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Health Care's Road to Ruin

By **ELISABETH ROSENTHAL** DEC. 21, 2013

HAVING spent the last year reporting for a series of articles on the high cost of American medicine, I've heard it all. There was Fred Abrahams, 77, a skier who had surgery on both ankles for arthritis — one in New York for more than $200,000 and one in New Hampshire for less than $40,000. There was Matthew Landman, 41, billed more than $100,000 for antivenin administered in an E.R. after a small rattlesnake bite. There was Robin Miller, a Florida businessman, who needed to buy an implantable defibrillator for his ill brother, who was uninsured; the machine costs tens of thousands of dollars, but he couldn't get a price for a make or a model.

Extreme anecdotes, perhaps. But the series has prompted more than 10,000 comments of outrage and frustration — from patients, doctors, politicians, even hospital and insurance executives.

As of Jan. 1, the Affordable Care Act promises for the first time to deliver the possibility of meaningful health insurance to every American. But where does that leave the United States in terms of affordable care?

Even supporters see Obamacare as a first step on a long quest to bring Americans affordable medicine, with further adjustments, interventions and expansions needed.

There are plenty of interesting ideas being floated to help repair the system, many of which are being used in other countries, where health care spending is often about half of that in the United States. For example, we could strictly regulate prices or preset payment levels, as is currently done for hospital stays under Medicare, the national insurance program for people over 65, or at least establish fair price corridors for procedures and drugs. We could require hospitals and doctors to provide price lists and upfront estimates to allow consumers to make better choices. We could stop paying doctors and hospitals for each service they performed and instead compensate them with a fixed monthly fee for taking care of each patient. We could even make medical school free or far cheaper and then require service afterward.

But the nation is fundamentally handicapped in its quest for cheaper health care: All other developed countries rely on a large degree of direct government intervention, negotiation or rate-setting to achieve lower-priced medical treatment for all citizens. That is not politically acceptable here. “A lot of the complexity of the Affordable Care Act arises from the political need in the U.S. to rely on the private market to provide health care access,” said Dr. David Blumenthal, a former adviser to President Obama and president of the Commonwealth Fund, a New York-based foundation that focuses on health care.

With that political backdrop, Obamacare deals only indirectly with high prices. By regulating and mandating insurance plans, it seeks to create a better, more competitive market that will make care from doctors and hospitals cheaper. But it primarily relies on a trickle-down theory of cost containment. The Princeton health economist Uwe E. Reinhardt has called it “a somewhat ugly patch” on “a somewhat ugly system.”

With half a billion dollars spent by medical lobbyists each year, according to the Washington-based Center for Responsive Politics, our fragmented profit-driven system is effectively insulated from many of the forces that control spending elsewhere. Even Medicare is not allowed to negotiate drug prices for its tens of millions of beneficiaries, and Americans are forbidden by law to re-import medicines made domestically and sold more cheaply abroad.

And so American patients are stuck with bills and treatment dilemmas that seem increasingly Kafkaesque. The hopeful news is that American health care spending has grown at a slower pace over the past four years. While that is partly because of the recession, economists say, many credit the cost-containing forces unleashed by Obamacare with a significant assist. Even at that rate, many models suggest that nearly 25 percent of gross domestic product will be eaten up by health care in 20 years. That is not sustainable.

"It's like a diet you can't just stop, because it's starting to work," said Michael Chernew, an economist at Harvard Medical School. "And remember, we haven't even lost weight yet, we're just gaining weight more slowly."

Many health economists say we must move away from the so-called fee-for-service model, where doctors and hospitals bill every event, every pill, every procedure, even hourly rental of the operating room. Though insurers try to hold down costs by negotiating discounts or limiting reimbursement, this strategy has limited power because armies of consultants now advise hospitals on what is known as "strategic billing": Losing money from trauma patients? Hospitals can add on a $10,000-plus "trauma activation fee." Medicare not paying enough for a broken wrist? Add a separate "casting fee" to the bill.

"People in fee-for-service are very clever — they stay one step ahead of the formulas to maximize revenue," said Dr. Steven Schroeder, a professor at the medical school of the University of California, San Francisco.

Given that national or even regional rate-setting is out of the question, most health economists argue that the nation needs a new type of payment model, one where doctors and hospitals earn more by keeping patients healthy with preventive care rather than by prescribing expensive tests.

Such models exist: A number of hospital and doctors groups engage in so-called capitated care, where they are paid an annual fee by an employer or individual for all patient needs and must work within that budget. The Affordable Care Act promotes a strategy focused on accountable care organizations, in which similar networks can earn financial rewards for figuring out how to save money while meeting standards for good care. But

such models are still far from the norm in a country where a majority of physicians are in business for themselves and doctors and hospitals bill separately.

The new law includes a number of incentives intended to nudge doctors, hospitals and insurers to join groups and focus more on value, “but we don’t know how well they’re going to work,” said John Holahan, a fellow at the Urban Institute’s Health Policy Center.

For example, the law will tax premiums for the most expensive insurance plans to keep luxury health care spending down. And Medicare, through a value-based purchasing program set up by the law, is providing bonuses to doctors and hospitals for meeting quality-care standards. But those are tentative steps. In fact, recent research published in the journal Health Affairs concluded that the magnitude of bonuses now offered to hospitals was too small to change behavior, noting that even supermarket coupons tended to offer benefits worth well over 10 percent of total value.

The Affordable Care Act generally requires patients to be responsible for more of their bills — copays and deductibles — so they will become more price-savvy medical consumers. But the deck is stacked against them in a system where doctors and hospitals are not required or expected to provide upfront pricing. Why not? They should tell and patients should ask. (In France, before a hip replacement on a private patient, doctors must sign a contract that includes a price.)

And policy makers need to address two of the biggest drivers of our inflated national health care bill: the astronomical price of hospitalizations and particularly end-of-life care.

Obamacare plans cap an individual’s annual out-of-pocket spending at $6,350 a year. That (happily) prevents bankruptcy, but it also means that patients will still not be very discerning shoppers when it comes to major hospitalizations, since — in the United States — they’ve quite likely surpassed their out of pocket maximum by the time they’ve been formally admitted.

On the private side, some companies and employee health plans are experimenting with new payment models to limit these large bills. They may

follow Medicare, which offers hospitals bundled payments for given procedures, or try a technique known as reference pricing, in which they pick a rate they think is fair for a procedure — say $32,000 for a knee replacement, all-inclusive. If a patient wants to go to a hospital with higher fees, the difference comes out of his pocket.

To rein in price increases, companies and insurers have begun offering patients narrower networks, already a major gripe about many Obamacare plans.

And as choices narrow while prices rise, I sense that many patients are no longer so devoted to a market-based health care system. Barbara Felton, 86, was "shocked" when she saw her $12,000 itemized hospital bill for a recent brief stay to repair a fractured femur in Pocatello, Idaho. "I've never been in favor of a single payer before, but now I am," she said, referring to a government-run health system.

The perfect recipe for containing medical costs remains to be written and must be tweaked thoughtfully. After all, the American health care system is a major part of the economy. As Dr. Blumenthal, the former Obama adviser, put it: "If you put our health care system on an island and floated it out into the Atlantic it would have the fifth-largest G.D.P. in the world. It's like saying you have to change the economy of France."

But after a year spent hearing from hundreds of patients like Mr. Abrahams, Mr. Landman and Mr. Miller, I know, too, that reforming the nation's $2.9 trillion health system is urgent, and will not be accomplished with delicate maneuvers at the margins. There are many further interventions that we know will help contain costs and rein in prices. And we'd better start making choices fast.

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