



HOW TO FIX MEDICARE: LET'S PAY PATIENTS, NOT PHYSICIANS

By Roger Feldman

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Should Medicare pay for patient expenses the way automobile insurers pay for car-repair bills?

In *How to Fix Medicare: Let's Pay Patients, Not Physicians* (AEI Press, June 2008), health economist Roger Feldman contends that such a radical shift in Medicare policy is not only possible but imperative. Under a “medical indemnity” system, Medicare would pay each patient a fixed amount of money, reserving larger subsidies for sicker people. Patients, in turn, could select their own medical providers and services, at whatever cost they chose. Empowering consumers would simplify the Medicare program, expand consumer choice, and improve program efficiency.

Current Medicare policy stifles consumer choice. Physicians are not free to set their own prices. Instead, Medicare sets standard fees for more than 8,000 separate procedures and services, totaling over \$60 billion annually. Although Medicare's fee schedules were intended to simulate a perfectly functioning competitive market, they have not been successful.

Medicare's formulas impede the efficient use of resources. These formulas underpay for some services, overpay for others, and discourage the use of primary care in favor of more expensive specialty services. Patients, on the other hand, have access to medical care at low or no cost, and therefore have little incentive to consider competitive alternatives to traditional Medicare.

Feldman proposes to replace Medicare's payment formulas and intrusive regulations with medical indemnities. Given a fixed amount of money to spend on medical care, patients would have strong incentives to spend wisely. Physicians would be free to set competitive prices and take on more patients.

A medical indemnity is not a new concept for health insurance. In fact, it is how health insurers used to pay patients, before doctors and hospitals decided that they would be better off with an insurance system promoting more medical care use. In 1930, for example, 90 percent of the benefits paid by “health insurance” policies were for lost income, not

for medical care. Today, although the term “medical indemnity” may be unusual, most people are familiar with indemnity coverage through auto insurance. Here is how it works:

- Once damage to an automobile is verified, insurers pay a fixed amount to the owner, who determines how to spend the money. Similarly, a patient, once diagnosed, would receive a fixed amount of money to spend on treatment of his or her choice.
- Car insurance payments generally cover the full cost of repair, minus a deductible. This payment generally does not cover optional services or extra charges from repair shops whose prices are above the average in the local market. The car insurer does not dictate the prices that repair shops can charge. Medicare too would pay for the basic cost of a treatment, minus a deductible; the program would not pay for extras. Patients would be free to choose their health care providers.
- Car owners can select any body shop to perform needed services and are free to choose full restoration or basic repairs. Any savings from selecting a less-expensive procedure are retained by the insured. Similarly, a patient would be free to choose the level and type of care and would keep any part of the medical indemnity not spent on care.

An indemnity system that has already been tested and proven successful in the Medicaid program for patients needing long-term care services is the Medicaid Cash and Counseling Demonstration. Instead of the traditional direct delivery of services by Medicaid contractors, cash indemnities put program beneficiaries in charge of their own personal assistance services. A study of the program found that patients and family caregivers who chose the indemnity received equal or better care compared with those in the traditional Medicaid long-term care program.

Feldman calls for a similar large-scale test of medical indemnities. A trial run would offer a chance to discuss how much medical care individuals should be compelled to use, and would allow policy-makers to design a system that protects patients whose conditions are much costlier than average, thus avoiding a potential proliferation of costly individual indemnities.

Instead of setting standard fees that stifle the market and hamper effective care, an indemnity system would give patients control of their own health care. Feldman’s proposal would also give beneficiaries an incentive to shop for the combination of services, providers, and prices that most closely meet their needs. “This is a proposal for smarter Medicare payments,” Feldman concludes. “It’s time to give it a try.”

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