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EDITORIAL

Reform and Medical Costs

Americans are deeply concerned about the relentless rise in health care costs and health insurance premiums. They need to know if reform will help solve the problem. The answer is that no one has an easy fix for rising medical costs. The fundamental fix — reshaping how care is delivered and how doctors are paid in a wasteful, dysfunctional system — is likely to be achieved only through trial and error and incremental gains.

The good news is that the bill just approved by the House and a bill approved by the Senate Finance Committee would implement or test many reforms that should help slow the rise in medical costs over the long term. As a report in The New England Journal of Medicine concluded, “Pretty much every proposed innovation found in the health policy literature these days is encapsulated in these measures.”

Medical spending, which typically rises faster than wages and the overall economy, is propelled by two things: the high prices charged for medical services in this country and the volume of unnecessary care delivered by doctors and hospitals, which often perform a lot more tests and treatments than a patient really needs.

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Here are some of the important proposals in the House and Senate bills to try to address those problems, and why it is hard to know how well they will work:

FORCED PRODUCTIVITY GAINS Both bills would reduce the rate of growth in annual Medicare payments to hospitals, nursing homes and other providers by amounts comparable to the productivity savings routinely made in other industries with the help of new technologies and new ways to organize work. This proposal could save Medicare more than $100 billion over the next decade. If private plans demanded similar productivity savings from providers, and refused to let providers shift additional costs to them, the savings could be much larger.

Critics say Congress will give in to lobbyists and let inefficient providers off the hook. That is far less likely to happen if Congress also adopts strong “pay-go” rules requiring that any increase in payments to providers be offset by new taxes or budget cuts.

CADILLAC COVERAGE The Senate Finance bill would impose an excise tax on health insurance plans that cost more than $8,000 for an individual or $21,000 for a family. It would most likely cause insurers to redesign plans to fall beneath the threshold. Enrollees would have to pay more money for many services out of their own pockets, and that would encourage them to think twice about whether an expensive or redundant test was worth it. Economists project that most employers would shift money from expensive

health benefits into wages. The House bill has no similar tax. The final legislation should.

SIMPLIFIED FORMS Any doctor who has wrestled with multiple forms from different insurers, or patients who have tried to understand their own parade of statements, know that simplification ought to save money. When the health insurance industry was still cooperating in reform efforts, its trade group offered to provide standardized forms for automated processing. It estimated that step would save hundreds of billions of dollars over the next decade. The bills would lock that pledge into law.

ELECTRONIC MEDICAL RECORDS The stimulus package provided money to convert the inefficient, paper-driven medical system to electronic records that can be easily viewed and transmitted. This requires upfront investments to help doctors convert. In time it should help restrain costs by eliminating redundant tests, preventing drug interactions, and helping doctors find the best treatments.

REFORM OF THE DELIVERY SYSTEM Virtually all experts agree that the fee-for-service system — doctors are rewarded for the quantity of care rather than its quality or effectiveness — is a primary reason that the cost of care is so high. Most agree that the solution is to push doctors to accept fixed payments to care for a particular illness or for a patient's needs over a year. No one knows how to make that happen quickly.

The bills in both houses would start pilot projects within Medicare. They include such measures as accountable care organizations to take charge of a patient's needs with an eye on both cost and quality, and chronic disease management to make sure the seriously ill, who are responsible for the bulk of all health care costs, are treated properly. For the most part, these experiments rely on incentive payments to get doctors to try them.

INDEPENDENT COMMISSION Testing innovations do no good unless the good experiments are identified and expanded and the bad ones are dropped. The Senate bill would create an independent commission to monitor the pilot programs and recommend changes in Medicare's payment policies to prod providers to adopt reforms that work. The changes would have to be approved or rejected as a whole by Congress, making it hard for narrow- interest lobbies to bend lawmakers to their will.

MANAGED COMPETITION The bills in both chambers would create health insurance exchanges on which small businesses and individuals could choose from an array of private plans and possibly a public option. All the plans would have to provide standard benefit packages that would be easy to compare. To get access to millions of new customers, insurers would have a strong incentive to sell on the exchange. And the head-to-head competition might give them a strong incentive to lower their prices, perhaps by accepting slimmer profit margins or demanding better deals from providers.

A PUBLIC PLAN The final legislation might throw a public plan into the competition, but thanks to the fierce opposition of the insurance industry and Republican critics, it might not save much money. The one in the House bill would have to negotiate rates with providers, rather than using Medicare rates, as many reformers wanted.

COMPARING TREATMENTS The president's stimulus package is pumping money into research to compare how well various treatments work. Is surgery, radiation or careful monitoring best for prostate cancer? Is the latest and most expensive cholesterol-lowering drug any better than its generic competitors?

The pending bills would spend additional money to accelerate this effort.

Critics have charged that this sensible idea would lead to rationing of care. (That would be true only if you believed that patients should have an unbridled right to treatments proven to be inferior.) As a result, the bills do not require, as they should, that the results of these studies be used to set payment rates in Medicare.

Congress needs to find the courage to allow Medicare to pay preferentially for treatments proven to be superior. Sometimes the best treatment might be the most expensive. But over all, we suspect that spending would come down through elimination of a lot of unnecessary or even dangerous tests and treatments.

NEGOTIATING DRUG PRICES The House bill would authorize the secretary of health and human services to negotiate drug prices in Medicare and Medicaid. Some authoritative analysts doubt that the secretary would get better deals than private insurers already get. We believe negotiation could work. It does in other countries.

MALPRACTICE REFORM Missing from these bills is any serious attempt to rein in malpractice costs. (Trial lawyers, major supporters of the Democratic Party, have seen to that.) Malpractice awards do drive up insurance premiums for doctors in high-risk specialties, and there is some evidence that doctors engage in "defensive medicine" by performing tests and treatments primarily to prove they are not negligent should they get sued.

Patients who are injured because of a doctor's or a hospital's negligence must have recourse. We favor reforms that would try to compensate injured people fairly and promptly — perhaps through mediation or expert tribunals — but would not prevent them from filing suit as a last resort or cap the awards they could receive. Even then, the savings might be modest. Doctors mostly perform high-cost tests because they want to help their patients and get paid handsomely for doing so.

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Republican critics say, correctly, that the health care bills would saddle the government with large new costs to cover the uninsured by expanding Medicaid and providing subsidies to help low- and middle-income people buy insurance. And they say, incorrectly, that the effort should not move ahead until a sure-fire way is found to rein in rising health care costs.

Their arguments overlook the fact that the government is already paying many of these costs, through special payments to hospitals, each time a person without insurance, and with no means to pay, goes to an expensive emergency room for treatment. It also overlooks the fact that both bills are designed to keep deficits from increasing over the next decade or two.

It would be unfair, and unnecessary, to leave tens of millions of people uninsured while we wait to figure out ways to hold down the rise in health care costs.

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This editorial is a part of a continuing series by The Times that is providing a comprehensive examination of

the policy challenges and politics behind the debate over health care reform.