CHAPTER 17: THE RETAIL SECTOR WILL SAVE US—IF WE LET IT

March Madness

If health care operated more like retail, lots of things would be different. There would be advertising and periodic sales. Loss leaders would get people in the door. Providers would open early, stay late, and compete for patients by offering services that are cheaper, better, and faster. Parking would be free and convenient. Providers would bundle goods and services to facilitate one-stop shopping. Many of these things are happening already in the part of the health care sector where consumers control the money.

Dr. Doug Stein, a Florida urologist, does vasectomies: 50 a week; 200 a month; 2,500 a year; more than 31,000 in his career.[1] To attract patients from across the state, he advertises on billboards and works out of multiple locations. He also advertises his price—$590. For his trouble, he pulls in about $300,000 a year—not the highest salary for a physician, but far more than most Americans make.

In advertising for patients, Dr. Stein is far from unique. One can find billboards touting vasectomies in many states. Occasionally, advertisements also appear on TV. In an especially creative effort to bring patients into its offices, Virginia Urology (VU) takes advantage of men's love of sports. Want an excuse for sitting on the couch and watching the NCAA March Madness basketball tournament for three days? Get a vasectomy. VU will

give you a note explaining that you need time off from work and a special recovery kit, which includes a free pizza. And your wife won't nag you either. She'll be thrilled that she no longer needs to worry about birth control. If VU's tactic sounds silly to you, don't go into advertising. Demand spikes every year when the tournament gets underway.[2] The campaign is so successful that other doctors are copying it.[3]

Dr. Stein, the Florida urologist, also brings in patients by having sales. Men who visit his clinics on days when he trains other physicians get $100 off.[4] In Indiana, the Valparaiso Vasectomy Clinic also offers vasectomies at half off: "Get one side done & the other is FREE," its billboard screams. Never let it be said that urologists lack a sense of humor.

Why Don't Hospitals Have Sales?

Still, at least vasectomy clinics have sales. Hospitals never do. They don't offer half-off specials, even though that might be a good way of attracting patients who are considering elective procedures. And they don't offer discounts to patients treated by medical students. This is strange because everyone knows that experience matters. That's why Dr. Stein charges less when patients are treated by trainees who haven't performed thousands of vasectomies. He also recognizes a good business opportunity. Vasectomies are elective procedures. To patients who want them but can't afford his standard price, the $100 discount may make the difference between having the procedure or an unwanted pregnancy.

The idea that hospitals should have sales strikes many people as funny. Our proposal, offered in 2001, that health care providers should be paid for curing patients, not for performing procedures, did too.[5] We suggested, for example, that a surgeon should receive a low fee if a patient died on the operating table or experienced an avoidable complication, and a higher one if the operation was a complete success. Our academic colleagues scoffed at the idea. Result-based compensation arrangements were almost unknown at the time, and the success of medical procedures depended on so many variables, they told us, that doctors and hospitals could not possibly guarantee their work. Today, "pay-for-performance" arrangements—known by the acronym P4P—are common. Even Medicare and Medicaid

use them. Ideas for reforming the payment system sometimes gain traction quickly, even if they seem nutty when proposed.

Besides, lots of health care providers attract business by offering discounts on their regular prices. Even hospitals do, when insurers and patients are willing to haggle. Sales and the chargemaster-based approach to pricing that hospitals normally employ are both forms of price discrimination, where sellers tailor their charges in light of purchasers' willingness to pay. The difference is that discounts off chargemaster prices are negotiated in secret while sales, which occur in public, convey more information, facilitate competition, and enable consumers to capture more of the gains from trade.

In the retail health care sector, sales are everywhere. Hospitals' opaque pricing practices seem odd by comparison.

Flu Shots as Loss Leaders

Consider the humble flu shot, which many retailers sell for $30 or less.[6] At Costco, they're only $15, a price that barely exceeds the $9–$10 wholesale cost of the medication. But the wheeling and dealing doesn't end there. Some retailers sell flu shots below cost by offering discounts on other items to customers who get them. At Target, an inoculation comes with a coupon good for 5 percent off a day of shopping. Randalls offers 15 percent off groceries. CVS's shopping discount is 20 percent. In 2016, Walmart dispensed flu shots for free. For many retailers, flu shots are teasers, not profit centers. They're ways of luring customers into stores, where they will see other things they want to buy.

Flu shots are simple procedures, but health care retailers offer specials on bigger-ticket items too. Consider treatments for spider veins and other cosmetic procedures. Varicose Vein Solutions, a Chicago clinic, ran a Groupon deal that cut its regular price for spider vein removal by half. Ariba Medical Spa, located in Freemont, California, offered the same deal. Its website also runs specials on Botox injections, Juvederm (another type of anti-wrinkle injection), and other services.[7] Looking further on Groupon, we found deals for laser skin treatments, Botox injections, LipoLaser, and liposuction. Dentists ran specials too, on procedures like routine exams,

cleanings, whitening procedures, veneers, Invisalign tooth straightening treatments, titanium implants, abutments, and crowns.

Hospitals offer hundreds of elective procedures, including vasectomies, vein treatments, liposuctions, vaginal rejuvenations, tummy tucks, arm lifts, breast lifts, surgery for droopy ears and ear restorations following earlobe piercings, removal of skin lesions, and Botox and Restalyn injections. But their cash prices are usually hidden and they never have sales. Isn't that *stranger* than our suggestion that providers should compete on price?

In the Retail Sector, Prices Decline

You may be thinking that the procedures we've discussed to this point are still too simple. Hospitals are places where doctors perform complex, invasive surgeries that require general anesthesia, heart and breathing monitors, and other fancy equipment. The fact that doctors and dentists who sell relatively simple services in the self-pay sector offer discounts may not say much about the pricing practices that hospitals should apply to more serious operations.

The observation that "a vasectomy is a vasectomy" provides one answer to this challenge. A man who wants a vasectomy can get one cheaply at one of Dr. Stein's clinics or much more expensively at a hospital, where a surgeon with far less experience will perform the procedure. The location shouldn't affect the price much, but it does. A survey of providers in New York City uncovered prices ranging from $300 to $3,500. A Planned Parenthood clinic was the cheapest, while a no-needle, no-scalpel procedure performed at the Weill-Cornell Medical Center was the most expensive.[8]

A second answer is that retail outlets also have sales on complex medical procedures. Consider breast augmentation, an invasive surgery performed under general anesthesia. The Coral Gables Cosmetic Center, located in South Florida, once held a summer sale during which it offered breast augmentation surgery with saline implants performed by board-certified plastic surgeons "for just $2,800." The price included implants, anesthesia, blood work, and operating room costs.[9] In late 2013, Westlake

Plastic Surgery, located in Austin, Texas, announced a winter special. Until January 1, 2014, women wanting to look their best at holiday parties would receive "$1,200 off" breast augmentation surgery performed by Dr. Robert Caridi, a board-certified plastic surgeon with over 25 years of experience.[10] The reduced prices—$4,600 for saline implants and $5,600 for silicone—covered all charges, including his fee and the fee of a board-certified anesthesiologist as well as the use of his operating room.

Many breast augmentation, reconstruction, and reduction surgeries are performed at hospitals. But unlike retail providers, hospitals never have sales. Why is that? In the retail segment of the health care market, patients are price sensitive because they spend their own dollars. Low prices attract customers, so retail providers offer discounts and other incentives that bring patients in. Hospitals, by contrast, gear their pricing strategies toward insured patients, the most lucrative ones for them to treat. Insured patients aren't price sensitive because they bear only a small fraction of the cost of the services they receive: about 3 percent of hospital-related costs, on average. That's why hospitals rarely post their prices or have sales.

The contrast between hospitals and retail providers could hardly be starker. Hospitals' prices are industry secrets that are negotiated with insurers behind closed doors. Retailers' prices are publicly disclosed hard numbers that make it easy for patients to comparison shop. The result? Hospital services cost more and more every year, while the cost of retail services holds steady and sometimes declines.

The now-classic example of declining retail prices is LASIK, an outpatient surgical procedure that ophthalmologists perform to improve patients' vision. LASIK isn't covered by insurance, so patients pay for it directly and price competition is fierce. Google "LASIK" and you'll find lots of advertisements from doctors who offer the service. Many ads include information about prices—the very information hospitals claim to be unable to provide about other surgeries. You can also find LASIK Groupons galore, and there are price-comparison websites that help explain doctors' pricing strategies.[11] If you decide to have LASIK, you'll know the cost up front and you won't have to worry about hidden charges or being gouged.

You'll also save money on LASIK if you buy it today because, from 1996 to 2005, the real price of the service fell by nearly 30 percent.[12]

Competition made LASIK *cheaper*, thereby making it more easily available to millions of Americans who would otherwise have done without it or, at least, put it off until they could afford it. In real dollars, cosmetic surgery became less expensive too. From 1992 to 2013, "the price of consumer goods, as measured by the inflation rate, increased by about 64 percent. . . . Yet, during this same period, the price of cosmetic medicine rose only about 30 percent—less than half of the consumer price increase."[13] At the same time, demand boomed. More than 10 times as many cosmetic procedures are delivered today as were performed two decades ago.[14]

Why did LASIK and cosmetic procedures become more affordable? Consumer demand, first-party payment, and competition. As Devon Herrick, a leading commentator on retail health care, explained:

> Doctors who perform cosmetic services quote package prices, and generally adjust their fees to stay competitive. The industry is constantly developing new products and services that expand the market and compete with older services. As more cash-paying patients demand procedures, doctors rush to provide them. There are few barriers to entry in cosmetic surgery. Any licensed physician can enter the field.[15]

When we pay for health care the same way we pay for other services—by spending our own money instead of an insurer's—good things happen: prices fall and quality improves as providers compete for business.

By comparison, over the same period that LASIK and cosmetic surgery became cheaper, the prices of medical services covered by insurers rose at two to three times the rate of inflation.[16] Can you think of a single hospital-provided service whose price, like LASIK, is 30 percent lower today than it was a decade ago? We can't. Prices rise even for services that use old technologies. Computers are faster and cheaper today than ever before, but the same cannot be said for magnetic resonance imaging (MRI), CT scans, electrocardiograms, or ultrasound tests when performed in hospitals.

Competition has also moderated or driven down prices for in vitro fertilization (IVF), a service that helps women get pregnant but that patients must usually pay for directly. In 2010, Marcie Campbell, a St. Louis resident, could not afford the going rate for IVF in her area,

which was about $20,000 plus several thousand more for medications. Then Dr. Elan Simckes opened Fertility Partnerships and started offering an inclusive IVF package for only $7,500. Dr. Simckes' thinking was Economics 101—competition among IVF providers would bring prices down. Unfortunately, there are limits on how effective this strategy can be, at least as long as the American Board of Obstetrics and Gynecology caps the number of new doctors that can be trained in the field each year: "The competition in fertility cannot develop if an organization can limit the number of people providing the service."[17]

Naturally, doctors with established IVF practices in St. Louis "felt threatened by the pricing model" and went ballistic. They shouted loudly that patients shouldn't choose providers on the basis of cost and that IVF services shouldn't be treated like an industry. Taking a jab at retail medicine, one of Dr. Simckes' competitors fumed, "This isn't Walmart. Embryos aren't like toothpaste." But what counts in the IVF world is the frequency with which live births occur after embryos are implanted, and on that metric, Fertility Partnerships outperformed the doctor who was complaining.[18]

Fast forward to 2016. Fertility Partnerships is still doing business in St. Louis, but now it has competition. The Missouri Center for Reproductive Medicine (MCRM) offers its inclusive premium package, IVF Gold, for less than $10,000 and also boasts of providing "medication protocols that yield successful outcomes at a cost as low as $1,000."[19] MCRM also offers discounts to military personnel, first responders, educators, and medical-service employees.

Other discounters are also entering the field, and some of them are bundling services even more attractively. Typically, IVF clinics bill for their services separately from the pharmacies they send their patients to for fertility-enhancing drugs. Pharmacies' charges add $3,000–$6,000 to the final tally. WINFertility, a company that "manages the treatment of thousands of infertility patients annually," makes one-stop shopping possible at an attractive all-inclusive price. It deals directly with drug manufacturers, specialty pharmacies, and qualified fertility specialists on a large scale, then includes drugs in its prices, which, on average, are 36.5 percent lower than prevailing unbundled rates.[20]

Embryos aren't toothpaste. But retailers can figure out how to deliver both toothpaste and successful pregnancies less expensively when given free rein to innovate.

Hospitals Jack up Prices . . . Because They Can

In 2017, *ProPublica* reported that Children's Hospital Colorado charged $1,877.86 to pierce a 5-year old girl's ears. The surgeon who performed the procedure charged the girl's family another $110 for that service, bringing the total to almost $2,000. (The girl's mother, who brought her in for a minor surgical procedure, assumed the doctor was throwing in the ear piercing for free, since her daughter was already under anesthesia.) To add insult to injury, "the surgeon's piercing of one ear was off-kilter so it had to be redone"—which it was, at a shopping mall, for $30.[21]

ProPublica's story is far from unique. Reports of absurd hospital charges are common. After having a cesarean section, one new mother received a hospital bill that included a $39.95 charge for holding her baby against her chest. The hospital labeled the charge "skin to skin."[22] After being bitten on the foot by a snake while taking out the garbage, Eric Ferguson went to the Lake Norman Regional Medical Center, where he was given anti-venom and monitored. The hospital's list price for the medication was $81,000. The discounted price his insurer negotiated was about $20,000. The retail price of anti-venom online? $750.[23]

In 2013, the *New York Times* compared retail charges for five routine supplies and services with the list prices charged by the California Pacific Medical Center (CPMC).[24] In every instance, the retail price was much lower. A pain pill that retailed for 50 cents fetched $36.78 when sold by CPMC. CPMC charged $137 for a bag of IV fluid that cost $1 and $154 for a neck brace whose retail price was $20.

Other price comparisons made hospitals look bad too. A breast-pump kit that cost $543 at the hospital was available for $25 online. A CT scan of the abdomen sold for $4,495 at the hospital versus $400 at an outpatient facility nearby. The hospital priced a blood count test and a blood electrolyte test at $259.06 and $293.25, respectively. The same tests usually cost less than $10 each at independent labs. The hospital billed a vial of

skin glue at $181, a tube of antibiotic cream at $125.84, and a vial of local anesthetic at $79.73. These items cost $15.99, $36.99, and $5, respectively, on the internet. And, lest one forget, hospitals buy medical supplies in bulk at wholesale prices.

Want more comparisons? How about charging $18 for diabetes test strips that are available on Amazon.com for 56 cents apiece in boxes of 50, and $24 for niacin pills that cost only 5 cents each at retail drugstores? That's what the Seton Medical Center in Daly City, California, did. It also charged $77 for a box of sterile gauze pads, the retail price of which was probably a few bucks.[25]

These are not isolated examples. Look online and you'll find countless articles reporting that hospitals charged obscene amounts for goods and services that were available much more cheaply at retail outlets. One appeared under the title "How to Charge $546 for Six Liters of Saltwater."[26] The "saltwater" was normal saline solution that hospitals purchased for 46 cents to $1.07 per liter bag then resold to patients for hundreds of dollars. "Some of the patients' bills . . . include markups of 100 to 200 times the manufacturer's price, not counting separate charges for 'IV administration.' And on other bills, a bundled charge for 'IV therapy' was almost 1,000 times the official cost of the solution." Insurers commonly pay hospitals twice as much for artificial joints as the devices cost.[27]

In 2015, *Health Affairs* published a study entitled "Extreme Markup: The Fifty U.S. Hospitals with the Highest Charge-to-Cost Ratios." Using bills filed by almost 4,500 hospitals, researchers compared hospitals' chargemaster rates to Medicare's allowable cost, which "includes both direct patient cost (for example, emergency department, operating room, and intensive care) and indirect general service cost (for example, administration, laundry, and pharmacy)" for all patients, not just seniors. "On average, U.S. hospital charges were 3.4 times the Medicare-allowable cost." As if that wasn't bad enough, the 50 hospitals with the highest charge-to-allowable-rate ratios "charge[d], on average, 10.1 times their cost. This means that they [we]re charging markups of more than 1,000 percent."[28]

Hospitals offer a variety of rationales for their listed prices. They claim to overcharge some patients in order to cover the cost of charity care

for others. They argue that their costs are high because they make ancillary services available and offer round-the-clock care. The truth is less pleasant.

Hospitals impose absurd markups because they *can*, and because by doing so they maximize their revenues and their managers' and employees' salaries. As the authors of the *Health Affairs* article concluded, the main causes of high markups are pricing opacity and hospitals' superior bargaining power. Another factor, discussed in Chapter 8, is that Medicare literally rewards hospitals for increasing their chargemaster prices. The predictable result is that many hospital services are cash cows. As Steven Brill writes, "Outpatient care is wildly profitable" and accounts for about $500 billion a year in overspending.[29]

The executives who run companies that deliver medical treatments in the retail sector are not angels, and those who run hospitals are not devils. All are managing their companies in profit-maximizing ways. Retail-medicine executives would probably charge outrageous prices too if they could. *But they can't, because they have to compete with other retailers for cost-conscious patients.* And that's the point.

Cheaper Hearing Aids Are on the Way

In the retail sector, ridiculous markups are impossible to maintain. Walgreens can't charge $100 for a few aspirin tablets when CVS sells a bottle of 100 pills for $5. To compete with their many rivals, whose prices are low and easy to find, retail pharmacies have to sell medical goods and services as cheaply as they can. This includes prescription drugs, whose prices once were hidden but are now advertised. There are even online price comparison websites that, when given the name of a drug and a zip code, will show the prices at nearby pharmacies.[30]

We're so confident that competition among retailers can make medical goods and services cheaper, we'll go out on a limb. Over the next 10 years, we predict, hearing aids will become better and more affordable. Why? Retailers have broken the lock audiologists once held on their distribution. Today, digital hearing aids are available at Costco, Sam's Club, and Amazon.com, high-volume sellers known for cutting costs. Smaller, more specialized outlets like Audicus.com offer fancier models that cost

up to $649—pricey but still far less than most audiologists charge. As more retailers enter the field, prices will become easier to compare and competition will intensify. Bargain-hungry consumers will look for better deals, but they will be interested in quality too. A hearing aid that works poorly isn't a bargain, even if it's cheap. With pressure on both quality and price, retail offerings are bound to improve.

We'll even make a second prediction: audiologists' charges will also fall, or audiologists will lose business. If they keep their prices high, they won't be able to compete with Costco Hearing Aid Centers, which offer similar services—including product demonstrations, hearing tests, follow-up appointments, cleanings, check-ups, loss and damage coverage (with no deductible), warranties, 10 extra batteries, and a 90-day trial period—at no additional cost. Currently, audiologists' charges for ancillary services like these "account for up to 70 percent of the final price of a hearing aid."[31] In the face of competition from retailers like Costco, we doubt that such steep markups will last. It seems likely that audiologists will have to price their hearings aids and services separately and minimize the cost of both.

We are confident that competition will make hearing aids more affordable because retailers have driven down prices for medical services before. Past being prologue, it is reasonable to expect them to do so again.

There is a complicating factor, however. Some insurance plans cover hearing tests and hearing aids. The more insurers are involved, the longer it will take the retail sector to force prices downward because insured patients care less than others about costs.

Retail Medicine Is Viral

Retail medicine can spread quickly too. Flu shots again provide an example. "Before the H1N1 pandemic of 2009, almost no pharmacists administered flu vaccines. But [in 2012], pharmacists working for Deerfield, Ill.-based Walgreen Co. administered 5.5 million flu shots among the 9 million vaccines they delivered."[32] CVS did 3.5 million more.[33] Although most people still go to doctors' offices to be treated, "about 20 percent of adults received shots at a retail pharmacy [in 2011], up from 12 percent the previous year, according to the Centers for Disease Control and Prevention."[34]

Many more people receive flu shots at mass inoculations staged by their employers, who'd rather get all their workers treated quickly and cheaply than lose work days to doctors' office visits or illness.

The trend away from traditional providers reflects price and convenience. Retailers have lots of locations, see patients quickly and without appointments, are open year-round, and charge bargain-basement rates. MedStar Health, a retail outlet that operates in Maryland, makes sure that its stores are easy to find by locating them near Starbucks coffee shops.

No wonder retail clinics are gaining ground in a host of areas that were formerly the bread and butter of traditional providers, including

- Vaccinations for pneumonia and shingles;
- Screenings for high cholesterol, lipid levels, blood pressure, pregnancy, and colorectal cancer;
- Assessment, treatment, and management of chronic conditions like asthma, diabetes, and hypertension; and
- Treatment of simple acute conditions such as upper respiratory infections, sinusitis, urinary tract infections, allergic rhinitis, influenza, bronchitis, sore throat, inner ear infections, swimmer's ear, and conjunctivitis.

As clinics become better established, they're offering a broader range of services too. WakeMed Health and Hospitals, which operates in Raleigh, North Carolina, responded to cardiovascular patients' desire for convenience by developing a pilot program for deep vein thrombosis testing.

To see how much ground retail pharmacies cover, how quickly they've spread, and where they're likely to wind up in the future, consider CVS, now arguably the country's biggest health care company.[35] Around the start of the 2010s, CVS operated about 650 MinuteClinics in 25 states and Washington, D.C. It also sold tobacco products, which brought in about $2 billion a year. Then, in 2014 and 2015, the company rebranded itself. It changed its name to CVS Health, removed all tobacco products from its stores, made plans to increase the number of clinics to 1,500 by 2017, established a host of relationships with existing health care provider networks, and bought all of Target's pharmacies and in-store clinics for

$1.9 billion. By 2016, CVS Health had 1,135 clinics up and running in 33 states, and "about 50% of the U.S. population actually live[d] within 10 miles of a Minute Clinic."[36] CVS Health literally bet the company that the retail medical marketplace will expand.

CVS Health is making the future happen too. In 2015, it teamed up with IBM, which can help CVS's clinical personnel improve the diagnosis and treatment of health problems by applying evidence-based decision techniques and using data mining to predict patients' likely medical needs.[37] With IBM and CVS working together, millions of people may one day be able to sit in kiosks and use a computer to quickly assess the accuracy of medical diagnoses, the desirability of recommended prescriptions, and the availability of alternatives. The joint venture may be an especially valuable source of information for patients with chronic diseases like hypertension, heart disease, diabetes, and obesity, four leading causes of death and disability that collectively account for more than 80 percent of health care spending.[38]

Target is using similar data-mining techniques to determine which of its customers are likely to be pregnant. It then sends them coupons and ads for things they are likely to need. Sometimes, Target knows about pregnancies sooner than some people might like.

> About a year after [Target began using the] pregnancy-prediction model, a man walked into a Target outside Minneapolis and demanded to see the manager. He was clutching coupons that had been sent to his daughter, and he was angry, according to an employee who participated in the conversation. "My daughter got this in the mail!" he said. "She's still in high school, and you're sending her coupons for baby clothes and cribs? Are you trying to encourage her to get pregnant?"
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> The manager didn't have any idea what the man was talking about. He looked at the mailer. Sure enough, it was addressed to the man's daughter and contained advertisements for maternity clothing, nursery furniture and pictures of smiling infants. The manager apologized and then called a few days later to apologize again.
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> On the phone, though, the father was somewhat abashed. "I had a talk with my daughter," he said. "It turns out there's been some activities in my house I haven't been completely aware of. She's due in August. I owe you an apology."[39]

When it comes to the use of technology to improve the delivery of health services, the future is now.

The Doctor Shortage May Be Organized Medicine's Undoing

Retail clinics provide lots of medical services on a first-party payer basis. Although they accept insurance, patients pay out of pocket one-third of the time. By contrast, patients who visit primary care physicians spend their own money only 10 percent of the time.[40] One should therefore expect retail clinics to give patients more of what they want—quality care delivered efficiently—and less of what insurers want—expensive care that makes insurers indispensable. Consumers' preference for retail providers will likely intensify in the near future, as a strategy that organized medicine has long used to inflate physicians' incomes finally backfires.

For decades, the medical profession has kept the number of doctors artificially low, by preventing new medical schools from opening and limiting the number of graduates. The Association of American Medical Colleges predicts a shortfall of 12,000 to 31,000 primary care doctors by 2025.[41] Most newly minted physicians receive 50 or more job offers during their residencies. Half receive 100 or more.[42] This induced shortage makes doctors wealthier than they would otherwise be.

But the shortage of physicians also means that patients must often wait to be treated. Even before Obamacare added millions of people to the insurance rolls, delays of two to three weeks were common in many cities.[43] Now, as demand for medical services increases, waits will predictably increase too. This signal of unmet demand substantially strengthens the "business case" for retailers to enter the health care market. With tens of thousands of credentialed pharmacists, physician assistants, and nurse practitioners available to see patients after waits of 15–20 minutes, traditional doctors' offices will be easy pickings.

The rise of retail medicine will also erode the norm of going to doctors' offices and emergency rooms for medical treatments. When getting a flu shot, being treated for a urinary tract infection, or having a diabetes check-up at a retail clinic feels normal, people will wonder why they ever wasted their time in waiting rooms, and physicians will struggle to hold on to patients. Urgent care clinics will do the same to hospital emergency

rooms. Why put up with the rigmarole, delays, and hidden costs that hospitals impose when an urgent care clinic can handle a minor emergency just as well and is conveniently located in the nearest shopping center?

Massachusetts, the state whose mandatory insurance program, enacted under Governor Mitt Romney, became the model for Obamacare, provides a taste of what is to come. From 2010 to 2012, the typical wait to see a family physician went from 29 to 45 days. Delays are especially long in Boston, where patients often wait two months to see their family physicians.[44] That's why, in the 2010–2012 period, CVS could profitably open 37 new MinuteClinics in Massachusetts, a state that had only 13 retail clinics *total* in 2009.[45] If the medical cartel had done a halfway decent job providing high-quality care conveniently and affordably, retail medicine would never have gotten off the launching pad.

Retail Is Here to Stay

Doctors haven't taken the threat from retailers lying down, of course. They first tried to kill the retail clinic movement in its infancy. When that effort failed, they launched a rear-guard action to limit further encroachments.

Since 2007, the American Medical Association (AMA) and state medical societies have called for governmental investigations of joint ventures between retailers and pharmacy chains and for restrictions on the services that retail clinics can provide.[46] They have tried to capture a portion of the profits that retail clinics generate by supporting regulations that require nonphysician providers to be supervised by physicians.[47] They also protect their turf by pushing "scope of practice" recommendations that, if adopted by state legislatures or regulators, would limit what clinics can do.[48]

Doctors don't want competition from other types of providers, either. "Physicians, whom the nurses call 'organized medicine,' are the main people standing in the way of bills that expand the scope of what nurses are allowed to practice."[49] Fortunately, nurses have won recent battles. Twenty-one states have enacted laws that give them what is known as full practice authority, meaning they can prescribe medications and operate without direct oversight from physicians. But the turf war continues. In mid-2017, the AMA's House of Delegates endorsed a measure requiring the organization to

oppose efforts by physician assistants to gain the freedom to practice without having to report to physicians.[50] For years, the AMA has fought legislation that would allow pharmacists to prescribe medications too.[51]

Despite these efforts, doctors haven't been able to prevent retailers from expanding. Their appeals to elected officials have faced several impediments. First, the medical industry is split. Although CVS Health and Walgreens operate most of the existing retail clinics, many hospital chains and physician groups are also involved, including big players like the Mayo Clinic, Aurora Health Care, and Sutter.[52] In Oklahoma, MinuteClinic teamed up with OU Physicians, a group of 560 doctors, some of whom became the clinics' medical directors. Providers with stakes in the success of retail clinics don't want them to fold. Second, the big retailers have enough wealth and lobbyists to counter organized medicine's political campaign.[53] Third, doctors' groups have an obvious financial conflict of interest, which makes it easier to dismiss their complaints. As Dr. Sam Unterricht, the president of the Medical Society of the State of New York, candidly admitted, his organization opposes retail clinics because they pose "a threat to physicians financially."[54] "Retail clinics will cost doctors money" isn't a winning public relations message.

Recognizing this, doctors' lobbies have also employed their traditional gambit of purporting to speak for patients. The medical profession contends that retail clinics endanger patients by using simplistic decision and treatment protocols, disrupting doctor–patient relationships, overprescribing medications, and fragmenting the delivery of health care.[55] These assertions have little or no empirical support.

In fact, when it comes to treating minor illnesses, retail clinics often achieve better quality scores than physicians. A 2007 study published in the *American Journal of Medical Quality* reported that retail clinics adhered to established clinical guidelines for the treatment of sore throats 99 percent of the time, a record few family physicians can match.[56] A 2011 study that appeared in the same journal found that children served at retail clinics received similarly high levels of recommended care.[57] A 2013 study found that patients who visited retail clinics generated lower total treatment costs than similar patients who were treated elsewhere.[58] These findings should not be surprising. Retail clinics are staffed by nurse practitioners, who have been shown in many studies to deliver primary care that "is as good

as and sometimes better than care given by physicians" and "patients often express higher satisfaction with care delivered by nurses."[59]

The most detailed study of retail clinics, led by researchers at RAND, was published in the *Annals of Internal Medicine* in 2009. It compared the treatments patients enrolled in a large Minnesota health plan received for three medical conditions—otitis media (ear ache), pharyngitis (sore throat), and urinary tract infection—at retail clinics, physician offices, urgent care centers, and emergency rooms. The evaluation covered three dimensions: cost, performance on 14 quality metrics, and receipt of seven preventive services. The conclusion was clear and unambiguous: "Retail clinics provide less costly treatment than physician offices or urgent care centers . . . with no apparent adverse effect on quality of care or delivery of preventive care." How much less costly? Forty to 80 percent less. The comparison to ERs was especially revealing: "In emergency departments, average prescription costs were higher and aggregate quality scores were significantly lower than in other settings." Retail clinics are far better places than emergency rooms for patients with minor problems.[60]

If You Can't Beat Them, Join Them

If retail clinics are here to stay—and the studies provide no basis for curtailing them—physicians will have to adapt. To hold on to patients, they will have to reduce wait times and cut costs. Many have already taken steps in both directions by bringing nurse practitioners and physician assistants on board. This is all to the good. Newly minted physicians cost more than $1 million each to produce. People educated that intensively should provide high-value services that require the creative application of medical knowledge. They shouldn't spend precious time on problems that other professionals can treat every bit as effectively at far less cost.

Some physician groups have decided to compete with retailers by becoming more consumer friendly. In 2007, HealthCare Partners Medical Group, California's largest private physician practice with more than 500,000 patients, posted its prices for 58 common procedures online. A chest X-ray ran $61, a physical exam for a middle-aged patient cost $140–$160, and flu vaccinations were $15, plus a $31 administrative fee.

Why the shift from secrecy to disclosure? "The move was motivated in part by the rapid advance of walk-in medical clinics at drugstore chains and discount retailers, such as CVS Caremark Corp. and Wal-Mart Stores Inc., where the prices of blood pressure checks and flu shots are as easy to spot as those for rubbing alcohol and cat food." When asked about the move, Dr. Robert Margolis, the practice group's founder and chief executive, replied sagely, "It feels like the right thing to do." Funny how it didn't feel like the right thing to do until retailers started poaching patients.[61]

In 2009, the Surgery Center of Oklahoma (SCO) did the HealthCare Partners Medical Group one better.[62] It posted all-inclusive charges for 112 common surgeries, refused to accept Medicare or Medicaid, and negotiated payment arrangements with employers that bypassed conventional insurers. Drs. Keith Smith and Steve Lantier, SCO's cofounders, adopted this approach after becoming disillusioned by the traditional hospital business model.

SCO is a for-profit business. It keeps its prices low by being efficient. Wait times for physicians and patients are minimized, increasing the number of procedures that can be performed. The staff is lean too. With few exceptions, every employee at SCO is directly involved in patient care. By comparison, Integris Health, a nominally nonprofit organization that runs the nearby Integris Baptist Medical Center in Oklahoma City, had 18 administrators whose compensation averaged $413,000. "One reason our prices are so low," Dr. Smith remarked, "is that we don't have administrators running around in their four or five thousand dollar suits."[63]

The impact on prices is enormous. Integris charged $33,505 for a complex bilateral sinus procedure, which helps patients with chronic nasal infections. This bill covered only hospitalization; the fees for the surgeon and the anesthesiologist were extra. At SCO, the *all-inclusive* price for the same operation is $5,885. Not surprisingly, Integris's bill was loaded with overcharges, including $360 for a steroid available at wholesale for just 75 cents, and $630 for three doses of a painkiller called fentanyl citrate, which all together cost the hospital about $1.50.[64]

SCO deals mostly in cash. Companies that self-fund their workers' health care benefits pay SCO directly, as do patients. Keeping traditional insurers out of the picture helps reduce costs. The same is true for other providers,

many of which are starting to offer discounts for cash. Sometimes the discounts are so big that patients are better off bearing the whole cost themselves, rather than using their insurance. Jo Ann Snyder learned this the hard way. A hospital in Long Beach, California, charged her $6,707 for a CT scan. Her deductible and copay brought her share of the bill to $2,336; her insurer paid the rest. She later learned that the *total* price would have been $1,054 if she had paid for the scan in cash.[65] She thought that her insurer, Blue Shield of California, had negotiated a good price for the service. It hadn't.

Other area hospitals offered even better deals. When Chad Terhune, the *Los Angeles Times* reporter who covered Snyder's story, called around, he discovered that the Los Alamitos Medical Center, which listed the price of an abdominal CT scan at $4,423 on a state-run website, had a negotiated rate with Blue Shield of $2,400 and a cash price of $250. All eight of the hospitals contacted reported similarly large discounts for cash, although Los Alamitos had the lowest price overall.

A hospital in Boulder, Colorado, that wanted $600 for a knee X-ray when a patient used her high-deductible insurance policy, charged only $70 when she paid cash up front.[66] When the patient later needed an MRI, the hospital offered her a choice between paying $1,100 with her insurance or only $600 in cash. Regional Medical Imaging in Flint, Michigan, charges $510 for an MRI of the knee when patients use high-deductible plans but only $265 when they pay cash. The perversity of this practice should be evident. In both cases, the patient may bear the entire cost because even the higher charge may fall wholly within a patient's deductible. But even so, bringing insurance into the picture, even if only to get credit against one's annual deductible, increases the price.

When it comes to insurance making things more expensive, generic drugs offer a clean example. Consider what Dr. David Belk, who blogs at True Cost of Healthcare, wrote about pharmacies' charges for amlodipine:

> I'll always ask a new patient about the cost of their medications. A patient might tell me (for example) "I have high blood pressure," and then hand me a prescription he recently bought of amlodipine (a common medication for high blood pressure). So I'll ask, "How much did you pay for this amlodipine?" "Not much," he'll say. "I have insurance, so it only costs me $10 a month."

> It only takes a few phone calls to change his view. I'll often start by calling the pharmacy where he bought the medication (CVS for example) and ask, "If someone buys your club card for a $15 annual fee, how much would three months (90 pills) of amlodipine cost? Answer: $12. Next, I'll call Costco and ask: "How much will a full year's supply (365 pills) of amlodipine cost a person who doesn't use insurance?" Answer: $26.49! For a full year!
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> So, what's going on? Why do patients get such bad deals when they use their insurance?[67]

Elsewhere, Belk answers his own question:

> In the last decade most of the patents for these medications have expired, and so now more than 80% of the medicines that are commonly prescribed by doctors are generic and very cheap. Medications that used to cost pharmacies $400 for 100 pills (and then were sold to you for a profit) now cost pharmacies anywhere from $1–$10 per 100 pills. That's right: many medicines got more than 100 times cheaper. What they sell them for, though, is their business.
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> Most pharmacies realized that it wasn't in their interest to tell anyone that drug prices were dropping. With everyone used to using insurance to buy their medication, the pharmacies could just continue to charge the same copay, and make a substantial profit without receiving any payment from the insurance company. In the meantime, the insurance companies were happy because people still bought prescription drug coverage for these medications, believing that they were saving money when, in fact, they weren't. It cost the insurance company nothing so everyone won (except the customer).
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> The copays are still based entirely on the insurance plan so the same medicine in the same pharmacy might cost $5, $10 or $25 for a months' supply. To see how much of a windfall this is for retail pharmacies, we need only to look at the finances of the two largest retail pharmacies in the US: CVS and Walgreens. Since 2001 both CVS and Walgreens have tripled their total revenue from retail pharmacy sales and doubled their number of retail pharmacies in the US. They were able to fund this growth mostly from the sale of generic prescription medications sold to customers, almost all of whom used a third-party payer (insurance) to buy their prescriptions.
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> What's more, people might pay several hundred dollars a year to get prescription drug coverage on their insurance, even though that coverage

> increases the cost of many medications and cost[s] the insurance company nothing. It's like buying a book of coupons that say "one for the price of two" at your local grocery store. You can see why they didn't want to tell you about it.[68]

Other commentators have also discovered that insurance coverage for generic medicines can be a scam.[69] More evidence that the interests of consumers and insurers are not the same.

Pay Your Doctor the Way You Pay Your Gym

At retail clinics, patients may see different medical professionals on different visits. One nurse may treat a patient's sore throat, and a different nurse may be on duty when the patient returns for a follow-up visit. This worries Shannon Brownlee, a leading commentator on health policy, who contends that many patients, especially those who are older or have chronic conditions, need ongoing relationships with physicians. Brownlee predicts that retailers will siphon off the easier and more profitable cases that can be handled quickly, leaving the less profitable patients who require extended consultations to primary care physicians. To protect the fragile finances of these doctors' practices, Brownlee wants "state regulators [to] limit the scope of services retail clinics are permitted to provide." Otherwise, "we will watch health care become a commodity, and an ancient and honored profession [will be] replaced by drugstore chains."[70]

Brownlee's recommendation is the sort of top-down, Rube Goldberg solution that only a mainstream health policy analyst could love. Wanting physicians to spend more time with patients who need longer visits, she would prevent millions of people from using retail health care delivery services that are quick, convenient, and cheap. Needless to say, her proposal fails to create the incentives that might make it work. Rather than spend extra time with needy patients, doctors would maximize their gains by handling lots of easy cases and telling everyone else to take a hike. But, even if the proposal would work, shouldn't more direct options be explored before the government curtails the freedom of millions of consumers?

A direct solution exists too. Patients who would benefit from longer consultations can simply pay for that service. They can buy nurses' or physician assistants' time at retail clinics. They can buy doctors' time too. They can even purchase advice for dealing with chronic illnesses online. Direct purchasing will drive down the cost of advice too, for the same reason that prices for simpler stuff fall: because people are spending their own money. When everyone pays directly, everyone gets what they need and no one is forced to use inferior delivery arrangements.

Consider patients who use concierge doctors. By paying a monthly fee, these patients receive unlimited access to basic medical services, just like members receive unlimited access to their gyms. Typically, the fees vary on the basis of age, which proxies for predicted usage. In 2015, Atlas MD, a concierge practice run by Drs. Doug Nunamaker and Josh Umbehr, charged $10 per month for children up to 19 years old, $50 for people who are 20 to 44, $75 for those who are 45 to 64, and $100 for patients 65 and older.[71] "Everything the doctors can do in their office is included in the fee. They also give a lot of advice by e-mail and on the phone."[72] Atlas MD also helps patients by negotiating deals with outside vendors on services the practice doesn't provide. A cholesterol test costs their patients $3, a tiny fraction of the $90 charge that the lab they deal with bills to insurers. An MRI costs $400 instead of $2,000, again the typical third-party charge.[73]

Concierge practices limit their size to ensure that patients will receive quick access to services and unhurried treatments. Doctors associated with Atlas MD are responsible for no more than 600 patients, far fewer than the 1,000 to 2,000 patients a typical family physician sees. The arrangement works well for older people and those with chronic conditions who want to spend more time with their doctors. Consider the case of Scotti and Lois Fullbright, who moved to Wichita, Kansas, to be near their grandchildren.[74] By paying $75 each per month, they "could see the primary care doctors at Atlas MD as many times as they wanted. Now, they get an appointment within a day, and they have unlimited access to the doctors by phone and e-mail."

Some practitioners who operate on the concierge model even make house calls. Heidi Johnson, a pediatric nurse practitioner, visits sick kids

at home. This eliminates the need for patients and their parents to travel, only to spend time waiting in a doctor's lobby with other sick children. Johnson charges $80 per visit and does not take insurance. The cost is comparable to the $77 fee patients' insurers ordinarily pay pediatricians and to the charges patients would incur at an urgent care clinic. If more than one child needs attention, Johnson gives a discount, charging just $50 for the second sick sibling she sees on the same visit. All of the prices are listed on Johnson's website. Johnson limits her practice to 1,500 patients, more than normal for a concierge practice; but, judging from her patients' evaluations, she manages the workload well.[75]

Concierge medicine is picking up steam. According to Tom Blue, chief strategy officer of the American Academy of Private Physicians, there were about 5,500 concierge doctors in the United States by 2013, up from 4,400 the preceding year.[76] That's a one-year annual growth rate of 25 percent. Most concierge doctors charge about $100 a month per patient—more than Atlas MD—and have 300 to 600 patients as members.

Concierge practices generate an obvious complaint: only people who are rich enough to pay the monthly fees can afford them. But many people pay more for insurance than Atlas charges, especially when the calculation includes employers' contributions, which are just deductions from workers' wages. Consumer demand may also encourage the creation of low-cost practice groups for people whose incomes are low. Retailers like Walmart have figured out how to provide lots of goods and services to this segment of the population. They may figure out how to deliver health care too, if given the freedom to do so.

Kathleen Stoll, director of health policy at a consumer advocacy group named Families U.S.A., expresses two related complaints about concierge medicine. She worries, first, that because concierge practices provide a limited range of services, patients who experience serious illnesses requiring expensive tests and procedures will be left on their own. She also has unspecified misgivings about patients paying for health care with their own money. "I'm always cautious when it's a cash basis," she said. "Are you somehow being put at risk? I'd have a list of questions."[77]

The first concern is legitimate. Patients who join concierge practices must make separate plans for catastrophic health care needs. They typically

do so by purchasing policies with high deductibles. These plans are much cheaper than traditional plans, but they do cost money. The second concern reflects the corrosive impact that widespread reliance on third-party payers has had on health policy analysts. First-party payment—the way people usually pay for cars, houses, food, computers, telephones, and pretty much everything other than health care—works extremely well for consumers. It puts them in the driver's seat by pressuring sellers to deliver the goods and services consumers want at prices they can afford. Our experience with third-party payment hasn't been nearly as good.

Let Costco Run the Mayo Clinic

It is hard to argue with a straight face that the health care system is run efficiently. So why shouldn't Costco, a members-only retail empire, be able to operate a soup-to-nuts program covering all of its customers' medical needs, including treatments now delivered in hospitals and doctors' offices as well as the basic services walk-in clinics provide? Costco would employ or contract with doctors, just as it currently employs or contracts with the medical professionals who staff walk-in clinics. Billing for most services would be handled internally on a cash basis, but customers with insurance could send receipts to their carriers for reimbursement. Costco would also handle all other logistics associated with the delivery of care.

Presumably, a Costco-run soup-to-nuts medical operation would draw on everything and anything that works: retail clinics for customers' basic needs, concierge services when the special talents of physicians are required, and surgical treatments based on SCO's fixed-price business model. And, if Costco's health care business had to compete with similar operations run by Sam's Club and CVS Health, competition would pressure all three retailers to do something they're good at—minimize prices by squeezing out inefficiencies while delivering services conveniently in surroundings that customers like. In theory, the retail sector could bring spiraling health care costs under control. The question is: Will we let it?

Although the answer should be yes, recent history indicates that the American Hospital Association and other industry representatives will fight tooth and nail to prevent competition. Twenty years ago, physician-owned

specialty hospitals were unheard of. In 2000, they accounted for about 1 percent of Medicare spending.[78] Within a decade, though, specialty hospitals had grown so much that they threatened the profitability of traditional hospitals. How did the old-line industry respond? By convincing Congress to put a provision into Obamacare that prevents new physician-owned hospitals from being built and also keeps existing specialty hospitals from expanding.[79]

The restriction is blatantly anti-patient. In 2012, Medicare designated hospitals to receive bonus payments as a reward for quality achievements. The first hospital on the list was Treasure Valley Hospital in Boise, Idaho—a physician-owned facility. In fact, 9 of the top 10 performing hospitals were physician owned, as were 48 of the top 100.[80] Specialty hospitals make up less than 10 percent of all hospitals in the United States, but they dominated Medicare's quality list.

No one knows what the next great innovation in the delivery of health care will be. It could be retail medicine, urgent care clinics, or a personal health "app" that a handful of entrepreneurs currently have on the drawing board. It could come from Amazon, which is positioning itself to break into the retail pharmacy market and may possibly combine efficient drug delivery with telemedicine.[81] But one thing is certain. Old-line providers will fight any innovation that would make health care better or cheaper at their expense. The past is the best predictor of the future, and they've done this time and again.

We don't let local hardware stores decide where Home Depot and Lowe's can open stores. We don't let local appliance stores control the spread of Sears, Kohls, or Best Buy. We don't let local grocers prevent Whole Foods, Trader Joes, or Walmart from invading their turf. And we should not give health care providers veto power over competitive entry.

The evidence that retailers can manage the delivery of medical treatments well is clear. There is no health care cost crisis in the retail sector and never has been. Retailers sell a vast array of health-related products, including pain relievers, antiseptics, toothpaste, dental floss, cold and heat packs, nicotine gum, pregnancy test kits, and treatments for colds, allergies, burns, warts, fungal infections, swimmer's ear, and a host of other conditions, all of which are competitively priced. If you're seriously devoted to good

dental health, you can buy a plaque-destroying Sonicare electric toothbrush for $50. That's about half what the same item cost 10 years ago.[82] Almost every retail pharmacy has a blood pressure machine that customers can use for free. When we buy health care directly at retail, we're treated very well.

The health care cost crisis is a byproduct of the third-party payment system. Imagine what the food business would look like if most people had "grocery insurance." As former senator Phil Gramm sagely observed in one of the epigraphs that begin this book, if we had a system "where 95 percent of what you put in your grocery basket [was] paid for by grocery insurance, you would eat differently, and so would your dog."[83] Americans will be much better off when we buy health care the same way we buy everything else.