JOHN C. GOODMAN

PRICELESS

CURING THE HEALTHCARE CRISIS

Oakland, California

The Independent Institute 100 Swan Way, Oakland, CA 94621-1428
Telephone: 510-632-1366 Fax: 510-568-6040 Email: info@independent.org
Website: www.independent.org

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Introduction

FORGET EVERYTHING YOU know about healthcare for a moment. I want to introduce you to a new way of thinking about it.

Our healthcare system is an example of what social scientists call *complex systems.* These systems are so complicated that no one person can ever fully grasp everything that is going on. As individuals, all we ever really see is a small slice of the system. That's usually the part of it we experience.

For example, the typical patient sees a doctor only a handful of times during any given year. A primary care doctor takes care of only about 2,500 patients. These interactions are important, but when we stop to realize that there are 300 million potential patients and 800,000 doctors, it's clear that the perspective of any one doctor or any one patient is extremely limited.

Other markets in our economy are also examples of complex systems, but healthcare is many times more complex than a normal market. The reason: in addition to garden-variety economic forces, the medical marketplace is institutionalized, bureaucratized, and extensively regulated. Doctors are heavily influenced by medical ethics and traditional ways of doing things. Almost everything they do is affected by third-party payer bureaucracies (insurance companies, employers, and government) and by regulations that are inconsistent, voluminous, and complex. They also face the ever-present threat of tort law litigation.

To make matters even more complicated, we have completely suppressed normal market processes in healthcare—in this country and all over the developed world. As a result, in healthcare few people ever see a real price for anything. Employees never see a premium reflecting the real cost of their health insurance. Patients almost never see a real price for their medical care. Even at the family doctor's office, it's hard to discover what anything costs. For something

complicated, like a hip replacement, the information is virtually impossible to obtain—at least in advance of the operation.

On the supply side, doctors and hospitals are rarely paid real prices for the services they render. Instead, they are paid on the basis of *reimbursement formulas*. Each payer may have a different formula. Medicare (for the elderly and the disabled) pays one set of fees. Medicaid (for the poor) pays another. BlueCross pays yet a third. All of the other insurers and all of the employer plans may also have separately negotiated fees. As a result, there really is no *market-clearing price* that brings supply and demand together in a way we experience in other sectors. Enormous amounts of money change hands every day in the medical marketplace, but most of the conventional rules of economics do not directly apply.

An interesting characteristic of complex systems is that when you perturb them (by passing a law, for example), there are always unintended consequences. The less you know about the system, the more unpredictable these consequences can be. Economic history provides numerous examples of governments that adopted policies in an attempt to improve things but ended up making the situation worse. Unfortunately, this happens in healthcare all the time.

For example, one of the goals of many public policies adopted in this country and around the world is to remove price as a barrier to care. Ideal health insurance is often said to be health insurance with no deductible or co-payment, making medical care essentially free at the point of delivery. Yet, if patients have no out-of-pocket costs their economic incentive will be to overuse the system, essentially consuming healthcare until the last amount obtained has a value that approaches zero. Also, if patients are not paying money for the services they receive, they're not likely to shop around for the best buy, so doctors, hospitals, and other providers will not compete for patients based on price, They will have no economic incentive to keep costs low—the way producers behave in other markets. To the contrary, the incentive of the providers will be to maximize against the payment formulas in order to enhance their incomes.

Well-intentioned public policies designed to make healthcare affordable for individuals, therefore, have had the surprising effect of causing healthcare spending to become unaffordable for the nation as a whole. Rising healthcare spending is the principal cause of our out-of-control federal deficit. It is bankrupting cities, counties, and state governments. It has created huge un-

funded liabilities for some of our largest corporations. It is contributing to the stagnation in worker take-home pay. It can potentially bankrupt the families of individuals who have the misfortune to become ill—even those with health insurance.

Another well-intentioned public policy initiative—adopted by some states—is to try to make health insurance affordable for people with pre-existing conditions by requiring insurers to charge the same premium to all buyers, regardless of health status. Yet, this legislation has the unintended consequence of encouraging people to remain uninsured until they get sick. As healthy people drop out of the market and only people with health problems remain, the premium needed to cover the insurers' cost begins to soar. In the state of New York, this sort of regulation has produced staggeringly high premiums. For a run-of-the-mill individual policy, United Healthcare Oxford charges a premium of $1,855.97 a month, or more than $22,000 a year. For a family, the premium is $5,707.11 per month, or more than $68,000 a year.[1] A policy designed to make insurance affordable, therefore, is pricing thousands of people out of the market.

Federal health programs provide other examples of unintended consequences of public policies foisted on a complex system. In 1965, Congress passed Medicare in an attempt to increase access to healthcare for the elderly and improve their health status. Members of Congress believed they could do so without any material impact on the rest of the healthcare system. Yet MIT professor Amy Finkelstein has discovered that the passage of Medicare had no effect on the health of the elderly—at least as measured by mortality—but the additional spending set off a bout of healthcare inflation for all patients—one that never subsided.[2]

In 2003, Congress passed a Medicare drug benefit, largely out of concern that senior citizens couldn't afford the coverage themselves. Since the new program (Medicare Part D) had no funding source, Congress created a $15.6 trillion unfunded liability for the federal government, looking indefinitely into the future—more than the unfunded liability in Social Security.[3] Yet economist Andrew Rettenmaier discovered that only 7 percent of the benefits actually bought new drugs for seniors. The other 93 percent simply transferred to government (and taxpayers) the bill for drugs the elderly or their insurers were already buying.[4] Only one in every thirteen dollars represented a new drug purchase. Interestingly, the help given to the small number of people who were

not otherwise getting medications actually reduced Medicare's spending, as drugs were substituted for more expensive doctor and hospital therapies.[5] But this profit on the truly needy was overwhelmed by the cost of giving the benefit to those who didn't need it—a cost that has created an enormous obligation for current and future taxpayers.

Here are two other unintended consequences of health policies designed to make healthcare free at the point of delivery. In other markets, producers don't compete only on price. They compete on quality as well. In healthcare, however, it appears that when providers don't compete on price, they often don't compete on quality either. That may be one reason why critics find that the quality of care we receive (including the very large number of avoidable errors and other adverse medical events) falls far short of what we would expect in a normal market.

Also, in most markets, we pay for goods and services with both time and money, and producers and sellers understand that we value our time as well as our pocket book. Public policies designed to suppress the role of money as a medium of exchange in the medical marketplace, however, have had the inadvertent consequence of increasing the importance of waiting times and other non-price barriers to care. These efforts to *increase* access to care may well have *decreased* access instead by making people wait longer to get appointments and to see the doctor once they reach her office.

How We Are Trapped

The premise of the book is that most of our problems arise because we are trapped. We are caught up in a dysfunctional system in which perverse economic incentives cause all of us to do things that raise the cost of care, lower its quality, and make access to care more difficult. Perverse incentives are faced by everyone: patients, doctors, nurses, hospital administrators, employees, employers, and so on. As we interact with the system, most of us spot ways to solve problems. We see things we could individually do to avoid waste and make care less expensive, for example. But the system generally penalizes us for doing the right things and rewards us for doing the wrong things. Anything we do as individuals to eliminate waste generally benefits someone other than ourselves.

So what's the answer? Let people out of the trap. Liberate them from the dysfunctionality that is causing us so much trouble.

This message is precisely the opposite of what you are likely to hear from other health policy experts—on the right and the left. The conventional view is that we have too much freedom, not too little. Doctors are said to have too much freedom to provide treatments that are not "best practice" or that are not "evidenced-based." Patients are said to have too much freedom to patronize doctors and facilities with inferior performance records.

Hence, the conventional solution: put even more restrictions on what doctors can do and where patients can go for their care. Ultimately, the conventional answer to the country's health policy problems is to have government tell doctors how to practice medicine and to tell patients what care they can have and where they can get it.

The biggest problem with this approach is that it would leave us even more trapped than we currently are. Incentives would be even more perverse. We would have a plan designed by folks in Washington. But 300 million potential patients, 800,000 doctors, almost 2.5 million registered nurses, and thousands of others working in the system would find it in their self-interest to undermine the plan. My answer is just the opposite. I want all those patients and all those doctors to discover it is in their self-interest to *solve problems*, not *create them*.

Under the conventional approach, every doctor, every nurse, every hospital administrator will get up every morning and ask, "How can I squeeze more money out of the payment formulas today?"

My answer is just the opposite. Under the approach I will recommend, all these people will be encouraged to start each day by asking, "How can I make my service better, less costly, and more accessible to patients today?"

Getting Out of the Trap: Emerging Entrepreneurs

That we need a new way of thinking is almost self-evident. After all, healthcare has been recognized as one of our most important national policy problems for over a quarter of a century. It has spawned thousands of conferences, briefings, speeches, legislative hearings, books, essays, and scholarly articles. It provoked legislation that envisions a complete overhaul of the system in just a

few years. Yet even with all of this, we are no closer to a genuine solution to our problems than we were twenty-five years ago.

In complex systems, there are always unmet needs and problems to be solved. The more dysfunctional the system, the more numerous are the unmet needs and the more severe are the problems. In other sectors, needs to be met and problems to be solved are the fertile ground from which entrepreneurs emerge. Where is healthcare's equivalent of a Bill Gates or a Steve Jobs?

The answer: There are literally thousands of entrepreneurs in healthcare. I meet them every day. In fact, I believe I can safely say that there is no serious problem in the business of health that is not already being substantially solved in some way by an entrepreneur somewhere in the system. Unfortunately, these efforts tend to be scattered and limited. Most of the time they run into three major barriers: insurance companies, employers, and government.

These are the three entities that pay most of the healthcare bills. They are the *third-party payers.* (The first two parties are the doctor and the patient.) With respect to healthcare, they tend to be bureaucratic, wedded to tradition, and resistant to change. They are, in a word, the entrepreneur's nemesis.

Take the subject of hospital costs. It is well known that the cost of procedures varies radically from hospital to hospital, as does the quality of care. So why not take advantage of this fact? In this book, I am going to argue that a version of what some call *value-based* health insurance could cut the typical health plan's hospital costs in half. How does it work? The insurer pays the cost of care at a low-cost, high-quality facility (which may require the patient to travel) and only that amount. Patients are free to go to another facility but must pay the full extra cost of their choice.

Now, I wasn't the first person to think of this. In fact, an Austin, Texas-based company, Employer Direct Healthcare, is offering employers a variation on that idea at this very moment. They negotiate rates with select hospitals that are from one-third to one-half lower than what other health insurers are paying. Most insurers are at the opposite end of the smart-buying spectrum, however. BlueCross of Texas, for example, not only does not steer patients to one hospital rather than another, there is not a single hospital in Dallas that is not in its network.

Part of the reason why the insurers are so resistant to cost-reducing innovations is that many of their employer clients are also resistant. The typical client

of Employer Direct Healthcare, for example, waives the deductible and co-payment for patients who choose the low-cost, high-quality facilities, but that is the full extent of the financial incentive. A step in the right direction perhaps, but a timid one. An aggressive strategy would be to let the employee pay the full extra cost of their choices.

Of the three third-party payer institutions, government is by far the worst at resisting entrepreneurship—even when the government itself is implementing radical change. As part of the Affordable Care Act (ACA), for example, states are to establish health insurance exchanges, allowing individuals to electronically select their health insurance from among competing plans. The federal government is offering millions of dollars to set up these exchanges. In some states, officials are arguing about how to spend the money, and in other states, they are actually refusing the money on the grounds that it amounts to acceptance of a health reform they do not like.

But why does any state need to spend millions to set up an exchange? Did you know that eHealth already has an electronic exchange, and more than 1 million people have health insurance purchased online through its system? The Obama administration is asking fifty state governments to spend a great deal of money to invent something that a private company has already discovered—and is ready to implement for the government for pennies on the dollar.

The administration is also spending millions of dollars trying to encourage electronic medical records. But did you know that eHealth already offers many of its customers an electronic medical record (including a record of doctor visits, prescriptions taken, etc.), based on insurance payment records?

Although we often associate the term *entrepreneur* with profit seeking, the healthcare field is teeming with innovators who are largely motivated by altruism. Take Dr. Jeffrey Brenner of Camden, New Jersey.[6] In any other field, Brenner would be a millionaire, but because he's in healthcare, he doesn't know how he's going to make ends meet. Like entrepreneurs in every market, Brenner thought outside the box. He discovered an ingenious way of lowering healthcare costs: focus on the "hot spots" of medicine—the high-use, high-spending patients—and solve their problems with unconventional care.

Brenner discovered that of the 100,000 people who used Camden's medical facilities over the course of a year, only 1,000 people—just 1 percent—accounted for 30 percent of the costs. He began with one of them: Frank Hendricks (a

pseudonym), a patient with severe congestive heart failure, chronic asthma, uncontrolled diabetes, hypothyroidism, gout, and a history of smoking and alcohol abuse. He weighed 560 pounds. In the previous three years, he had spent as much time inside hospitals as he spent outside them.

Some of what Brenner did to help Hendricks was simple doctor stuff, but a lot of it was social work. For example, Brenner and his colleagues helped Hendricks apply for disability insurance so that he could leave the chaos of welfare motels and have access to a consistent set of physicians. The team also pushed him to find sources of stability and value in his life. They got him to return to Alcoholics Anonymous, and when Brenner found out that Hendricks was a devout Christian, he urged him to return to church. As a result, Hendricks's health improved, and his medical expenses plummeted.

Following that success, Brenner formed the Camden Coalition to apply his methods to more patients. He tells me he can drive down the streets of Camden, point to entire buildings, and say how much the people who live there are costing the taxpayers. By targeting these patients in unconventional ways, Brenner is saving millions of dollars for Medicare and Medicaid. Were others able to do the same thing in other cities, the savings for taxpayers would be huge.

Now for the bad news. How much does Medicare reward Brenner for all the savings he creates for our nation's largest health plan? Zero. How much does Medicaid pay for all the savings it realizes? Not a penny. In fact, Brenner is able to do what he does only because of grants from private foundations.

Getting Out of the Trap: Overcoming Unwise Policies

Like many other providers of low-cost, high-quality care, Brenner and his colleagues leave tons of money on the table when they fail to practice medicine in conventional ways. Of the thousands of tasks that Medicare pays doctors to perform, social work is not among them. Brenner's attempts to get Medicare and Medicaid to pay him in a different way have all drowned in a bureaucratic morass, even as Medicare is spending millions on pilot programs and demonstration projects "to find out what works."

Experiences just like Brenner's are repeated again and again, day in and day out, around the country. No one knows if Brenner's techniques can be replicated (any more than we know if the medical practices of the Mayo Clinic or the

Cleveland Clinic can be replicated). But there's one way to find out: Let Brenner out of the trap. How do we do that? By letting him become rich. Rich? Yes, rich.

The federal government should offer to let Brenner and his colleagues keep twenty-five cents of every dollar they save the government. Then let every other doctor, nurse, social worker, hospital administrator, and so on in the country know that the government is willing to change the way it pays for care. The message should be: If you can save taxpayers money, you can make money—the more money you save us, the more you earn for yourself. Let a thousand millionaires bloom.

Sadly, the trend of federal health policy right now is in the opposite direction. Not only will it not let Brenner out of the trap, it will make the trap more confining. Under the new health reform law, doctors are being encouraged to join Accountable Care Organizations (ACOs), where a federal bureaucracy will virtually dictate the way medicine is practiced.

Brenner, in fact, is trying to get his organization qualified as an ACO. In my opinion, this is a mistake. Under the new rules, bureaucrats will ask: Did Brenner have the prescribed electronic medical record? Did he follow the checklist of inputs ACOs are supposed to follow? Did he manage all of the care—including hospital care? Sadly, the answers are no, no, and no.

It is almost impossible for an entrepreneur to flourish in an environment that fundamentally dislikes entrepreneurship. Fortunately for the innovators, however, patients are paying for more healthcare bills out of their own pockets. And wherever we find health markets dominated by patients paying for care directly, entrepreneurship is thriving.

Getting Out of the Trap: Emerging Markets

In fields as diverse as cosmetic surgery and LASIK surgery, we are discovering that healthcare markets can give patients transparent package prices and that costs can be controlled—despite a huge increase in demand and enormous technological change (of the type we are told increases costs for healthcare generally). For services as diverse as walk-in clinics and mail-order drugs, we are seeing that price competition is possible and that price competition promotes quality competition as well. In the international market for medical tourism, we are discovering that almost every type of elective surgery can be subjected to the

discipline of the marketplace; that discipline is increasingly evident within our borders in the emerging market for domestic medical tourism, where patients willing to travel to other cities can find cheaper, higher-quality care.

In each of these cases, new products and new services have cropped up to meet the needs of patients spending their own money. These are products and services that were made possible precisely because the third-party-payer bureaucracies were not standing in the way. If the private sector is left free to continue with such innovations, there is much more to come.

Among the current buzzwords in Washington policy circles are such terms as electronic medical records, medical homes, coordinated care, integrated care, and so on. To hear the policy wonks tell it, the ACA is designed to bring all these new ideas to the practice of medicine—prodded by the guiding hand of government regulators.

But did you know that sensible, workable electronic records systems (including the ability to electronically prescribe drugs) have been in use for over a decade by walk-in clinics, by private telephone and email consultation services, and by concierge doctors (who give their patients more time, more services, and special attention) without any guidance from Washington or from any employer or insurance company? Did you know that sensible, workable medical homes—together with diverse doctors providing integrated, coordinated, low-cost, high-quality care—have been emerging in the private sector for some time, without any federally funded pilot program or any advice, encouragement, or harassment from any third-party payer?

I stress the words *sensible* and *workable* because in the hands of impersonal bureaucracies, shielded from marketplace competition and subject to pressures from every special interest group imaginable, we are likely to get systems that are neither sensible nor workable.

Liberated from the confinement of legal impediments and suffocating bureaucracies, doctors, patients, hospital personnel and profit-seeking entrepreneurs are perfectly capable of solving our most serious health policy problems. All they need is the freedom to be able to do so.