REDUCING COST AND IMPROVING QUALITY IN HEALTH CARE

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Testimony to the

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Crossing the Quality Chasm in Health Reform

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Mr. Chairman and members of the committee, we offer these comments for your consideration as you debate solutions to the health care quality problem. Notably, policy makers seldom hear about free-market solutions during hearings on health care reform. Most experts suggest we should expand programs that are already underfunded and inefficient. Or they suggest creating new programs to replace the old ones, but which are built on the same faulty principles. Nevertheless, we hope you will consider the following free-market solutions in the context of improving and reforming the nation's health care system. We represent the National Center for Policy Analysis, a nonprofit, nonpartisan public policy research organization dedicated to developing and promoting private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector.

The Medical Care Marketplace

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. 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.

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, this results in 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.

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.

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.

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.

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. 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.

Health Markets without Third-Party Payers

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 this Committee is examining. In fact, these solutions are usually a necessary part of the entrepreneurs' business models. What follows are some brief 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.

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.

Solutions to Remove Obstacles to Health Care Entrepreneurs

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 this Committee is examining. Public policy should encourage, not discourage, these types efforts.

Some advocates suggest 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. 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.

Solution: Reward Quality Improvements in Medicare and Medicaid. 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 jump-start the entrepreneurial process in this way, private insurers are likely to follow suit. In this way, government could promote entrepreneurship, instead of stifling it.

Solution: 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. 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 that 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.

Solution: 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.

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. 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.

Solution: Remove 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.

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.

Solution: 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. 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. 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. Ownership is not restricted as much in other industries where very low error rates are required for safety. Take the airline industry, for instance. 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.

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.

Thank you for considering these comments.