

Health Care Entrepreneurs: The Changing Nature of Providers¹

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by Devon M. Herrick

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The market for medical care does not work like other markets. Providers typically do not disclose prices prior to treatment because they do not compete for patients based on price. Payments are usually not made by patients themselves but by third parties — employers, insurance companies or government. And the amounts paid are not really market-clearing prices; they are “reimbursement” rates negotiated with bureaucratic institutions and networks. Furthermore, when providers do not compete on price, they usually do not compete on quality either. In fact, in a very real sense, doctors and hospitals are not competing for patients at all — at least not in the way normal businesses compete in markets.

Executive Summary

This lack of competition for patients has a profound effect on the quality and cost of health care. Long before a patient enters a doctor’s office, third-party bureaucracies have determined which medical services they will pay for, which ones they will not and how much they will pay. The result is a highly artificial market plagued by problems of high costs, inconsistent quality and poor access. In addition, critics complain about fragmented care, uncoordinated care, failure to use simple technology (including the telephone, e-mail and the Internet), lack of electronic medical records (EMRs), the absence of safety-enhancing software, the lack of adequate patient education and problems related to rationing care by waiting.

Can the market for medical care be different? Interestingly, in health care markets where patients pay directly for all or most of their care, providers almost always compete on the basis of price and quality. And because they are not trapped in a system that pays for predetermined tasks at predetermined rates, providers are free to repackage and reprice their services — just like vendors in other markets. It is primarily in these direct-pay markets that entrepreneurs are creating many innovative services to solve the very problems about which critics of the health care system complain. In fact, these solutions are usually a necessary part of the entrepreneurs’ business models. What follows are some examples.

Cosmetic Surgery. Cosmetic surgery is rarely covered by insurance. Because providers know their patients must pay out of pocket and are price sensitive, patients can typically (a) find a package price in advance covering all services and facilities, (b) compare prices prior to surgery, and (c) pay a price that has been falling over time in real terms — despite a huge increase in volume and considerable technical innovation (which is blamed for increasing costs for every other type of surgery).

Laser Eye Surgery. Competition is also holding prices in check for vision correction surgery, and laser surgeons compete on quality as well. Recent quality improvements include more accurate correction, faster healing, fewer side effects and an expanded range of patients and conditions that can be treated. For instance, rather than traditional Lasik surgery, patients can pay \$200 to \$300 more per eye for the newer, Wavefront-guided Lasik.



About the Author

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Laboratory and Diagnostic Testing. Patients can order their own blood tests without a doctor's appointment and compare prices at different diagnostic testing facilities. Prices are 50 percent to 80 percent lower than identical tests performed in a hospital setting. These services lower the patients' time costs as well as money costs. In many cases, the results are available online within 24 to 48 hours.

Price Competition for Drugs. Walmart became the first nationwide retailer to aggressively compete for buyers of generic drugs by charging a low, uniform price — \$10 for a 90-day supply. In many cases, patients with drug coverage have found the cash price at Walmart is lower than their health plan's copay at conventional pharmacies. Other chain drug stores have responded with their own pricing strategies.

Price Competition for Drugs over the Internet. Rx.com was the first mail-order pharmacy to compete online in a national market for drugs. To compete with local pharmacies, they offer lower costs and more convenient service, including free home delivery. They also compete on quality. For instance, high-volume mail-order pharmacies have much lower dispensing error rates than conventional pharmacies. Online mail-order pharmacies have thrived on the business model of improved quality, lower cost and greater convenience.

Patient Education for Drugs as a Product. DestinationRx.com is a pharmacy benefits management company. In addition to operating an online mail-order drug delivery service, it also offers a Web site to help patients identify low-cost therapeutic substitutes to the drugs they currently take. In addition, the firm is partnering with Safeway supermarkets to install drug comparison kiosks in store pharmacies.

Retail Clinics. Walk-in clinics in shopping malls and drug stores offer primary care services. They compete by offering low money costs and low time costs. In order to ensure a consistent level of quality, nurse practitioners follow computerized protocols, and EMRs are a natural adjunct of that process. Further, once an EMR system is in place, electronic prescriptions are a straight-forward next step. And electronic prescribing allows the use of error-reducing software. Thus, one study found MinuteClinics follow treatment guidelines better than traditional medical practices.

Telephone-Based Practices. TelaDoc now has two million customers — paying for something that is almost impossible to get from a conventional general practitioner: a telephone consultation. It offers patients access to a doctor at any time of day from any location.

And because each on-call physician needs access to patients' medical histories (and the treatment decisions of previous physicians), personal and portable EMRs are a necessary part of the company's business model. The physicians prescribe drugs electronically — facilitating the use of safety-enhancing software that checks for harmful interactions.

Concierge Medical Practices. Some innovative physicians are rebundling and repricing medical services in ways that are not possible under third-party insurance. For a fixed monthly fee, they offer such services as price and fee negotiations for diagnostic tests and specialist services, patient education and more convenience and accessibility for primary care. Concierge physicians tend to relate to their patients in much the same way lawyers, accountants, engineers and other professionals interact with their clients — including phone calls, e-mail consultations and convenient Web-based services.

Medical Tourism. Increasingly, cash-paying patients are traveling outside the United States for surgery. Facilities that cater to such medical tourists typically offer: (1) package prices that cover all treatment costs, including physician and hospital fees, and sometimes airfare and lodging as well; (2) electronic medical records; (3) low prices that are often one-fifth to one-third the cost in the United States; and (4) high-quality care in facilities (and by physicians) that meet American standards. Moreover, a new company, Healthplace America, has been formed to facilitate medical travel within the United States. It offers price and quality transparency for a network of 15 hospitals. Savings are typically 30 percent to 50 percent.

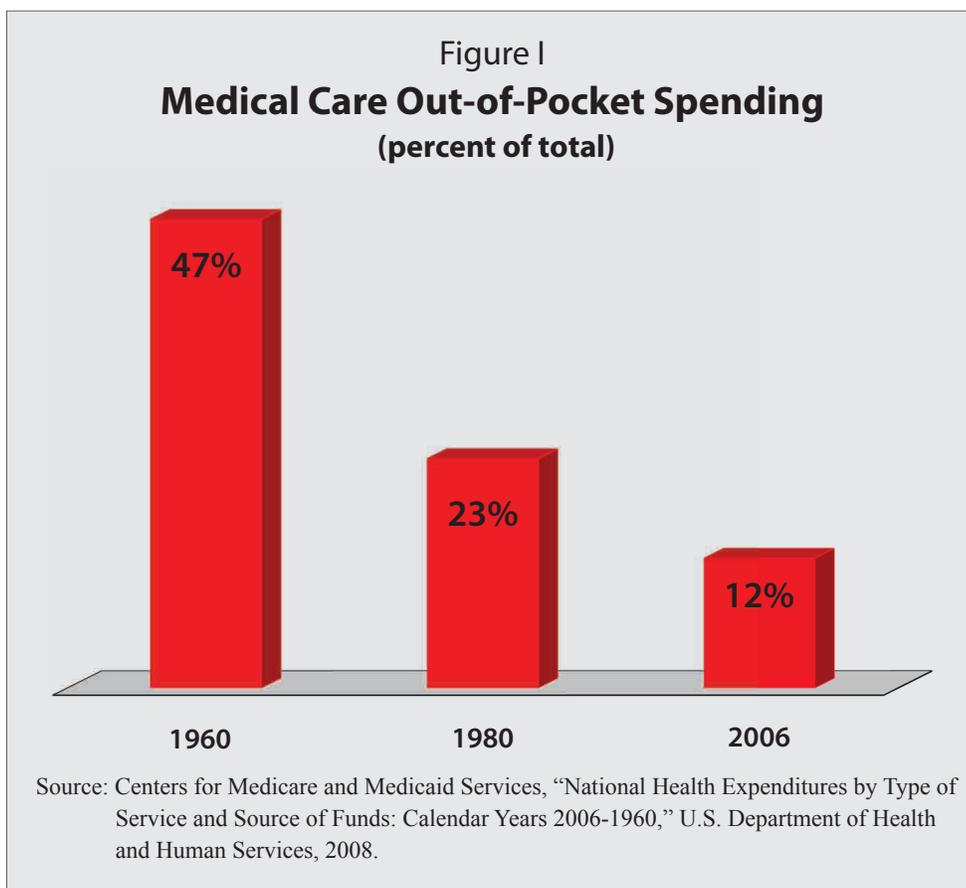
Third-Party Payer Innovations. Some entrepreneurs are adopting innovative practices within the third-party payer system. For example, American Physician Housecalls treats Medicare patients with multiple health problems in their homes and assisted living facilities. Because each specialist needs to know how others are treating the patient, EMRs and the consequent coordinated care are a necessary part of the treatment model. If a senior is readmitted to a hospital, the company loses a paying client. Thus, it has a financial incentive to adopt the best medical practices as part of its business plan.

What lessons can we learn from these examples of entrepreneurship in health care? The most important is that entrepreneurs can solve many of the health care problems that critics condemn. Public policy should encourage, not discourage, these efforts.

Introduction

The market for medical care does not work like other markets. Providers typically do not disclose prices prior to treatment because they do not compete for patients based on price. Payments are usually not made by patients themselves but by third parties — employers, insurance companies or government. And the amounts paid are not really market-clearing prices; they are “reimbursement” rates negotiated with bureaucratic institutions and networks. Furthermore, when providers do not compete on price, they usually do not compete on quality either. In fact, in a very real sense, doctors and hospitals are not competing for patients at all — at least not in the way normal businesses compete in markets.

However, in health care markets where third-party payers do not negotiate the prices and pay the bills, providers compete for patients’ business on price and quality. And because they are not trapped in a system that pays for predetermined tasks at predetermined rates, providers are free to repackage and reprice their services — just like vendors in other markets. It is primarily in these direct-pay markets that entrepreneurs are creating many innovative services to solve the very problems about which critics of the health care system complain. In fact, these solutions are usually a necessary part of the entrepreneurs’ business models, as the examples in this study show.



The Medical Care Marketplace

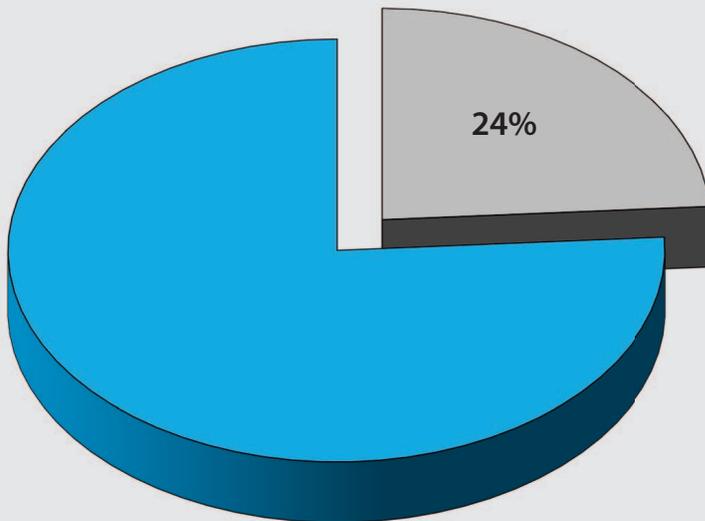
Every day, millions of American consumers go shopping. In doing so, they compare the price and quality of goods and services ranging from groceries to cellular telephone service to fast food to housing. But there is one major sector of the economy where consumers typically do not make decisions based on comparison shopping, even though it accounts for one-sixth of the U.S. economy. That sector is health care.

In health care, prices are difficult to obtain and often meaningless when they are disclosed. Patients who inquire about the price of a medical procedure are likely to be

disappointed.² Typically, neither the hospital nor the doctor will know the cost until the procedure is completed. Further, the same procedure may have many different prices, because each health insurer may have negotiated a different discount. And each enrolled patient entering the hospital may be charged a slightly different amount. Of 100 patients entering a hospital for the same procedure, no two may incur a bill for the same amount.

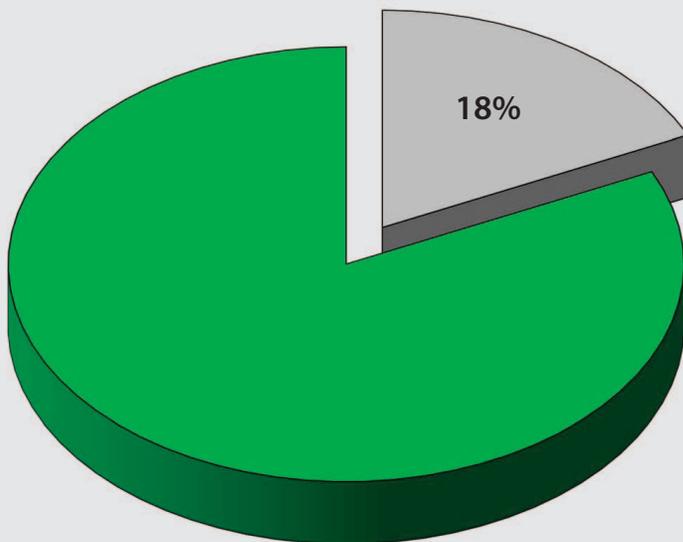
However, the problem goes much deeper than a lack of price transparency. “Real” prices are hard to obtain because they do not serve the same purpose in health care as in other markets. In markets where consumers shop, compare prices and pay their own bills, they are

Figure II
Physicians Using E-mail



Source: Allison Liebhaber and Joy M. Grossman, "Physicians Slow to Adopt Patient E-mail," Center for Studying Health System Change, Data Bulletin No. 32, September 21, 2006.

Physicians Using Electronic Medical Records



Source: Catharine W. Burt and Jane E. Sisk, "Which Physicians and Practices Are Using Electronic Medical Records?" *Health Affairs*, Vol. 24, No. 5, September/October 2005, pages 1,334-43.

the decision-makers. But in health care, patients rarely make their own decisions about which medical service they receive. And in most cases, they do not pay the bills.

Problems Created by Third-Party Payment. Doctors and hospitals do not disclose prices in advance of performing services because they do not compete for patients based on price. The reason: Patients rarely pay their own health care bills. Instead, they are paid by third-party payers. And, it turns out, when providers do not compete on price, they do not compete on quality either.³ Conversely, when patients do not pay their own bills, they do not act like typical consumers because they care little about the cost of the care they receive. As Figure I shows, the proportion of health care paid directly by American consumers has been falling for decades:⁴

- In 1960, consumers paid about 47 percent of overall health care costs out of pocket.
- That proportion fell by almost half to 23 percent in 1980.
- In 2006, consumers paid only 12 cents out of their own pockets every time they spent a dollar on health care.

As the proportion of medical care that patients pay for directly falls, prices do not give consumers the information they need to choose one medical service or provider over another. In many cases, these choices are taken out of the patient's control altogether and are given to insurers or health plan administrators. But this is only half of the picture.

Physician Services: Rationing by Waiting Instead of Price. On the average, every time American patients spend a dollar on physician services, they pay only 10 cents out of their own pockets. Millions of people pay nothing at the point of service: Medicaid enrollees, Medicare enrollees with medigap insurance, and people who get free care from community health centers and hospital emergency rooms. And in most employer-provided plans, employees make only modest copayments for primary care services.⁵

Since the services of physicians are a scarce and valuable resource, at a price of zero (or at a very low out-of-pocket price) the demand for these services far exceeds supply. In other markets, supply and demand are brought into balance through prices paid by consumers. Clearly, health care consumption is not rationed on the basis of price. Instead, people typically pay for physicians' services with their time, just as they do in other developed countries. According to a study in the *American Journal of Managed Care*, nearly half of patients must wait more than 30 minutes to see their doctor after arriving for an appointment.⁶ And this is in addition to the time it takes to travel to and from the doctor's office.

Like money, time is valuable. So the higher the time cost to patients, the lower the demand will be for physicians' services. Thinking of market wages as a proxy for the opportunity cost of time (the next-best use of time), the cost of an hour of time is higher for a high-income patient than a low-income

patient. Accordingly, physicians' practices in high-income areas need shorter waiting times to ration the same amount of care as practices in low-income ones. This suggests the longest waiting times of all will be for Medicaid patients and patients in hospital emergency rooms, where the money price is usually zero and people have a lower opportunity cost of time.⁷

The evidence appears to bear out this "rationing by waiting." A recent survey found two-thirds of Medicaid patients were unable to obtain an appointment for urgent ambulatory care within a week.⁸ Those who turn to hospital emergency rooms for their care find the average wait is about 222 minutes.⁹ One consequence of rationing by waiting is that the time of primary care physicians is usually fully booked, unless they are starting a new practice or working in rural areas. This means almost all the physicians' hours are spent on billable activities. Further, there is

"Patients usually pay for health care with their time."

very little incentive to compete for patients the way other professionals compete for clients. The reason: Neither the loss of existing patients nor a gain of new patients would affect the doctor's income very much. Loss of existing patients, for example, would tend to reduce

the average waiting time for the remaining patients. With shorter waiting times, the remaining patients would be encouraged to make more visits. Conversely, a gain of new patients would tend to lengthen waiting times, causing some patients to reduce their number of visits. Because time, not money, is the currency patients use to pay for care, the physician doesn't benefit (very much) from patient-pleasing improvements and is not harmed (very much) by an increase in patient irritations. The upshot is: When doctors do not compete for patients based on price, they do not compete on quality either. In a very real sense, they do not compete at all.

Effects of Lack of Competition

The lack of competition for patients has a profound effect on the quality and cost of health care. Long before a patient enters a doctor's office, third-party bureaucracies have determined which medical services they will pay for, which ones they will not and how much they will pay. The result is a highly artificial market plagued by problems of high costs, inconsistent quality and poor access. Specific problems include fragmented care, uncoordinated care, failure to use simple technology (including the telephone, e-mail and the Internet), lack of electronic medical records (EMRs), the absence of safety-enhancing software, the lack of adequate patient education and problems related to rationing care by waiting. These are consequences of the lack of competition under the third-party payment system.

Figure III
**Average Individual Health Plan Deductible
(Preferred Provider-Organization)**



Source: “Mercer Survey Finds \$1,000 Health Plan Deductible was the Norm in 2008,” Mercer, Web document, November 19, 2008.

Lack of Convenient Care.

Many patients have difficulty finding a physician, obtaining an appointment and taking time from work for a traditional office visit. To get an answer to even the simplest medical question from a physician, patients must usually make an office visit. It is even more difficult to reach a physician after office hours. Often, the only way to reach a physician after hours is in a hospital emergency room — which is both costly and time consuming.¹⁰ Access to medical care outside of the traditional office setting is particularly important — and particularly difficult — for patients with multiple chronic medical problems.

In other markets, limited supply and excess demand are brought into

balance through the prices paid by consumers — but not in health care.

Lack of Efficient Care. Over the past 60 years, health care expenditures have risen at twice the rate of national income. And medical prices have risen at about three times the rate of inflation. In general, the historical increase in health care spending has led to improvements in medical services.¹¹ But a substantial proportion is spent on care that is apparently unnecessary or wasteful. Currently, where excellence exists, it is often the result of a few dedicated individuals and rarely copied by competitors.¹² For example, regions of the country with the best outcomes for Medicare patients with chronic conditions typically spend less per

patient than areas that have worse outcomes. Compared to regions that use far more resources, patients in low-cost, high-quality regions such as Salt Lake City, Utah, Rochester, Minn., and Portland, Ore., are admitted less frequently to hospitals, spend less time in intensive care units and see fewer specialists. Mortality rates are lower.¹³

If every region provided care similar to the Mayo Clinic (in Rochester), one in every six dollars currently spent could be saved. If hospitals and physicians in every region in the country followed practice patterns similar to those in Salt Lake City, Medicare spending would be reduced by nearly one-third.¹⁴

Lack of Integrated Care. In normal markets, goods and services are naturally bundled and priced to please the customer. But in health care, services aren’t bundled or priced the way they would be if the industry even remotely resembled an efficient, competitive marketplace. Medical care is fragmented among specialties and different providers, and communication among providers treating the same patient is often nonexistent.¹⁵

Take diabetes, for example. Care tends to be delivered in discrete bundles, each with its own price. No single provider is responsible for desirable outcomes, such as fewer emergency room (ER) visits, lower blood sugar levels and so forth. This is because no one has bundled “diabetic care” as such — taking responsibility for final outcomes over a period of time in return for a fee. Because of the failure to bundle and price in

sensible ways, costs are higher and quality is lower.¹⁶ [See the case of HealthPoints, below.]

Lack of Information Technology. Doctors and hospitals often fail to use simple technology, including the telephone, e-mail and the Internet. Lawyers and other professionals routinely communicate with their clients by telephone and by e-mail. They charge clients for the time, but clients are willing to pay for convenience. In most offices, e-mail is ubiquitous, but only about one-quarter of physicians communicate with patients that way — even for routine prescriptions.¹⁷ It is not surprising that medical practices and hospitals that don't use a well-established technology (telephony) don't use newer technologies, including EMRs and safety-enhancing software.

Patients technically own their own medical records and have the right, at least in principle, to access them. But if they request a copy of their medical records, they are likely to receive a stack of smudged copies that includes illegible handwritten notes, undecipherable codes and obscure, abbreviated medical terminology. On their first visit to a medical practice, patients are required to fill out a medical history. Every time they are referred to a specialist, they are typically required to fill out similar forms again. Manual record-keeping is inefficient and dangerous. Handwritten prescriptions are also a major source of medical errors. Nearly 200,000 adverse drug events occur in hospitals each year because they don't have computerized physician order entry.¹⁸ Despite the capacity

of electronic medical record (EMR) systems to improve quality and greatly reduce medical errors, less than one-in-five physicians have such systems.¹⁹ [See Figure II.] The reason? Few health insurers pay physicians to install or maintain EMR systems.

“In most health care markets, providers do not compete for patients’ business.”

Health Markets without Third-Party Payers

In health care markets where third-party payers do not negotiate the prices or pay the bills, provider behavior is radically different. In these markets, entrepreneurs compete for patients’ business by offering greater convenience, lower prices and innovative services unavailable in traditional clinical settings. Until recently, such markets were confined to the types of procedures health insurance doesn't cover, such as cosmetic surgery and vision correction surgery. Today, competitive markets are emerging outside the third-party payment system covering services ranging from primary care to major surgery. The reason is because when patients pay for more services with their own money, providers compete on price and quality and are free to repackage and reprice.

Over the past few years, tax law changes have extended to individual self-insurance some of the same tax advantages traditionally enjoyed by third-party health insurance. Specifically, an increasing number of employees have personal accounts from which they pay medical expenses directly rather than rely on third-party insurance. This consumer-driven health care (CHDC) revolution gives individuals the opportunity to benefit financially from consuming health care wisely.²⁰ Many of these plans include personal accounts, such as Flexible Spending Accounts (FSAs), Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs).

Regardless of the plans, workers’ cost-sharing and required deductibles have been rising over the past decade. For instance, the median deductible for an employee in a managed care network (Preferred Provider Organization) with single coverage quadrupled from \$250 in 2000 to \$1,000 in 2008.²¹ [See Figure III.] Large employers are now asking their workers to pay more out of pocket for their health care in the form of high-deductible health plans.²² As a result of these changes, the number of people with a financial stake in the cost of their health care will continue to grow.

Cosmetic Surgery.²³ Cosmetic surgery is rarely covered by insurance. Because providers know their patients must pay out of pocket and are price sensitive, patients can typically (a) find a package price in advance covering all services and facilities, (b) compare prices prior to surgery, and (c) pay a price that has been falling over time in real

terms — despite a huge increase in volume and considerable technical innovation (which is blamed for increasing costs for every other type of surgery). In other words, cosmetic surgeons compete for patients on the basis of price — as in most other markets.

“In some markets, health care providers compete for cash-paying patients.”

From 1992 to 2005, a price index of common cosmetic surgeon fees rose only 22 percent while the average increase for medical services was 77 percent; overall, prices for all goods increased 39 percent.²⁴ [See Figure IV.]

The low prices, competition and easy access to information about price and quality found in the cosmetic surgery market depend on several factors. First, when patients pay with their own money, they have an incentive to be savvy consumers. Second, as more people demand the procedures, more surgeons begin to provide them. Since almost any licensed medical doctor may obtain training and perform cosmetic procedures, entry into the field is relatively easy. Third, providers have become more efficient. Many have operating facilities located in their offices, a less-expensive alternative to outpatient surgery at a hospital. Further, absent are the gatekeepers, prior authorization and large billing staffs

needed when third-party insurance pays the fees. Fourth, competition has led to lower prices and innovative substitute products.²⁵ These cost-saving efficiencies also apply to other medical markets where patients pay out of pocket, such as vision correction surgery.

LASIK Surgery. Laser surgeons are competing on quality as well as price. Competition and innovation are holding prices in check for vision correction surgery, which is rarely covered by insurance. The cost per eye of conventional vision correction laser surgery (LASIK) averaged about \$2,100 between 1999 and 2005. By 2005 the price had fallen to just over \$1,600.²⁶ New techniques are constantly being developed that offer such quality improvements as more accurate correction, faster healing and fewer side effects. Technical improvements are also expanding the range of patients and conditions that can be treated. For instance, patients now have a choice of traditional Lasik or can pay \$200 to \$300 more per eye extra for the newer, Wavefront-guided Lasik.²⁷

Case Studies of Innovative Providers

Entrepreneurial health care providers are creating many new services to better serve patients by offering greater convenience and lower prices. These services are often unavailable in traditional clinical settings, while in other cases, convenience and access have improved. Many of these services initially began outside the third-party

payment system. In virtually all cases, adopting quality-enhancing or patient-pleasing amenities is an integral part of their business model.

Laboratory and Diagnostic Testing. When diagnostic tests are needed, patients can order their own blood tests without a doctor’s appointment and compare prices at different testing facilities. Patients can also avoid a second doctor’s appointment to receive the test results. In many cases, the results and an analysis are available online within 24 to 48 hours. Another option is cash-based storefront locations or mobile coaches, which are beginning to offer affordable lab tests in a convenient setting. These provide results quickly and without a visit to a physician’s office. Results are stored in a personal health record and accessible to patients.

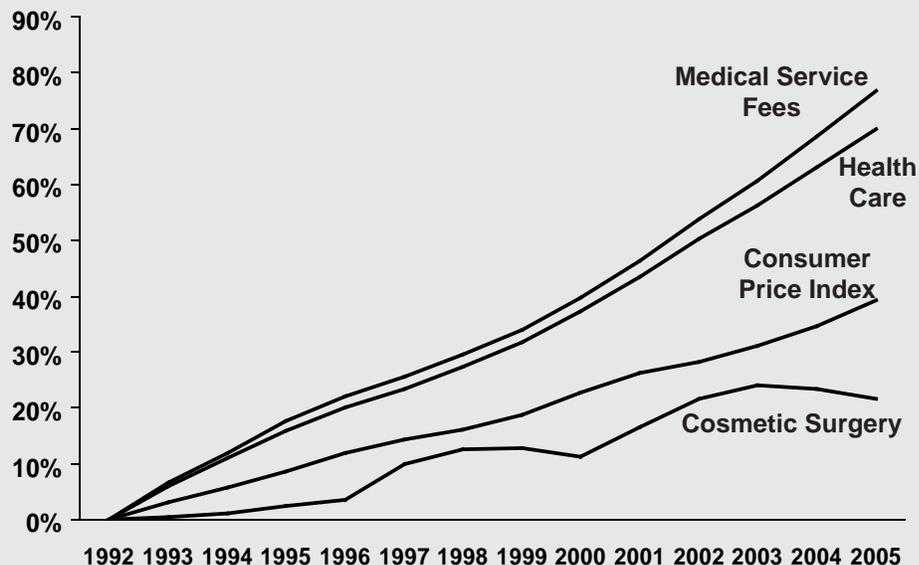
For example, MyMedLab.com offers full range of laboratory tests and sells bundled packages designed to meet the needs of different groups of patients — by age, sex and family medical history. Prices are 50 percent to 80 percent lower than identical tests ordered by a physician, and a general health screen of 30 blood metrics costs about \$54. Patients who order online save an additional 10 percent. Patients can access the service by visiting more than 2,000 collection centers nationwide. The firm also stores customers’ lab tests results electronically for later comparison.²⁸

HealthFair, a health care screening company based in Winter Park,

Fla., operates a fleet of mobile screening “Health Coaches.” The firm is accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), and it claims to have performed over 1 million preventive screening tests since 1999. Its big sellers are preventive screens to assess the risk of heart attack, stroke and aneurism. The 7-test package consists of an echocardiogram, electrocardiogram, an Adrenal Stress Index test, carotid artery ultrasound, ultrasound to detect abdominal aortic aneurysms, an ankle-brachial blood pressure index test and bone density ultrasound. In some locations, patients are offered a full lipid panel, glucose test, and a choice of one thyroid, prostate, C-reactive protein or ALT/AST (liver function) test for an additional fee.

HealthFair claims its popular 7-test pack would cost around \$2,300 if performed in a hospital setting. But it offers a promotional package deal (with interpretation) for only \$195 — an 85 percent discount off the price of having the same tests performed piecemeal at a local hospital. Why so cheap? For one thing, HealthFair streamlines the scanning process, keeping overhead low and offering package deals. Results are automatically sent to the patient and his primary care physician. But the primary reason the price is so dramatically lower is that patients pay cash at the time of services. When patients pay with their own dollars, firms must offer value and convenience.²⁹ These firms are competing on price in order to attract cash-paying customers.

Figure IV
Cosmetic Surgery Prices



Source: Authors’ calculations based on American Society of Plastic Surgeons data and the Consumer Price Index from the Bureau of Labor Statistics.

Innovative Pharmaceutical Services. Patients have much better access to prescription drug prices and information today than in the past. They can reduce the cost of some common drug therapies using the same techniques they routinely employ when shopping for other goods and services. These include comparing prices, buying in bulk and looking for low-cost substitutes. Patients can also look for an over-the-counter or generic alternative or a therapeutic substitute in place of a high-priced, name-brand drug. In some cases, patients may be able to buy medications in double-strength and split them in half.³⁰

There are three areas of the drug market in which entrepreneurs are

competing for patients shopping for lower prices.

Price Competition for Drugs. Walmart became the first nationwide retailer to lower the prices of a 30-day supply of generic drugs to \$4. Not long afterward, other national pharmacies followed suite — including Target.³¹ Walmart has since lowered the price of most generic drugs to \$10 per 90-day supply.³² Many people who once would have accepted a prescription without question are now asking their doctor whether or not a prescribed drug is on Walmart’s \$4 list. Historically, generic drugs were sometimes marked up 1,000 percent or more. Now, largely due to Walmart, generic drug prices have become highly competitive.

In many cases, patients with drug coverage are finding the cash price is lower than their health plan's negotiated copay for a generic drug.

Price Competition for Drugs over the Internet. Rx.com and other mail-order pharmacies are competing with local pharmacists by creating a national drug market. In order to attract business from local pharmacies, they must offer lower costs and greater convenience (such as free home delivery). They must be able to fill a high volume of prescriptions without errors. Research shows that high-volume mail-order pharmacies have much lower dispensing error rates than conventional pharmacies. Thus, improved quality, lower cost and greater convenience is a necessary part of the business models of mail-order pharmacies.

Drug Education as a Patient Service. DestinationRx.com is a pharmaceutical benefits management company that provides competitive mail-order drug delivery and assists patients with identifying low-cost alternatives to the drugs they currently take. To find opportunities for lower-cost substitutes, patients can log on to DestinationRx.com's Web-based tool (Rxaminer.com) and enter their prescription medications, prescribed strength levels and dose schedules. The Web site produces a report that includes therapeutic and generic substitutes and over-the-counter alternatives for name-brand prescription drugs. The report explains the patient's options and can be printed out to discuss with a physician. The firm is partnering with Safeway grocers to install drug comparison kiosks in

store pharmacies to help customers identify low-cost alternatives, and also provides drug comparison tools for private insurance and for Medicare Part D plans on Medicare.gov.

“Price competition leads to innovation.”

Innovative Physician Services

Entrepreneurs have created a number of innovative medical practices in the past few years.

Retail Clinics.³³ Walk-in clinics are small health care centers located inside big-box retailers, or storefront operations in strip shopping centers. They are staffed by nurse practitioners and offer a limited scope of services but added convenience.³⁴ Originally, patients were expected to pay the cost out-of-pocket. However, as the service has proven to be convenient and efficient, insurers are beginning to reimburse for the service.

MinuteClinic is the pioneer of clinics operating within larger retailers — allowing shoppers in Cub Foods, CVS pharmacies and Target stores to get routine medical services such as immunizations and strep tests. No appointment is necessary and most office visits take only 15 minutes. MinuteClinics clearly list prices, which are often only half as much as a traditional medical practice — most treatments cost \$59.³⁵

MinuteClinics use proprietary software to guide practitioners through diagnosis and treatment protocols based on evidence-based medicine. In contrast to standard physician practice, medical records are stored electronically and prescriptions can also be ordered that way. There is also evidence that the quality of routine care in walk-in clinics is comparable to treatment in traditional physicians' practices. MinuteClinics received high marks for quality of care in the recent Minnesota Community Measurement Health Care Quality Report.³⁶ The report measured appropriateness and quality of care for two common ailments among children: colds and sore throats. For example, in treating sore throats, each medical practice was evaluated on the basis of whether they administered a strep test and only prescribed antibiotics when test results were positive. For appropriate care:³⁷

- MinuteClinics scored around 99 percent.
- Mayo Clinics scored 77 percent.
- The average provider rating was 81 percent.
- The lowest provider score reported was 26 percent.

On care of children with colds:

- Mayo Clinics scored 95 percent.
- MinuteClinics scored 87 percent.
- The average provider rating was 84 percent.
- The lowest provider score reported was 37 percent.

MinuteClinics scored at least as well as the average and there was far less variation.

To be successful, retail clinics must provide consistent, high-quality service and a way to share patient information with customers' primary care physicians. These require the use of technology, including computerized protocols, decision-support tools and EMRs. When patient records are stored electronically, it is more efficient and accurate to prescribe electronically than to handwrite a paper prescription that is then transcribed into an electronic record. Furthermore, the use of EMRs and electronic prescribing allows for error-reducing software to check for drug errors, patient allergies, contraindications and drug interactions. These are systems that health care reformers believe all doctors should adopt, but few actually do. However, in these cash-pay markets, providers have adopted quality-enhancing information technology because their business model virtually requires them to do so. Without it, retail clinics would find it difficult to compete.

Many other entrepreneurs are launching similar limited-service clinics. Walmart leases space for walk-in clinics to MinuteClinic and RediClinic (among others) and has begun to expand these operations nationwide.³⁸ RediClinic also allows patients to order numerous lab tests for fees that are nearly 50 percent less than tests ordered by physician offices.³⁹ Competition from these new clinics may lead traditional physician practices to adopt new technology and offer more convenient weekend and extended hours.⁴⁰

Telephone-Based Practices.⁴¹ Many medical conditions do not

require the physical presence of a physician or the time and expense of an office visit. Some of these could be easily diagnosed, and treatment recommended, over the phone. However, many patients report having a hard time reaching their physician on the phone — especially after hours. To meet this demand, entrepreneurs are creating nontraditional medical services in which clinical care is available at more convenient locations, by telephone or through virtual offices on the Internet. They are staffed by physicians who will order tests, initiate therapies or treatments and prescribe drugs. These services are not designed to replace primary care physicians. Rather, they are for patients who urgently need a consultation but are unable to contact their regular physician.

TelaDoc Medical Services, located in Dallas, is a phone-based medical consultation service that works with physicians across the country. Consultations are available around the clock, but patients must sign up in advance so their medical histories can be placed online.

When a patient calls TelaDoc, several participating physicians near the caller are paged. The first physician to respond is paid for the consultation. TelaDoc guarantees a return call within 3 hours, or the (\$35) consultation is free — but most calls are usually returned within 30 to 40 minutes.⁴² Further, unlike most primary care practices, TelaDoc retrieves and stores patient records electronically so that participating physicians can access the patient's medical history. Because patients are not in the physician's

office (and the physician can vary from one consultation to the next), patient records must be stored and retrieved electrically. Drug therapies also must be prescribed electronically — facilitating safety-enhancing software that checks for harmful interactions. Due to the nature of telemedicine, firms like TelaDoc must have EMRs to perform tasks. Some telemedicine firms also have computerized protocols to assist the physician in diagnosing ailments. Thus, competition to reduce waiting or enhance convenience using telemedicine leads to personal and portable electronic medical records.

“Medical entrepreneurs rebundle and reprice services.”

AmeriDoc is a new startup that provides telephone consultations and e-mail follow-up to individual subscribers and health plan members with immediate telephone access to licensed physicians.⁴³ According to AmeriDoc, patients often find it difficult to contact their regular physician by phone after hours.⁴⁴ With few options, people searching for peace of mind or reassurance (such as mothers of sick children) often turn to emergency rooms. In many cases, a phone call avoids an unnecessary ER visit. Although initially not reimbursed by insurance, many health plans are beginning to see the value of telephone-based consultations. Many patients are also beginning

to appreciate the convenience of accessing a doctor by phone and are willing to make the nominal copayment.

Concierge Medical Practices.

Some innovative physicians are creating practices designed to be convenient and accessible to patients.

These so-called concierge physicians compete on two different facets of cost: time cost as well as money costs. Time costs refers to the waiting and inconvenience often entailed in traditional physician office visits. Thus, some of these physicians provide after-hours office visits, patient education and house calls.

Physicians in concierge practices relate to their patients in much the same way lawyers and accountants interact with their clients — including phone calls, e-mail consultations and convenient Web-based services. These practices are essentially rebundling and repricing medical services in ways that are not possible under third-party insurance. Thus, a necessary part of their business model is to find patient-pleasing services that solve the problem of excessive time costs and poor quality.

Doctokr Family Medicine is the Virginia medical practice of Dr. Alan Dappen, who practices medicine mostly by telephone and e-mail contact. Patients can schedule an appointment or e-mail the doctor, all from the Doctokr.com Web site. In fact, Dappen's waiting room is a Web page. Patients can also make appointments to be examined in his office, and though he will even

make house calls for some patients, he encourages most patients to consult with him by e-mail or telephone.

Like attorneys, Dappen bases his consultation fees on the amount of time required. Charges are billed in five-minute increments and range from \$67.50 for in-office visits (first 10 minutes; \$22.50 each additional 5 minutes) to \$22.50 for phone consultations with patients who have set up membership accounts. A simple call to renew a prescription or ask questions generally costs less than \$20. Although the office does not bill insurance companies for services, most patients can easily turn in a claim themselves. Patient records are kept electronically.⁴⁵

“Entrepreneurs compete on price, quality and/or convenience.”

Concierge medicine is normally associated with personalized services for the wealthy. Depending on the practice, these services can be expensive — in some cases more than \$2,500 a year per person. However, in the Dallas suburb of Collin County, Texas, physician Nelson Simmons offers a version of that service for less than \$500 a year.⁴⁶

About 70 small business owners pay \$40 per employee per month for Simmons' plan. In return, employees get same-day primary

care services and steep discounts on diagnostic tests and specialist care. Enrollees must pay out-of-pocket for specialist care, surgeries and diagnostic tests. But Simmons negotiates the rates, which are typically much lower than what others pay. For example, a tonsillectomy for a child costs less than half of the normal fee (\$2,100 versus \$4,800) and an MRI scan can be less than one-fourth of the standard charge (\$350 versus \$1,600).⁴⁷

Medical Travel

Increasingly, cash-paying patients are traveling outside the United States for surgery that is up to 80 percent less expensive than medical procedures performed domestically.⁴⁸ Facilities that cater to such medical tourists typically offer: (1) package prices that cover all the costs of treatment, including physician and hospital fees, and sometimes airfare and lodging as well; (2) electronic medical records; (3) low prices that are often one-fifth to one-third the cost in the United States; and (4) high-quality care in facilities, and by physicians, that meet American standards. Prices for major procedures are so much lower that patients save money even with the added cost of travel.

India is the largest hospital market in the world where people pay out-of-pocket. In India, 78 percent of medical care is paid out of pocket, compared to 12 percent in the United States. People are free to purchase the level of service they desire and can afford. As a result, Indian hospitals compete for

patients on the basis of price and quality. If they compete on quality, they must make quality indicators available. Many post quality metrics on Web sites, similar to such facilities as Cleveland Clinic and Mayo Clinic. Many Indian hospitals that compete for patients use EMRs to enhance quality, improve service and facilitate treatment among multiple physicians. Electronic record-keeping leads to continuous quality improvement.

BridgeHealth International, based in Denver, has a provider network of offshore hospitals, clinics and physicians. It works with individuals, insurers and employer health plans to facilitate workers' treatment abroad. BridgeHealth International's medical staff carefully screens the travel-readiness of potential clients using a proprietary algorithm to assess their health risks. Staff members then help clients choose appropriate physicians and destinations to obtain high-quality medical care.

Most of the patients traveling abroad for surgery are uninsured. However, that is about to change as more health plans begin to cover medical travel. BlueShield of California has a health plan, *Access Baja*, designed for Americans and Mexicans who choose to receive medical care in northern Mexico. In 2007, BlueCross BlueShield of South Carolina established Companion Global Healthcare, a network of foreign-based hospitals that includes internationally accredited medical facilities.⁴⁹ WellPoint, an insurer, recently announced a pilot project to allow a self-insured firm's

700 workers to travel to India for non-emergency procedures, including major joint replacement. The plan would waive all cost-sharing and travel expenses for a worker and companion.⁵⁰ Insurers Aetna and Cigna both report growing interest in medical tourism among employers. Mercer Health, an employee benefits consulting firm, is helping several Fortune 500 employers use medical travel to help stem the rising cost of employer-provided medical coverage.⁵¹

“By traveling, patients can obtain lower prices and higher quality.”

La Moreleja is an assisted-living community for American retirees located in San Luis Potosí — a colonial city in northern Mexico. When the residential development is finished in 2009, it will include accommodations for 180 assisted-living clients and 250 senior apartments for independent living. After an initial \$9,000 fee, the cost of assisted-living will be approximately \$1,100 per month — including meals and a full range of services. The average rate across the United States is more than \$3,000 per month.⁵² Baby boomers facing financial ruin from the cost of health care after retirement now have an opportunity to outsource their own care to warmer climates where costs are lower.

Now, a new phenomenon is emerging: medical tourism within

U.S. borders. Some American hospitals are beginning to follow the overseas model when it comes to price transparency — if you're willing to travel. For example, soon after grocer Hannaford, which is headquartered in Scarborough, Maine, negotiated its deal to allow workers to travel to Singapore for certain procedures, several U.S. hospitals offered to match the Singapore prices. Currently, the company has a contract with a Boston hospital for hip, knee and spine surgery.

Moreover, a new company, Healthplace America, has been formed to facilitate medical tourism within the United States. It offers price and quality transparency for a network of 15 hospitals. Savings are typically 30 percent to 50 percent of what patients and their insurer/employer would otherwise pay. It is important to note that all this is happening without any coaxing or mandate from the U.S. Department of Health and Human Services. This is the marketplace at work.

Innovations within the Third-Party Payment System

Once innovative practices have been found to lower costs or improve quality, a few companies within the third-party payment system are adopting them. In some cases, entrepreneurs are providing ways to improve health care for health insurers and government programs.

Chronic Disease Management. HealthPoints is a firm that provides chronic disease management for

health plans and third-party payers. For instance, diabetes is a costly burden on insurers and especially on public programs such as Medicaid, Medicare and Veterans Affairs. HealthPoints takes advantage of the latest information technology to monitor diabetics remotely. Enrollees use a small, high-tech blood glucose-testing monitor with a wireless Bluetooth connection. A Web-based computer or Personal Digital Assistant (PDA) sends the blood glucose readings electronically to the HealthPoint office. A patient who forgets to take a reading at the appointed time receives a reminder by e-mail or phone. An extremely high reading will notify a health coach or diabetes nurse at HealthPoints to call the patient and inquire about foods recently eaten. The (multiple) daily blood glucose readings become part of a medical record that can be used to establish health metrics and a baseline of a patient's progress. A health coach can also counsel patients on ways to improve compliance.⁵³

American Physician Housecalls (APH) is a Texas-based, multi-specialty physician practice that provides house calls to appropriate home-bound Medicare patients in their home, apartment or assisted-living center. American Physician Housecalls coordinates the care of frail seniors who are at high risk of an expensive hospital readmission after discharge. The multispecialty physicians' group works as a team and coordinates all the medical needs of home-bound seniors.

APH's transitional care bridges the treatment gap when seniors are discharged from a hospital to their

home. Coordinating care after discharge of frail, home-bound seniors reduces Medicare patients' hospital length of stay, in addition to lowering the likelihood of their being readmitted to a hospital due to complications.

APH specializes in managing congestive heart failure, chronic obstructive pulmonary disease, diabetes and hypertension. These diagnoses afflict the sickest 5 percent of seniors, and they account for about half of Medicare spending. A wide variety of services are provided to home-bound seniors including: portable x-ray imaging, echocardiograms, phlebotomy and other lab procedures, podiatry and geriatric psychology consultations.⁵⁴

“Providers within the third-party system are adopting proven innovations.”

Electronic medical records are a necessary part of the treatment model in order to facilitate and coordinate care among multiple physicians. Coordinated care that is managed in the least costly setting is something that health care reformers wish all doctors and hospitals would provide. However, for most providers it is not in their financial interest to do so. American Physician Housecalls adopted best practices as part of a business plan in pursuit of profits. If a senior is readmitted to a hospital, the company loses a paying Medicare client.

FreeMD.com.⁵⁵ Nurses at the Veterans Health Administration (VHA) use a sophisticated software program, developed by DSHI Systems, to provide health advice to veterans over the phone.⁵⁶ Starting with a patient's primary health complaint, age and gender, the software processes patient responses to a series of questions and generates an urgency assessment, including:

- A potential diagnosis of the most serious likely cause.
- Whether or not the caller requires a doctor's care, and an indication of the urgency of the condition.
- Recommended ways the caller can care for himself in the interim.

A consumer version is now available on the Web at FreeMD.com. A patient or family member enters the symptoms of the primary complaint — for instance, shortness of breath and severe back pain migrating to the chest — and is prompted to answer a number of questions from the virtual doctor. Within a few minutes the Web site produces a diagnosis — in this case, *aortic thoracic dissection*. The program would then recommend the emergency room as the most appropriate place to seek care — with the following advice:⁵⁷

- Consider calling an ambulance.
- You need to see a doctor now or your condition could worsen.
- Do not eat or drink anything until you see the doctor.

Innovative Benefits. Not every worker can afford, or wants to bear the cost of, a comprehensive health plan. Those without health coverage or who have a limited benefit or high-deductible plan often find they pay the highest rates for medical

goods and services. Yet, some firms are providing ways to help workers navigate the health care system.

New Benefits is a pioneer in the industry providing (noninsurance) discount health care benefit programs, including prescription drugs, dental care, hearing aids and vision benefits. The benefit package is tailored to the specific needs of employers. In return for a discount similar to the negotiated rates health plans enjoy, workers pay for medical care at time of service. The program is not designed to replace health insurance; rather it is designed to provide additional health benefits to employer compensation plans.

Among the benefits offered by the firm is access to physicians online, by phone or through a health card program. Members can also access a nurse hotline or request medical assistance for conditions that occur while traveling. One of the more innovative services offered is a Medical Health Advisor, which assists members in navigating the health care and insurance systems. A personal health advocate works with clients to resolve issues and problems they encounter in billing, getting services covered, second opinions and so on.⁵⁸

Obstacles to Health Care Entrepreneurs

Some transparency advocates argue that doctors, hospitals and insurers must be compelled to fully disclose prices and quality measures. But the evidence suggests that where markets are competitive, transparency is a natural outcome.⁵⁹ In normal competitive markets, the role of government with respect to price

and quality is mainly the prosecution of fraud. In health care, the greatest barriers to transparency, innovation and competition are government laws and regulations. Deregulating health care and equalizing the tax treatment of self-insurance and third-party insurance are important steps in the right direction.

“Some firms offer cost-saving discount plans.”

Needed Reforms: Remove State Laws Restricting the Practice of Medicine.

In many states, current laws prevent medical practices from being organized in innovative ways. The courts have removed many anticompetitive restrictions on medical professionals, such as the prohibition on advertising, but the practices of physicians, physician assistants, nurses and technicians are still highly regulated. The most widespread limit on health care professionals is the requirement that they must be licensed by each state in which they practice. With 50 separate state markets for health care rather than one national market, this situation creates inefficiencies that boost costs and limit patients’ access to care. For example, after Hurricane Katrina in 2005, thousands of doctors and nurses displaced to Texas were unable to legally treat evacuees until they received limited, emergency licenses from the state of Texas.

Conversely, physicians, nurses and military-trained medics could not legally assist victims in Louisiana and Mississippi without special permission. If physicians and other medical professionals licensed in any state were allowed to more easily practice in any other state, labor markets for these professions would be more efficient and patients would have more treatment options.⁶⁰

While some restrictions on the practice of medicine have been removed in recent years, many still exist.⁶¹ For example, restrictions on telemedicine make it generally illegal for a physician in one state to consult with a patient online in another state without an initial face-to-face meeting. It is also illegal in most states for a physician who has examined a patient from another state to continue to treat the patient via the Internet. The physician must be licensed in the state where the patient resides, or his treatments are considered practicing medicine without a license. It may even be illegal in some states to consult online with a patient who resides in the same state as the physician; however, regardless of its legal status, many medical societies consider it unethical.⁶²

More examples are the scope-of-practice laws and the types of medical professionals allowed to practice independently. Nurse practitioners and physicians’ assistants can deliver some routine medical care without the direct supervision of a physician. However, some medical societies want to limit their independence by requiring the strict supervision — and even the physical presence — of a physician. A 2006

Florida law allows a single physician to supervise no more than four retail clinics that are staffed by nurse practitioners.⁶³ This regulation will effectively slow the growth of these efficient clinics. Georgia legislators attempted to limit the number of clinics a physician could supervise to three and the Missouri Legislature considered banning clinics inside pharmacies, if the clinics were staffed only by nurse practitioners.⁶⁴

Needed Reforms: Remove Restrictions on the Employment of Doctors. About one-third of states have enacted laws banning the “corporate practice of medicine,” which prevents corporations from hiring physicians to practice on their behalf.⁶⁵ The implication is that a corporate employer might exert undue pressure to skimp on quality in order to increase or preserve profits. These laws ostensibly aim to ensure quality of medical care, but in practice they inhibit innovative service arrangements.⁶⁶ In some cases, this means a retailer, such as Walmart, cannot open a health kiosk inside a store and hire practitioners to staff the clinic. Corporations are generally free to lease space to companies that provide medical services by independent contractors, but subcontractors often face the same problem because corporations are forbidden to hire them as well.

The states should repeal restrictions against the corporate practice of medicine.⁶⁷ Ownership is not restricted as much in other industries where very low error rates are required for safety. Take the airline industry. If airlines were prevented from hiring pilots and owning airplanes, the industry would

likely be very different. Rather than numerous carriers flying thousands of large airliners across thousands of regularly scheduled routes, the industry would likely be dominated by charter pilots flying small propeller-driven planes.

“Restrictions on innovative practices should be repealed.”

Corporate ownership of airlines has not reduced safety. In fact, the health care industry is increasingly looking to quality improvement procedures in the airline industry for insight into ways to improve patient safety.⁶⁸ For instance, flight crews receive training designed to empower all members of the crew to speak up if they feel safety is compromised. Many experts think the lack of communication among surgical staff in operating rooms leads to some preventable medical errors.⁶⁹ Corporate ownership also has the advantage of better access to capital markets, economies of scale and the ability to integrate the expertise of other professionals (such as industrial engineers).

Needed Reforms: Relax Restrictions on Collaboration among Health Care Providers. The federal “Stark laws” make it illegal for physicians to self-refer patients for treatment to any clinics in which they have a financial interest. It is also illegal for physicians to reward providers who refer patients to them

or to hospitals in which they have a financial interest. Unfortunately, laws meant to prevent self-dealing and kickbacks also inhibit beneficial activities between doctors and hospitals.⁷⁰ For instance, the Stark laws could prevent a walk-in clinic from referring a patient with a chronic condition to an affiliated full-service practice. Likewise, a full service practice likely could not refer a chronic patient to a convenient walk-in clinic for simple services like blood tests.

The federal Stark laws prohibiting self-referral should be modified to allow beneficial arrangements where care is coordinated and provided in a more efficient manner. Currently, a physician practice cannot recommend patients seek care in a setting where the referring physician has a financial interest. With revised legislation, for instance, a traditional physician practice could offer integrated services, including disease management for chronic conditions, walk-in clinics for minor problems and discounted lab work.

Needed Reforms: Remove Tax Penalties on Self-Insurance. Traditionally, the tax law has favored third-party insurance over individual self-insurance. Every dollar an employer pays for employee health insurance premiums avoids income and payroll taxes. For a middle-income employee, this generous tax subsidy means government is effectively paying for almost half the cost of health insurance. On the other hand, until recently, the government taxed away almost half of every dollar employers put into savings accounts for employees

to pay their medical expenses directly. The result was a tax law that lavishly subsidized third-party insurance and severely penalized individual self-insurance. This has encouraged consumers to use third-party bureaucracies to pay every medical bill, even though it often makes more sense for patients to manage discretionary expenses themselves.⁷¹

If the tax laws made it easier for people to self-insure instead of relying on third-party payers, competition would improve the efficiency of the medical marketplace. Currently, Health Savings Accounts (HSAs) are allowing millions of people to partly self-insure. However, congressional tax-writing committees have made decisions about the design of HSAs that more properly should be determined by the market.⁷² For instance, the government legislates the amount of the HSA deposit and the accompanying health insurance deductible. Instead, the market should be allowed to answer such questions as: What is the appropriate deductible for which service? Should different amounts be deposited into the accounts of the chronically ill? In finding answers, markets are smarter than any one of us because they benefit from the best thinking of all of us. Further, as medical science and technology advance, the best answer today may not be the best answer tomorrow.

Needed Reform: Reward Quality Improvements in Medicare and Medicaid.⁷³ The goal is to encourage a competitive market on the provider side — in which

every doctor and every facility is encouraged to continuously search for ways to rebundle and reprice medical services in quality-enhancing, cost-reducing ways. Medicare stands to gain the most since it is the largest health care payer.

At last count, Medicare pays for about 7,500 specific tasks. Telephone consultations are not among them. Nor are e-mail consultations or electronic record-keeping. Under the current system, Medicare and Medicaid stifle entrepreneurial activity and financially punish efforts to lower costs or improve quality. Why can't these agencies reward improvements instead? Suppose an entrepreneur offered to replicate the Mayo Clinic in other parts of the country — potentially saving Medicare 25 percent of costs and improving quality of care along the way. Medicare should be willing to pay, say, 12.5 percent more than its standard rates in order to achieve twice that amount in lower total costs. That would leave the entrepreneur with a 12.5 percent profit — an amount that should encourage other entrepreneurs to enter the market with even better ideas.

Any provider should be able to propose and obtain a different reimbursement arrangement, provided that (1) the total cost to government does not increase, (2) patient quality of care does not decrease and (3) the provider proposes a method of measuring and assuring that (1) and (2) have been satisfied.

Once government agencies jumpstart the entrepreneurial process in this way, private insurers are likely

to follow suit. In this way, government could promote entrepreneurship, instead of stifling it.

Conclusion

At first glance, the medical marketplace is dysfunctional — with health care expenditures rising at twice the rate of national income and medical prices rising at three times the rate of inflation. Data on prices and quality are generally not available to patients in the U.S. health care system, and patients care little about what they spend. However, in health care markets where third-party payers do not pay the bills, the behavior of providers and patients is radically different. In these markets, entrepreneurs compete for patients' business by offering greater convenience, lower prices and innovative services unavailable in traditional clinical settings. Until recently, such markets were confined to the types of procedures health insurance doesn't cover, such as cosmetic surgery and vision correction surgery. Today, competitive markets are emerging outside the third-party payment system covering services ranging from primary care to major surgery. The reason: Patients are paying for more services out of pocket.

What lesson can we learn from these examples of entrepreneurship in health care? The most important is that entrepreneurs can solve many of the health care problems that critics condemn. Public policy should encourage, not discourage, these efforts.

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59. For example, Harvard Business School professor Regina Herzlinger, a strong proponent of consumer-driven health care, has proposed a regulatory body modeled on the U.S. Securities and Exchange Commission to oversee transparency in health care. See Regina E. Herzlinger, "Testimony Before the Subcommittee on Health of the House Committee on Ways and Means," July 18, 2006. Available at <http://waysandmeans.house.gov/hearings.asp?formmode=view&id=5139>. Accessed July 21, 2006.
60. This could be accomplished by federal legislation, or through a compact among the states.
61. Devon M. Herrick, "Convenient Care and Telemedicine."
62. The American Medical Association (AMA) has come out against prescribing medication over the Internet prior to a physical examination. Richard F. Corlin, President, American Medical Association, letter to the editor, "AMA to The Wall Street Journal: Shut Down Illegal Internet Pill Pushers," *Wall Street Journal*, November 6, 2001.
63. In most states, nurse practitioners must be supervised by a licensed physician to some degree. Some states merely require a small percentage of a nurse practitioner's case files be reviewed by a physician.
64. Rachel Burton, "Rapid Expansion of In-Store Clinics Has Lawmakers Watching," National Conference of State Legislators, Vol. 27, No. 3, August 7, 2006. Available at <http://www.ncsl.org/programs/health/shn/2006/sn473.htm>. Accessed November 10, 2006.
65. Devon M. Herrick, "Demand Growing for Corporate Practice of Medicine," *Health Care News* (Heartland Institute), January 1, 2006. One-third of the states have passed laws allowing some firms (such as hospitals and health plans) to hire physicians directly to practice on their behalf. In the rest of the states, the laws are either unclear or appear to support or restrict the practice to varying degrees. For a discussion, see Mary H. Michal et al., "Corporate Practice of Medicine Doctrine: 50 State Survey Summary," National Hospice and Palliative Care Organization and the Center to Advance Palliative Care, September 2006.
66. Nicole Huberfeld, "Be Not Afraid of Change: Time to Eliminate the Corporate Practice of Medicine Doctrine," *Health Matrix*, Vol. 14, No. 2, 2004, pages 243-91.
67. Ibid.
68. Kate Murphy, "What Pilots Can Teach Hospitals about Patient Safety," *New York Times*, October 31, 2006.
69. Research at NASA found most aviation accidents were human error and often could have been prevented by

better communication among the flight crew. A protocol called “crew resource management” is now standard training for all flight crews. See “New Surgeon-In-Chief Adapts Airline Safety Program to Improve Patient Safety,” *Medical News Today*, November 13, 2006. Available at <http://www.medicalnewstoday.com/medicalnews.php?newsid=56496>. Accessed December 14, 2006. Also see Eric J. Thomas and Robert L. Helmreich, “Will Airline Safety Models Work in Medicine?” in Marilyn M. Rosenthal and Kathleen M. Sutcliffe, eds., *Medical Error: What Do We Know? What Do We Do?* (San Francisco, Calif.: Jossey-Bass, 2002), pages 217-34.

⁷⁰ Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results* (Boston, Mass.: Harvard Business School Press, 2006).

⁷¹ John C. Goodman, President, National Center for Policy Analysis, “Health Savings Accounts,” Testimony Before the U.S. Senate Special Committee on Aging, May 19, 2004.

⁷² John C. Goodman, “Making HSAs Better,” National Center for Policy Analysis, Brief Analysis No. 518, June 30, 2005.

⁷³ John C. Goodman, “A Framework for Medicare Reform,” National Center for Policy Analysis, Policy Report No. 315, September 2008.

The NCPA is a nonprofit, nonpartisan organization established in 1983. Its aim is to examine public policies in areas that have a significant impact on the lives of all Americans — retirement, health care, education, taxes, the economy, the environment — and to propose innovative, market-driven solutions. The NCPA seeks to unleash the power of ideas for positive change by identifying, encouraging and aggressively marketing the best scholarly research.

Health Care Policy.

The NCPA is probably best known for developing the concept of Health Savings Accounts (HSAs), previously known as Medical Savings Accounts (MSAs). NCPA President John C. Goodman is widely acknowledged (*Wall Street Journal*, WebMD and the *National Journal*) as the “Father of HSAs.” NCPA research, public education and briefings for members of Congress and the White House staff helped lead Congress to approve a pilot MSA program for small businesses and the self-employed in 1996 and to vote in 1997 to allow Medicare beneficiaries to have MSAs. In 2003, as part of Medicare reform, Congress and the President made HSAs available to all nonseniors, potentially revolutionizing the entire health care industry. HSAs now are potentially available to 250 million nonelderly Americans.

The NCPA outlined the concept of using federal tax credits to encourage private health insurance and helped formulate bipartisan proposals in both the Senate and the House. The NCPA and BlueCross BlueShield of Texas developed a plan to use money that federal, state and local governments now spend on indigent health care to help the poor purchase health insurance. The SPN Medicaid Exchange, an initiative of the NCPA for the State Policy Network, is identifying and sharing the best ideas for health care reform with researchers and policymakers in every state.

**NCPA President
John C. Goodman is called the
“Father of HSAs” by *The Wall
Street Journal*, WebMD and the
National Journal.**

Taxes & Economic Growth.

The NCPA helped shape the pro-growth approach to tax policy during the 1990s. A package of tax cuts designed by the NCPA and the U.S. Chamber of Commerce in 1991 became the core of the Contract with America in 1994. Three of the five proposals (capital gains tax cut, Roth IRA and eliminating the Social Security earnings penalty) became law. A fourth proposal — rolling back the tax on Social Security benefits — passed the House of Representatives in summer 2002. The NCPA’s proposal for an across-the-board tax cut became the centerpiece of President Bush’s tax cut proposals.

NCPA research demonstrates the benefits of shifting the tax burden on work and productive investment to consumption. An NCPA study by Boston University economist Laurence Kotlikoff analyzed three versions of a consumption tax: a flat tax, a value-added tax and a national sales tax. Based on this work, Dr. Goodman wrote a full-page editorial for *Forbes* (“A Kinder, Gentler Flat Tax”) advocating a version of the flat tax that is both progressive and fair.

A major NCPA study, “Wealth, Inheritance and the Estate Tax,” completely undermines the claim by proponents of the estate tax that it prevents the concentration of wealth in the hands of financial dynasties. Actually, the contribution of inheritances to the distribution of wealth in the United States is surprisingly small. Senate Majority Leader Bill Frist (R-TN) and Senator Jon Kyl (R-AZ) distributed a letter to their colleagues about the study. In his letter, Sen. Frist said, “I hope this report will offer you a fresh perspective on the merits of this issue. Now is the time for us to do something about the death tax.”

Retirement Reform.

With a grant from the NCPA, economists at Texas A&M University developed a model to evaluate the future of Social Security and Medicare, working under the direction of Thomas R. Saving, who for years was one of two private-sector trustees of Social Security and Medicare.

The NCPA study, “Ten Steps to Baby Boomer Retirement,” shows that as 77 million baby boomers begin to retire, the nation’s institutions are totally unprepared. Promises made under Social Security, Medicare and Medicaid are completely unfunded. Private sector institutions are not doing better — millions of workers are discovering that their defined benefit pensions are unfunded and that employers are retrenching on post-retirement health care promises.

Pension Reform.

Pension reforms signed into law include ideas to improve 401(k)s developed and proposed by the NCPA and the Brookings Institution. Among the NCPA/Brookings 401(k) reforms are automatic enrollment of employees into companies’ 401(k) plans, automatic contribution rate increases so that workers’ contributions grow with their wages, and better default investment options for workers who do not make an investment choice.

The NCPA's online Social Security calculator allows visitors to discover their expected taxes and benefits and how much they would have accumulated had their taxes been invested privately.

Environment & Energy.

The NCPA's E-Team is one of the largest collections of energy and environmental policy experts and scientists who believe that sound science, economic prosperity and protecting the environment are compatible. The team seeks to correct misinformation and promote sensible solutions to energy and environment problems. A pathbreaking 2001 NCPA study showed that the costs of the Kyoto agreement to reduce carbon emissions in developed countries would far exceed any benefits.

Educating the next generation.

The NCPA's Debate Central is the most comprehensive online site for free information for 400,000 U.S. high school debaters. In 2006, the site drew more than one million hits per month. Debate Central received the prestigious Templeton Freedom Prize for Student Outreach.

Promoting Ideas.

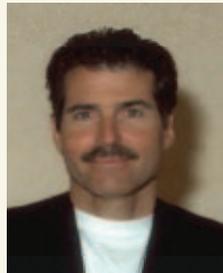
NCPA studies, ideas and experts are quoted frequently in news stories nationwide. Columns written by NCPA scholars appear regularly in national publications such as the *Wall Street Journal*, the *Washington Times*, *USA Today* and many other major-market daily newspapers, as well as on radio talk shows, on television public affairs programs, and in public policy newsletters. According to media figures from Burrelle's, more than 900,000 people daily read or hear about NCPA ideas and activities somewhere in the United States.

What Others Say About the NCPA



"The NCPA generates more analysis per dollar than any think tank in the country. It does an amazingly good job of going out and finding the right things and talking about them in intelligent ways."

Newt Gingrich,
former Speaker of the U.S. House
of Representatives



"We know what works. It's what the NCPA talks about: limited government, economic freedom; things like health savings accounts. These things work, allowing people choices. We've seen how this created America."

John Stossel,
co-anchor ABC-TV's *20/20*



"I don't know of any organization in America that produces better ideas with less money than the NCPA."

Phil Gramm,
former U.S. Senator



"Thank you . . . for advocating such radical causes as balanced budgets, limited government and tax reform, and to be able to try and bring power back to the people."

Tommy Thompson,
former Secretary of Health and
Human Services