James L. Holly, M.D.

The Failure of Medicare and Market Forces

Dr. Tolbert:

It was surprising and pleasant to receive your response to my note to you. What is missing, often, from public discourse is a polite dialogue between people whose differences are significant but who can respect the person and position of others. Thank you for that. As you will see below, in my judgment, your subscription-fee-based care still has deficiencies.

Everyone Takes His Side in Favor of the Many or of the Few

Your statement, "Letting the free market set prices, and then the government follow, historically has resulted in a much better allocation of resources," is at the root and the hub of our differences. "Free markets" have made America great but even free markets have their limitation. Those who are unable to participate in a market place will have no influence upon the activity of that market and conversely, the market place will take no note of those "non-participants" except as some external force requires the market place to include those who, due to no resources or skills, cannot participate independently. The former is the arena of entrepreneurial markets; the latter is the legitimate place for regulation. It is often difficult to categorize a person with simple names. I am a "social liberal; but, I am a "fiscal conservation," and to make matters worse, I am a "theological fundamentalist." In such a case, dialogue is critical to clarify our principles and solutions.

In their later years, John Adams and Thomas Jefferson, bitter political adversaries for most of their lives, developed a warm friendship. In an 1813 letter to Adams, Jefferson said, ""To me... it appears that there have been differences of opinion and party differences, from the first establishment of government to the present day, and on the same question which now divides our own country; **that these will continue through all future time; that everyone takes his side in favor of the many, or of the few**, according to his constitution, and the circumstances in which he is placed... that as we judge between the Claudii and the Gracchi, the Wentworths and the Hampdens of past ages, so of those among us whose names may happen to be remembered for a while, the next generations will judge favorably or unfavorably according to the complexion of individual minds and the side they shall themselves have taken; that nothing new can be added to what has been said by others and will be said in every age in support of the conflicting opinions on government; and that wisdom and duty dictate an humble

resignation to the verdict of our future peers." (emphasis added) The reality is that these are not pure divisions as the market place often operates to the financial benefit of the few but to the comfort of the many.

It is, I think, a reality that the market place has been a colossal failure in bringing equitable solutions to the healthcare arena. Remember the 1977 "moral test of a government" enunciated by Hubert Humphrey. In a simpler time, when community was the principle organizing force of society, benevolence and charity often equilibrated the unequal distribution of resources which the market place ignored. As society became more complex with less integration, disparities grew and grew. When those disparities were measured by how big a house or how nice a car a person owned, they were relatively inconsequential. But, when those disparities were in regard to access to healthcare, they increasingly represented a failure of a society's covenant with all members of that society.

The Failures of Medicare

Your statement, "Currently, medical prices in the United States are set by CMS. CMS sets Medicare prices, and then private carriers base the prices they pay off of those Medicare prices. This is opposite from how the majority of the rest of our economy operates. Usually, our free market sets prices, and the government uses those prices as a baseline when deciding what to pay for goods and services," is true, but it ignores the fundamental flaw in Medicare from its creation in 1965. It has only been in the past 20 years that Medicare has sought to control the total, annual expenditure for beneficiaries, but it did this only by trying to control the unit cost of procedures, tests or services.

While in other nations, an element of quality was added, in the United States, the unit cost was decreased, but there was no assessment of the quality or the necessity of the services delivered. For instance in England, if a certain percentage of the cardiac catherizations performed by a provider were normal, that provider's privilege to perform that service was either limited or eliminated. In the United States, if 80% or even more of the catherizations done by a provider are normal, nothing is done. Because the market place had no effective or valid way of measuring the appropriateness of a service and because there were no standards established, even with the decreasing of the unit cost of services, the total cost to CMS went up each year.

The current primary health crisis both in manpower and in reimbursement for services was created by CMS' shortsighted reimbursement principles which greatly valued procedures and tests and undervalued the counseling, management and coordination of services in primary care. It is probable that this was done because it is easier to measure one of these and two of those, than it is to quantify trust and confidence a patient has in a provider and then to quantify the value in quality of care and control of cost of those relationships.

Healthcare reform efforts currently often are an attempt to correct the errors of CMS' past decisions. Traditionally, CMS has paid different fees for the same services depending upon where those services are delivered. For instance, a service delivered in a healthcare provider's office is paid "X" and the same service delivered in a hospital emergency or even in an ambulatory centered owned by a hospital is paid "1.5X." This created opportunities for entrepreneurial providers to profit, without improving the quality of care and/or without expanding access to care, simply by changing the name or legal structure of the venue in which the services are being delivered. This is an anti-market place policy. It drives up cost and does nothing for healthcare transformation. Currently, there is a move among hospitals to buy or "lease" medical practices, which allows them to legally pay providers for their relationship and to charge more for the same services.

Subscription medicine does nothing to control the total cost of healthcare, but in fact will increase that cost, and subscription medicine does nothing to address the over utilization or the inappropriate utilization of healthcare services.

Medicare Driven by Legality Rather than Science

Early in Medicare, the dysfunction of market principles was seen. For instance, if a patient needed to have an upper gastrointestinal x-ray (Upper GI), CMS would only pay for that if it was done as an inpatient. It did not take the dysfunctional market long to know that if a patient was put in the hospital when there were no regulations on admission decisions --- CMS would pay for the UGI. A test, the UGI, which might at that time cost $75 dollars, done in the hospital so that "insurance would pay for it," now cost $986. It should have surprised no one that the expected cost of Medicare in the first 25 years of its existence which was expected to be "X" was almost "10X."

Being a government program, Medicare was also subject to the market forces of lobbyists and other pressure groups. Increasingly, healthcare policy makers encouraged the application of science, in the form of evidence-based medical decision making, on the practice of medicine. Yet, because of the politics of healthcare an artificial and irrational market force decisions, which often were adverse to public health, were and are made. In 2010, I attended a lecture by a Senior Executive at CMS. At the end of the lecture there was time for
questions. At the end of this dialogue, I asked, "Sir, you and CMS are committed to evidence-based medicine?" The answer was, "Yes." "And, sir, you and CMS are committed to changing the cost curve of healthcare?" Again, the answer was "Yes." Finally, I asked, "Then why is CMS paying billions of dollars a year for care which is not only not supported by scientific evidence but which actually contradicts scientific evidence?" The executive said, "What are you talking about?" I responded, "Chiropractic services!" His response, identified the market forces which drive CMS decision making. He said, "They are paid for because the services are legal." I was shocked and said, "Ah, I thought you were in favor of evidence-based medicine but you are really in favor of procedures and care which are legal, but not necessarily scientific."

The market forces driving healthcare costs are capricious and are often irrational when left to a laissez faire market forces without regulation and without being driven by principles. Even healthcare, public policy makers are subject to those capricious and irrational forces. The solution is simple; if the services are legal and if they are not evidence-based, and if a patient wants them, they can have them, if they wish to pay for them. Ultimately, the cost curve of health care is only going to be affected by limiting payments to evidenced-based medicine and by measuring quality and appropriateness of services.

Healthcare Market has unique Features

Your statement, "Letting the free market set prices, and then the government follow, historically has resulted in a much better allocation of resources," ignores the fact that the healthcare market is unique. The automobile market is driven largely by forces of public opinion, desire, aesthetics, etc. However, still there are non-market, regulatory safety demands placed on the automobile market for public safety and now for environmental concerns. The principle difference, however, between the automobile market and healthcare market is that one is a consumer item where the buyer has a choice as to which care to buy based on their ability to pay and or their need; and in the other, healthcare is a market which is not driven mostly by personal choice but by life and death necessity. Second, the healthcare market is often a mystery to the consumer. One healthcare organization publicizes its assurance of integrity and its care for its reputation, while at the same time the same organization has been repeatedly sued by its partners for fraud and dishonesty and lack of integrity. Unfortunately, the clever and pleasant presentation of sales promotion by the organization is delivered in one venue and the accountability for illegal and immoral behavior is in another and the two do not cross in the market place. Third, in traditional markets measurement of quality and value are relatively objective, but in healthcare no such objectivity currently exists. Car manufacturers publish safety records for their vehicles; healthcare providers only recently have been publishing safety and quality metric outcomes for their services. And, sometimes those publications are so obscure that it is almost impossible to understand what they mean.

Subscription Medicine does nothing to improve care

Evidence-based medicine is giving providers and consumers objective measures for process and outcomes in healthcare quality. Patient-Centered Medical Home (NCQA, AAAHC, URAC, Joint Commission) are providing objective criteria for measuring the quality and effectiveness of the care delivered in various venues. CMS and other insurers are experimenting with providing extra per-member-per-month reimbursement to practices which prove their outcomes. Subscription-fee-based care provides no such mechanism. At the very best, subscription medicine might provide more access to care, but only for those who can afford it.

Subscription Medicine provides no required funding for quality improvement initiatives. If a primary care provider receives a $60 per member per month subscription fee, in that there is no quality performance tied to the receipt of that money, a provider with 1,000 subscribers can

increase his/her income by $720,000 without a commensurate improvement in the quality of care received by the patients. Like screening and preventive medical initiatives there is an initial cost increase to quality improvement in care with a payoff for a sustained effort over a long period of time.

Subscription Medicine fees are a net increase to the cost of healthcare with no mechanism for slowing the growth-curve of cost, or for requiring the transformation of care. Even if insurance costs are adjusted to remove the cost of primary care from the premium, the subscription cost will be a net increase in the total cost of healthcare, particularly if, as you state, you intend for CMS ultimately to pay that fee. Because nothing has been done to the payment structure for primary or specialty care, there is no mechanism in your model for the fulfillment of the Triple Aim.

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