summer 2005, available online at http://www.kff.org/medicare/upload/Medicare-Chart-Book-3rd-Edition-Summer-2005-Report.pdf.

15 According to data from the Organisation for Economic Co-operation and Development,(OECD) in 2006, less than 13 percent of the U.S. population was over 65, while 19 percent of the population in Germany, Italy, and Japan had reached that age. In the average OECD country, roughly 16 percent of all citizens had celebrated their sixty-fifth birthday.

16 Kaiser Family Foundation, "Health Care Spending in the United States and OECD Countries," January, 2007, available online at http://www.kff.org/insurance/snapshot/chcm010307oth.cfm.

17 "Global Aging," *Business Week*, January 31, 2005.

18 Reinhadt used this chart as part of a Powerpoint presentation at the World Health Care Congress–Europe (WHCCE) in March of 2008. See also Maggie Mahar, "Will Boomers Bankrupt Our Health Care System? Myths and Facts," Health Beat, May 13, 2008, available online at http://www.healthbeatblog.org/2008/03/will-boomers-ba.html.

19 Jon Skinner et al.,"Is Technological Change in Medicine Always Worth It? The Case of Acute Myocardial Infarction," *Health Affairs,* March/April 2006, available online at http://content.healthaffairs.org/cgi/content/full/25/2/w34?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=Skinner&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT. MedPac points to this study in its March report.

20 MedPac, "Report to the Congress: Medicare Payment Policy," p. 16.

21 Berenson made this remark at a New America Foundation conference, "Sustainable Medicare," July 23, 2008.

22 Marcia Angell, "The Forgotten Domestic Crisis," *New York Times*, October 13, 2002.

23 Maggie Mahar, "Obstacles to Health Care Reform: The Power of Lobbyists," March 24, 2008, Health Beat, available online at http://www.healthbeatblog.org/2008/03/obstacles-to-he.html; Medpac, "Report to Congress: Reforming the Delivery System," p. 116. MedPac cites J. Peppercorn, E. Blood, E. Winer, et al., "Association between Pharmaceutical Involvement and Outcomes in Breast Cancer Clinical Trials," *Cancer*, April 1, 2007.

24 MedPac, "Report to the Congress: Medicare Payment Policy," p. 38.

25 For a short list of stories citing the Dartmouth Research in the *Wall Street Journal*, the *New York Times*, the *Philadelphia Inquirer*, the *Miami Herald*, and the *St. Louis Post Dispatch*, see Maggie Mahar, "The State of the Nation's Health," *Dartmouth Medicine*, Spring 2007, available online at http://dartmed.dartmouth.edu/spring07/html/atlas.php. Also see Shannon Brownlee's excellent book, *Overtreated: Why Too Much Medicine Is Making Us Sicker and Poorer* (New York: Bloomsbury, 2007).

26 Mahar, "The State of the Nation's Health."

27 Medicare reform will need an initial investment to fund the recommendations discussed below. But there are many areas where money can be saved so that, over time, even as medical technologies advance, health care spending will not need to grow faster than GDP.

28 Brownlee, *Overtreated*.

29 Maggie Mahar, "Braveheart," *Dartmouth Medicine*, Winter 2007, available online at http://dartmed.dartmouth.edu/winter07/html/.

30 Maggie Mahar, "Braveheart."

31 Maggie Mahar, "Screening for Prostate Cancer: Before Medicare Pays, Patients Need to Know More About Risks," Health Beat, August 27, 2007, available online at http://www.healthbeatblog.org/2007/08/screening-for-p.html.

32 National Cancer Institute, Cancer Topics, Summary of Evidence, available online at http://www.cancer.gov/cancertopics/pdq/screening/prostate/healthprofessional.

33 Medpac, "Report to Congress: Reforming the Delivery System," p. 107.

34 Maggie Mahar, *Money-Driven Medicine: The Real Reason Health Care Costs So Much* (New York: Harper/Collins, 2006).

35 Medpac, "Report to Congress: Reforming the System," p. 116.

36 Maggie Mahar, "Overcoming the Obstacles to Health Care Reform: Nice," Health Beat, March 26, 2008, available online at http://www.healthbeatblog.org/2008/03/obstacles-to--1.html.

37 Mechanic, *The Truth about Health Care.*

38 That Congress stood up to the insurance lobbyists in July when legislators refused to cut physicians' fees, and instead voted to reduce payments to Medicare Advantage insurers, is heartening. Legislators saw a clear choice: on the one hand, lobbyists representing for-profit corporations; on the other hand, seniors and the AARP. They knew whom to fear.

39 In testimony before the Senate Finance Committee in July, CBO director Peter Orszag called for a "federal health board" that would compare effectiveness and noted that "Senator Baucus and Federal Reserve Board Chairman Bernanke expressed interest in that idea during the Finance Committee's recent summit on health care reform." Peter S. Orszag, Congressional Budget Office Testimony, "The Overuse, Underuse, and Misuse of Health Care," July 17, 2008.

40 Gina Kolata, "Co-Payments Soar for Drugs With High Prices," *New York Times*, April 14, 2008.

41 See Maggie Mahar, "Complaints About Medicare Advantage Mount," Health Beat, December 13, 2007, available online at http://www.healthbeatblog.org/2007/12/complaints-abou.html; Maggie Mahar and Niko Karvounis, "The High Cost of Medicare Advantage," Health Beat, April 11, 2008, available online at http://www.healthbeatblog.org/2008/04/the-high-cost-o.html; Maggie Mahar, "The Trouble with Medicare Advantage," HealthBeat, July 9, 2008, available online at http://www.healthbeatblog.org/2008/07/the-trouble-wit.html.

42 Robert Laszewski, "The End of Medicare Private Fee-for-Service—The Questions to Ask the Health Plans during the Earnings Season," *Health Care Policy and Marketplace Review*, July 22, 2008, available online at http://healthpolicyandmarket.blogspot.com/search/label/Medicare%20Advantage.

43 MedPac, "Report to Congress: Reforming the Delivery System," p. 23. MedPac cites T. Bodenheimer, "Primary Care–Will It Survive?" *New England Journal of Medicine* 355, no. 9 (August 31, 2006): 861.

44 "2007 Review of Physician and CRNA Recruiting Incentives," Merritt Hawkins & Associates, 2007, available online at www.merritthawkins.com. Merritt Hawkins is a national health care search and consulting firm specializing in the recruitment of physicians in all medical specialties. The salaries cited represent "Low" and "Average" base salary or income guarantee offered to recruits in 2007. These numbers do not include bonuses or benefits.

45 E. S. Fisher, D. E. Wennberg, T. A. Stukel, D. J. Gottlieb, F. L. Lucas, and E. L. Pinder, "The Implications of Regional Variations in Medicare Spending: Part 1: The Content, Quality, and Accessibility of Care," and "Part 2: Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine*, February 18, 2003, available online at http://www.dartmouthatlas.org/atlases/bibliography.shtm.

46 J. E. Wennberg, E. S. Fisher, S. M. Sharp, M. McAndrew, and K. K. Bronner, T*he Care of Patients with Severe Chronic Illness: A Report on the Medicare Program by the Dartmouth Atlas Project*, The Trustees of Dartmouth College, 2006, available online at http://www.dartmouthatlas.org/atlases/atlas_series.shtm.

47 Mahar, *Money-Driven Medicine*, p. 163.

48 Fear of malpractice suits in particularly litigious states comes to mind as a reason why some doctors and hospitals might be more zealous in performing diagnostic tests and interventional procedures. But even proponents tort reform say that malpractice caps would reduce hospital spending by only 5 percent to 9 percent—not enough to explain twofold differences in the cost of care.

49 Mahar, "The State of the Nation's Health."

50 Mahar, *Money-Driven Medicine*, p. 172.

51 Ibid.

52 MedPac, "Report to Congress: Reforming the Delivery System," p.25.

53 A Medicare advisory committee called the RVS Update Committee (or RUC) updates fees. The RUC flies under the radar, and it is quite secretive, yet it is enormously powerful. Medicare's fee schedule has become the basis for most private insurers' payments as well.

54 Maggie Mahar, "Who Decides How Much Specialists Are Paid?" Health Beat, January 11, 2008, available online at http://www.healthbeatblog.org/2008/01/who-decides-how.html.

55 A. S. Casale et. al., "Proven-Care: A Provider-Driven Pay-for-Performance Program for Acute Episodic Cardiac Surgical Care," *Annals of Surgery*, October 2007.

56 John E. Wennberg, Elliott S. Fisher, David C. Goodman, Jonathan S. Skinner, *"Tracking the Care of Patients with Severe Chronic Illness,"* Executive Summary, *The Darmouth Atlas of Health Care 2008,* The Dartmouth Institute for Health Policy and Clinical Practice, June 2008, p. 8.