The New York Times

Cut Medicare, Help Patients

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August 22, 2011

MEDICARE is going to be cut. That is inevitable. There is no way to solve the nation's long-term debt problem without reducing the growth rate of federal health care spending. The only question is whether the cuts will be smart ones.

Smart cuts eliminate spending on medical tests, treatments and procedures that don't work — or that cost significantly more than other treatments while delivering no better health outcomes. And they can be made without shortchanging patients. There are plenty of examples; here are three.

Late last year, the Food and Drug Administration determined that the drug Avastin, which has serious side effects, is not effective for treating breast cancer. Astonishingly, Medicare declared it will still pay for Avastin — at a cost of about $88,000 per year for each patient.

Consider colonoscopies. The United States Preventive Services Task Force recommends not doing colonoscopies for most people over 75 because there is no evidence that they save lives in this population. Moreover, the risk of perforating the intestines rises with age. Yet Medicare pays for the procedure regardless of the patient's age.

Every year more than 1 million cardiac stents are placed in patients to open blocked arteries. Stents are essential immediately after a heart attack, but a 2007 randomized trial conducted at 50 medical centers in the United States and Canada showed that for patients with stable heart disease, stents do not reduce the number of heart attacks or save lives when compared with drug therapy. And they are substantially more expensive.

Because stents are more effective at reducing pain in some patients, the best practice is to start patients on drug therapy and insert a stent only for those who do not respond to treatment. Yet many patients who receive stents paid for by Medicare are either experiencing no pain or have not tried medication first.

The list of procedures Medicare pays for that are proven to have no benefit goes on and on. Cutting payment for these is not rationing. It saves money, but it also protects patients from the pain, stress and risks associated with unnecessary care.

Smart cuts can also be achieved through better coordination of patient care. One program, at the University of Pennsylvania, sends a nurse to visit older adults at home immediately after they have been discharged from the hospital. By reducing readmissions, the program saves $5,000 per Medicare patient. It also improves health outcomes. By assigning a nurse case manager to high-cost Medicare patients, Massachusetts General Hospital has reduced spending on these patients by 4 to 5 percent and also reduced mortality.

Group Health Cooperative in Washington State transformed its primary care practices in a pilot program by creating teams of doctors, nurses and pharmacists who work together, extending its regular office visits to 30 minutes and introducing "care coordinators" who follow up with patients after office visits, hospitalizations and procedures. After two years, quality of care and patient satisfaction improved; emergency room visits declined by 29 percent and hospitalizations by 6 percent.

Unfortunately, Washington is preoccupied with ill-conceived cuts. Three kinds of cuts got serious consideration in the recent debt limit negotiations, and are likely to resurface as the special Congressional committee tries to achieve $1.5 trillion in additional deficit reduction:

• Meat-cleaver cuts hack spending indiscriminately. Across-the-board cuts in payments to Medicare providers (which will kick in if the special committee doesn't come to an agreement) fall into this category. Cuts that fail to distinguish between high-value and low-value medical care would do more harm than good.

• Cost-shifting cuts don't actually reduce health care spending; they just shift costs from the government to the private sector. Increasing Medicare's eligibility age from 65 to 67, as Senators Tom Coburn and Joseph Lieberman have proposed and as the Obama administration reportedly floated during the debt ceiling negotiations, is a classic example. While raising the eligibility age would reduce government spending on Medicare, it would shift the costs to individuals and businesses. It would also increase the number of uninsured 65- and 66-year-olds, leading to worse health outcomes and making it harder for older Americans to find work.

• Penny-wise, pound-foolish cuts reduce current spending by a little but raise future costs by a lot. Raising co-payments for office visits and medications is a good example. Research shows that when older adults are charged higher co-payments, they reduce their primary care visits and use of prescription drugs. But the research also shows that forgoing this outpatient care leads to an increase in expensive hospitalizations.

THE sad truth is, Washington is never going to do a good job of making smart cuts to Medicare. Elected officials hate being blamed for directly restricting access to medical treatments — even when those treatments are proven to be worthless. Moreover, much wasteful spending occurs in situations where care that is appropriate for some patients is given to patients for whom it is inappropriate. It is impossible for Medicare to write payment rules that cover all such circumstances.

The responsibility for ending unnecessary medical spending needs to be placed in the hands of doctors and hospitals. This can happen only if we change our fee-for-service payment system. Today doctors and hospitals that develop new programs to keep patients healthy lose money in two ways. They spend money re-designing care and then, with fewer office visits and hospitalizations, the payments they receive go down.

The seeds of a solution lie in the accountable care organizations, medical homes and bundled payment reforms that were authorized by last year's Affordable Care Act. Accountable care organizations are groups of health care providers and hospitals that work together to treat patients. Medical homes coordinate primary care services. And bundled payments consolidate the many costs of an episode of care, like a hospitalization, into a single payment, incentivizing efficient delivery of tests and treatments. All of these reforms allow payments to be based primarily on the number of patients cared for and the quality of that care rather than on the volume of services provided.

To control Medicare spending and reduce the deficit, we need to stop paying for wasteful procedures, accelerate adoption of the Affordable Care Act reforms and empower doctors, nurses and hospitals to provide higher-quality and more efficient care. The path to smart cuts is clear.

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