INTRODUCTION

The Republicans' Dilemma

Is Obamacare doomed? Well before President Donald Trump took office, the House of Representatives and the Senate had already voted to repeal almost all of the statute. When Trump defeated Hillary Clinton in the 2016 election, it seemed that the last remaining obstacle had disappeared. As we write this Introduction, however, Obamacare is still the law of the land. The House of Representatives passed a bill—the American Health Care Act—that supposedly "repeals and replaces" Obamacare, but the Senate did not. There, several measures failed, including the "repeal and replace" bill that was favored by the Senate leadership, the repeal-only bill that was preferred by the hard right, a "skinny repeal" bill that would have eliminated some features of Obamacare while leaving most of the program in place, and a last-ditch effort that would have repealed some provisions while devolving the law's spending and control over other provisions to the states. The 2017 tax reform law eliminated the tax penalties for being uninsured, but left the rest of Obamacare intact. And in both the House and the Senate, Democrats have supported Obamacare steadfastly, even though they admit it is in need of repair and falls far short of the goal of providing universal health care that many of them hoped to reach.

Whatever Congress ultimately does (or does not do), the reality is that Obamacare has been experiencing serious difficulties for years. Health

care insurers are dropping out of its exchanges, people in many areas of the country have access to only one insurer, premiums are high and rising fast, many states have refused to expand their Medicaid programs, and the cost of funding those that did is enormous and growing. Obamacare also disappointed on many of the promises its proponents made. President Obama predicted that it would save $2,500 per family per year, but health care spending per capita substantially increased. Americans were told that poor people would get medical services from doctors' offices instead of emergency rooms (ERs) once they were covered by insurance or Medicaid, but they actually went to doctors' offices *and* ERs more often. Health care quality and efficiency remained stagnant, even though Obamacare was supposed to pressure providers to improve both. One article published in 2017 asked, "Why Are Medical Errors Still a Leading Cause of Death?"[1] Another observed that "Needless Medical Tests Not Only Cost $200B—They Can Do Harm."[2] In the Bloomberg Health-Care Efficiency Index, the United States continues to rank near the bottom of the heap.[3]

Obamacare did dramatically increase the number of Americans with some form of coverage for health care costs, so that promise was kept. But even the Medicaid expansion turned out to be a disappointment when leading health economists found that many people who were brought under the program's umbrella didn't value the benefit all that highly—and certainly wouldn't have purchased it had they been spending their own money.

But they were not doing that. Instead, Obamacare was spending our money—and doing so at a ferocious clip. Overall health care spending reached $3.4 trillion in 2016, more than $10,000 for each person in the United States. In an official report, government actuaries dryly noted that "2015 expenditure growth was primarily the result of increased use and intensity of services as millions gained health coverage, as well as continued significant growth in spending for retail prescription drugs."[4] Obamacare proved two things: people use more medical services when they are insured, and the health care sector will absorb as much money as we are willing to throw at it.

Because Obamacare failed to address many of the problems of the American health care system, the obvious question is: What comes next? As we write this book, it is impossible to be certain; but, even if the Republicans in Congress can unite behind a new program, it seems increasingly

clear that the replacement will be some version of "Obamacare-lite." All the proposals that Congress considered in 2017 stripped out certain features of Obamacare while retaining others. Evidently, Republicans no longer think it is politically feasible to rip out Obamacare root and branch, even though that is what their most ardent supporters want.

Why such timidity, after running on a platform of outright repeal? Because Trump and the rest of the GOP face a dilemma. Although Republican party loyalists hate Obamacare's individual mandate (which required people to buy insurance), other features of the program are popular—especially the guarantee of coverage for people with pre-existing medical conditions and the provision allowing parents to keep their kids on their policies until the age of 26. (In fairness, support exists mainly when pollsters ask people whether they like these provisions; it drops dramatically when respondents are told how much these provisions cost.[5]) By eliminating these benefits, Republicans would immediately cause millions of Americans to lose insurance—including many children of the white upper-middle class. Rolling back the Medicaid expansion would cause millions of poor Americans to lose coverage as well. Outright "repeal" without some form of "replace" seems likely to result in loud protests and civil unrest.

The health care industry also opposes outright repeal. Providers don't want to treat millions of patients for free. That's why hospitals and many physicians have been major supporters of Obamacare's Medicaid expansion. They know that demand for health care services will drop sharply if millions of people lose their insurance. The medical establishment has a long history of lobbying aggressively to reverse even the threat of a modest reduction in the *rate of increase* in health care spending. If threatened with an actual reduction in revenue, it will go ballistic.

Insurance companies also lobbied aggressively to keep Obamacare, which delivered millions of new customers to them and has the potential to deliver millions more. What industry wouldn't want the enormous weight and power of the federal government forcing every person in the United States to purchase its products? And, for those unable to pay full freight, the government helped cover the premiums and out-of-pocket expenses. If the government wants the Obamacare exchanges to succeed, it will have to contribute enough money for insurers to find it worthwhile to stick around.

But insurers may not stick around now that the GOP has neutered the individual mandate while leaving the guarantee of coverage intact. The coverage guarantee enabled millions of high-cost sick people to buy heavily subsidized insurance. The insurance mandate was supposed to provide much-needed financial balance by requiring millions of low-cost healthy people to buy coverage too. By zeroing-out the mandate penalty while leaving the coverage guarantee in place, the GOP has guaranteed that insurers will either jack up their prices even higher or withdraw from the market even faster. Health care coverage will then be completely unavailable or so expensive that only the richest people can afford it.

It's a safe bet that Congress will neither force providers to take a haircut, bankrupt the insurance industry, nor anger millions of voters by depriving them of insurance. How Congress will finesse this tricky situation is anybody's guess. The most plausible prediction seems to be that it will do nothing, as long as it possibly can.

Rather than focus on the specifics of legislation that may or may not pass Congress in the next year or so, we think it is more useful to step back and explain why our health care system is so dysfunctional. That is what Part 1 of this book is all about. For those who cannot wait, there are five big problems with the current system for financing and delivering health care.

Problem #1: Political Control of Health Care Spending

Political control is the biggest obstacle to making health care more affordable. Obamacare made it through Congress because providers knew that health care spending would increase. Wall Street understood that too. After Obamacare was signed into law, stock prices for health insurers, hospital chains, and drug manufacturers soared. Why? Because Obamacare forced millions of people to buy insurance and put millions more on Medicaid. Once these people had coverage, it was predictable that they would use more medical services and bring billions in new revenue to health care providers doors. Obamacare also helped the sector by significantly reducing the need for charity care. Health care businesses lose money on services they provide for free, so this aspect of Obamacare delighted them.

Obamacare was far from the first government-funded financial bonanza for the health care sector. Every time Congress wades into this swamp, it winds up sending health care providers more money. In 2016, the federal government included $6 billion in pork barrel spending in the 21st Century Cures Act. In 2015, Congress enacted the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act, which will inflate the deficit by an estimated $500 billion over the next 20 years, to ensure that the payments doctors receive from Medicare keep increasing. Obamacare, with its coverage mandate, premium subsidies, and enormous Medicaid expansion, became the law in 2010. In 2009, the federal government blew $30 billion on electronic health records in the Health Information Technology for Economic and Clinical Health Act. In 2003, it committed to spending trillions of dollars on prescription drugs for seniors by enacting Medicare Part D. So long as Congress controls the health care economy, spending will only go up and up and up.

President Trump's about-face on drug price regulation provides more evidence of how things work in Washington, D.C. Right after taking office, he held a press conference at which he accused pharmaceutical companies of "getting away with murder" and threatened to authorize Medicare to bargain down prices.[6] But, when a draft of his executive order was floated a few months later, the tough talk had disappeared. In its place were proposals written by the Pharmaceutical Research and Manufacturers Association (PhRMA), the drug industry's lobbying arm. Vinay Prasad, a professor of medicine at Oregon Health and Sciences University, remarked that "[the] six-page document contains the kind of solutions to the cost-of-drugs problem that you would get if you gathered together all the executives of pharma and asked them 'What sort of token gestures can we do?'"[7]

Why the reversal? The usual reasons. Former industry insiders appointed to powerful positions in government dominated the task force that produced the draft, and the industry spent $10 million more on lobbyists than it had the year before.[8] According to a report by Kaiser Health News, "PhRMA, the drug industry's largest trade group, spent $7.98 million during the quarter—more than in any single quarter in almost a decade . . . topping even its quarterly lobbying ahead of the Affordable Care Act's passage in 2010."[9] Individual drug makers reached

into their pockets too.[10] The millions of dollars that Pfizer and other pharma-associated interests "donated" to Trump's inaugural festivities couldn't have hurt either.[11] Political control of health care financing is the most fundamental reason health care spending always rises.

Problem #2: Third-Party Payment

Third-party payment for most health care expenses compounds the problems created by political control of health care spending. Consider what happened to a mutual friend of the authors, whose stitches gave out after he sustained a minor wound. He went to a hospital-owned urgent care center in a strip mall and spent 30 minutes having his injury treated. He subsequently received a bill for $3,000, which he thought was absurd on its face, and likely fraudulent. However, the center granted a $1,170 discount based on its relationship with his insurance company, which then unquestioningly paid the "allowed" amount—$1,770—leaving him with a nominal bill of $60. When he saw that he personally owed so little, he shrugged his shoulders and paid the balance. Does anyone believe his reaction would have been the same if he had been responsible for the full $1,830 the center received—let alone the $3,000 list price? Does anyone believe that health care providers would send out such inflated bills if third-party payment were not the rule?

Proponents hailed Obamacare as a revolutionary transformation, but it really just doubled down on the failed strategy of third-party payment. The payment system was already funneling unprecedented amounts of money into the health care sector—and Obamacare threw gasoline on the fire by offering subsidized insurance and vastly expanding Medicaid. If cost control was ever the object, Obamacare was designed to fail.

At this point, many readers will object: Don't we need insurance and government programs to pay for health care because it is too expensive for us to afford on our own? Sometimes. But historically, cause and effect have run in the opposite direction. Medical services became expensive *after and because* they were insured. Before the role of third-party payers expanded dramatically during and after World War II, health care was cheap and people paid for it directly.

Spending really took off in the 1960s, when Medicare and Medicaid came online. As Professors Ted Marmor and Jon Oberlander write:

> In the first year of Medicare's operation, the average daily service charge in American hospitals increased by an unprecedented 21.9%. The average compound rate of growth in this figure over the next five years was 13%. . . . In the eleven months between the time Medicare was enacted and the time it took effect, the rate of increase in physician fees more than doubled, from 3.8% in 1965 to 7.8% in 1966. The average compound rate of growth in physician fees remained a high 6.8% over the next five years. In the first five full years of Medicare's operation, total Medicare reimbursements rose 72%, from $4.6 billion in 1967 to $7.9 billion in 1971. Over the same period, the number of Medicare enrollees rose only 6%, from 19.5 million in 1967 to 20.7 million in 1971.[12]

The problem isn't trying to guess whether the chicken or the egg came first. Third-party payment drastically increases health care prices and spending.

It is worth reflecting on how enormous the spending increase has been. In 2016, Americans spent about $3.4 trillion on health care. In 1960, we spent only $27 billion. That's an average increase of 9 percent per year. Had health care spending grown at the same rate as the general economy, it would have been about $220 billion in 2016, just under 7 percent of the figure it actually was.

As health care spending was exploding, however, the percentage of dollars that came directly from consumers (rather than being routed through the hands of third-party payers) drastically declined. In the early 1960s, patients paid about $1.80 out-of-pocket for every $1 spent by third-party payers. After Medicare and Medicaid were created, that ratio declined so steeply that, by the end of the decade, it was approximately $1 to $1. Today, consumers directly contribute less than 20 cents for every dollar shelled out by a third-party payer. The less direct responsibility consumers bear for the costs of medical services, the more total spending increases.[13]

Christy Ford Chapin, a history professor who published a column in the *New York Times* in 2017, got the connection between third-party payment and health care spending right. "With Medicare, the demand for health services increased and medical costs became a national crisis."

"The challenge of real reform," she continued, is that, "to actually bring down costs, legislators must roll back regulations to allow market innovation outside the insurance company model."[14] To bend the cost curve downward, we need to rely less on third-party payers and more on ourselves.

The fundamental cause of spiraling health care costs isn't aging, technology, defensive medicine, or any of the other causes that are commonly cited. It is that we too often let others buy medical treatments for us instead of paying for them ourselves. Worse, excessive reliance on third-party payers has convinced Americans that they cannot and should not pay for medical services themselves. Tens of millions of people who would never think of using insurance to pay their mortgages or their rent reflexively use their health care coverage to pay for doctors' office visits and other medical services that cost far less. To dig ourselves out of this hole, we have to learn to treat health care like everything else. We should pay for most medical treatments directly, the same way we pay for housing, transportation, electricity, water, food, and clothes. Insurance should be reserved for calamities.

Problem #3: The Prices Are Too Damn High!

You could not design a more expensive health care system than the one we have if you tried. It's not just that the U.S. health care sector is expensive. The payment system behaves as though its *purpose* is to move as much money as possible into the pockets of health care providers, and to avoid doing anything that interferes with that goal.

That is not its acknowledged purpose, of course. If you ask politicians, providers, or health care policy experts, they will offer a variety of more palatable rationales. They will say that the payment system is supposed to motivate providers to deliver high-quality care at reasonable cost, to protect the elderly and the poor from going without, or to provide all Americans with the best health care money can buy.

We are certain that many people sincerely believe these high-minded pronouncements, and many changes to the payment system may have been made with lofty goals in mind. But we are just as sure that none of these accounts describes what, over time, the payment system has become.

The reality of paying out trillions of dollars a year has turned our payment system into a well-oiled money-moving machine. The most accurate account of the system today is that it exists to move the largest possible number of dollars from the sources that feed it into the hands of health care providers. That is why health care spending sets new records year after year.

All of the payment system's basic features can be explained by assuming that its function is to move the largest possible number of dollars into the medical sector. Start with Medicare. To get the program enacted, President Lyndon Johnson and Congress effectively gave doctors and hospitals the keys to the federal treasury. At the outset, there were no controls on the prices providers could charge, the services they could perform, or total funding for the program. Medicare even guaranteed that hospitals would be profitable, and that as their costs rose their profits would increase. No one should have been surprised that prices and spending quickly spiraled out of control.[15] Over time, controls were added on the prices that providers could charge—but there were still no restrictions on the volume of services that could be performed or total funding.

Medicare also has few quality controls. It pays doctors who deliver services that are unnecessary, unproven, and even negligent. It pays hospitals when their patients experience avoidable complications or die from medical mistakes. Until quite recently, it made no efforts even to track the quality of care. Of course, if the purpose of Medicare's payment system is just to move money from taxpayers to providers, these pathological practices are readily explained.

The goal of moving money also explains why Medicare and Medicaid are plagued by fraud, waste, and abuse. The fastest way to enrich health care providers is to pay claims without checking to see that services were even provided. That's why these programs pay first and ask questions later—if ever. This approach, commonly known as "pay and chase," makes it easy for career criminals and Main Street providers to steal billions of taxpayers' dollars. And, once the money is gone, there is no hope of getting it back. In 2014, the Department of Justice had one of its best years ever, making fraudsters cough up $3.3 billion.[16] But that very same year, wrongdoers drained almost $100 billion from the Treasury by filing false Medicare and

Medicaid claims.[17] The feds are not even fighting the criminals to a draw; they are getting creamed.

An even worse problem is that it is often hard to tell the career criminals from the legitimate health care providers who happen to bill the Treasury for all manner of unnecessary services. The cost of unnecessary treatments and other forms of waste far exceeds the cost of fraud. Reputable authorities believe that the annual combined cost of fraud, waste, and abuse is *$1 trillion or more*. That's one dollar out of every three spent on health care in the United States. If the purpose of the payment system is to move money, rampant waste is easy to explain.

The same assumption explains why we overpay for prescription drugs. As we discuss in Chapter 1, Martin Shkreli, the notorious "pharma-bro," briefly became the most hated person in America after he raised the price of Daraprim, a medicine used to treat patients with AIDS and other illnesses, from $13.50 a tablet to $750. But, by the time he came along, pharma execs had been jacking up drug prices for years. Shkreli was also small beer. With fewer than 9,000 prescriptions for Daraprim being written each year, Shkreli's ill-gotten gains did not even amount to a rounding error on the share of the national health care budget spent on pharmaceuticals. As we explain in Chapter 2, other pharma execs have exploited patient populations that run into the millions.[18]

Hospitals also gouge patients.[19] A recent example focused on a pregnant woman who timed her arrival at the Boca Raton Regional Hospital a bit too late: she delivered her baby in the hospital's parking lot.[20] Seven months later, the hospital billed her $7,000, its full price for maternity care. Another Florida hospital charged a patient with a broken pelvis $32,767, even though he was wheeled into its ER and quickly wheeled out again because the hospital didn't have the necessary specialist. The bill amounted to $800 per minute.[21] A cyclist with road rash was billed $12,500; an uninsured woman with superficial cuts incurred a fee of $33,000; and a 35-year-old woman with burned fingers who spent an hour at St. Mary's Medical Center was hit up for $13,626.[22] The parents of a one-year-old with a cut finger were charged $629 for a five-minute visit and a Band-Aid.[23]

Why is price gouging so common? The dominance of open-ended third-party payment allows providers to charge whatever they want because

patients are so insulated from prices they don't care enough to resist. The same dynamic also explains why money spent on medical services receives preferential tax treatment. Deductions for insurance premiums and medical savings accounts make it cheaper for Americans to buy health care than goods and services of other types. There is no good reason for this favorable tax treatment. Health care isn't intrinsically more important than food, housing, water, electricity, sanitation, or transportation. Most of the time, most people need other things more urgently than health care. It makes little sense to put health care on a plateau above everything else. Yet that is what tax deductions do. Once again, the payment system acts as if its primary purpose is to enrich the medical sector at the expense of the rest of the economy.

Researchers who focus on health care quality like to say, "Every system is perfectly designed to get the results it gets."[24] Americans pay twice as much for drugs and medical services as people in other developed countries because our payment system is perfectly designed to move money from the rest of us into the health care sector.[25]

Problem #4: Health Care Quality in Lake Wobegon

If you ask any questions at all when your doctor refers you to a particular specialist or hospital, you will probably hear that the new provider is top-notch or the best in town. Just like the children in Garrison Keillor's mythical Lake Wobegon, in America's health care sector, all doctors and hospitals are above average.

Except that they aren't. Some doctors and hospitals are worse than others. To a mathematical certainty, 50 percent of them are below the median. Ten percent are in the bottom decile. These differences affect outcomes. Choosing the wrong surgeon can double or triple a patient's odds of dying on the operating table.[26] Rates of hospital-acquired infections (HAIs)—which afflict 650,000 people a year and kill 75,000, more than twice the number of fatalities caused by car crashes[27]—vary greatly across hospitals. Some are very good. Others, including some prestigious teaching hospitals, have terrible infection rates.

Even when their lives hang in the balance, however, few patients have any clue how good or bad their surgeon or hospital actually is. If you had

an operation recently, you probably had no idea where your hospital ranked. You probably knew nothing about your hospital's postsurgical mortality and morbidity rates, either.[28] Even if you tried, you probably wouldn't have been able to find out how your surgeon's performance compared to others. This information is crucially important for patients, but many hospitals do not even collect it. Others have the information but keep it to themselves.

What happens when someone finally ranks providers by their actual performance? Then, a sort of reverse Lake Wobegon effect kicks in. Low-scoring providers rationalize their poor showings by asserting that their patients are sicker than average. Rather than confront the reality that not all health care providers are terrific, the industry blames its failures on patients.

Again, if we assume that the payment system's primary purpose is to move money into the health care sector, persistent subpar performance is easy to explain. Quality is not Job #1 because providers are not paid to deliver outstanding care. They are paid to treat patients, period. As a result, they deliver enormous volumes of care, including an ocean of services that are dangerous and unnecessary. And, with few exceptions, they will not voluntarily generate information that would help patients shop, because intelligent shopping has no upside for them.

Problem #5: Opaque Prices

No consumer would buy a car, a computer, or any other costly item without knowing the price in advance. But, when it comes to medical treatments that cost thousands (or tens of thousands) of dollars, it is all but impossible to get a single, all-inclusive price for most things that will be done even at the time a service is delivered. Instead, patients receive bills after the fact and piecemeal, from every provider that happened to be in the neighborhood, some of whose charges are covered by insurance while others are not.[29] And every bill is filled with meaningless acronyms and phony charges that seem to have been plucked out of thin air. Why do patients need a Rosetta stone to make sense of their bills? Because opacity makes it easier for the payment system to move money to health care providers. How better to disguise what's going on than with confusing bills?

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Having identified the major shortcomings of the health care system, we now briefly describe the four lessons that should be drawn from our work.

Lesson #1: The Health Care System Is Full of Good People—But Good People Can't Save a Bad System

If we are right about the perverse incentives that are baked into our health care payment system, how do we explain the existence of islands of clinical excellence where patients can go for topflight care at reasonable cost? These islands don't exist by accident. They are the result of careful planning and sustained efforts by conscientious frontline providers, backed up by outstanding business management.

The islands prove that good people sometimes prevail despite bad incentives. Unfortunately, good people cannot save a bad system, where the incentives encourage bad acts.

Consider the problem of central line–associated bloodstream infections (CLABSIs). CLABSIs are a particularly nasty form of HAI. Of the roughly 250,000 Americans who contract CLABSIs each year, almost one-quarter die, often after lengthy and expensive hospital stays. Although experience has proven that CLABSIs can be effectively eliminated with minimal inconvenience and at trivial expense, many hospitals' intensive care units (ICUs) still have high CLABSI rates.

It's easy to explain why CLABSIs are common. The problems we identify above have warped the payment system to the point where preventing CLABSIs is unprofitable. Thanks to political control, third-party payment, and the rest, hospitals literally make more money by treating patients for deadly infections than by preventing them. Patients spending their own money would never allow hospitals to profit by giving them infections. But because CLABSIs generate higher revenues, hospitals have no financial incentive to eliminate them.[30]

The same goes for other avoidable complications of surgery and medical errors. Hospitals can make more money by treating patients they have harmed than by preventing those harms in the first place.

Still, despite the extra money to be made by treating patients for avoidable infections, some ICUs have low CLABSI rates. Self-interest cannot explain the behavior of these high-performing units. What does?

The answer is wonderful and caring health care workers, administrators, and researchers who want to help patients. Hospitals and other health care providers employ hundreds of thousands of doctors, nurses, physician assistants, and other professionals who are committed to saving lives, regardless of the impact on their institutions' bottom lines. The successes that many ICUs have had in combating CLABSIs attest to the power of selflessness, as do millions of other miracles that health care workers have pulled off.

Good people have made the health care system better than it would otherwise be. But they have not made it better than it is—which is to say, expensive and mediocre. Why? Because incentives matter too. When quality is a losing proposition—as it is when hospitals make more money by harming patients than by treating them well—failures are easy to rationalize and the pressure to improve is reduced. When a hospital's mortality rate is unusually bad, it is not that the surgical practices used there are deficient; the problem is that the hospital's patients are unusually frail. When the information needed to benchmark a hospital's performance isn't readily available, the hospital's employees are not neglecting quality; they are too busy helping patients to waste time collecting data. The efforts of wonderful people cannot overcome a payment system that makes quality a money-losing proposition.

And let there be no mistake: under existing payment arrangements, quality improvement and cost reduction are often money-losing propositions. Doctors and hospitals have learned time and again that what is best for their patients is financially bad for them. In a market less distorted by political control and third-party payers, the interests of providers and patients would align more closely, and providers would be incentivized to serve patients better.

Popular rhetoric to the contrary, the problem is not that medical treatments are delivered by profit-seeking businesses. For-profit businesses add enormously to our quality of life. They bring us most of the goods and services we enjoy, including houses, cars, computers, cellphones, food,

and millions of other things, all of which they deliver at prices we can afford. If consumers purchased medical treatments directly rather than via government bureaucracies and insurance companies, for-profit businesses would serve our health needs well too. The problem is our payment system, which breaks the link between profits and consumer satisfaction and makes it financially advantageous for providers to serve patients poorly.

Lesson #2: If the Bottom Leads, the Top Will Follow

Obamacare was doomed from the start. The core problems of health care are political control of spending and the overuse of insurance, and Obamacare offered more of both. The only reforms with real potential to transform our health system are those that give consumers control of health care dollars and require providers to compete for their business. We can rescue ourselves from the mess we have created by helping people buy medical goods and services and health insurance directly—the same way they buy other goods and services.

Politicians have little incentive to enact reforms that force providers to offer better treatments at less cost. For the better part of a century, industry groups have been paying politicians and lobbying them to do the exact opposite. Greater spending means more money for doctors, hospitals, drug companies, and insurers. That's why the health care sector always backs legislation that will increase spending and always opposes proposals that might reduce it. Mainstream health care providers will never support reforms that would subject them to market forces.

If change for the better is going to happen, consumers will have to exert pressure for it from below. Fortunately, CVS Health, Walgreens, Walmart, Costco, and many other retailers have opened new outlets for medical services that are inexpensive and as close as the nearest shopping mall. A growing number of treatments are sold directly to patients who pay for them with their own money. The list includes vision services like LASIK surgery, eyeglasses, and contact lenses; cosmetic procedures like Botox injections, breast augmentation, dental veneers, and tooth whitening; and medical treatments like in vitro fertilization, flu shots, tests for various illnesses, and vaccinations.

Services sold at retail have not been caught up in the same cost spiral that has affected the rest of health care. Their prices have held steady or declined. Why? Because patients who buy things with their own money comparison shop. They look for high-quality goods and services that are delivered conveniently and at a reasonable cost. They look for sales and discounts and will drive across town to save a few dollars. And, because they spend their own money, they buy only things that they value.

The retail sector responds by catering to consumers' desires. It offers convenient locations and times, transparent prices, and good quality. Many goods and services come with money-back guarantees. Retail medical outlets even have sales—something that your local hospital or doctor probably never does. That's what happens when providers compete for patients' dollars.

Retailers are good at figuring out how to sell things that people want at prices they can afford. Retailers also know how to make shopping easy and pleasant. That's why traditional health care providers are trying to prevent them from moving in. Like the old-line taxicab companies that want to stifle Uber and Lyft, they know that their business models can survive only as long as customers have no choice but to use them. Their best option is to thwart competition by excluding new entrants. These dinosaurs should be on the road to extinction, but they will use their political muscle to prolong their existence.

One of the medical establishment's most fundamental accomplishments has been to convince Americans that doctors alone should control the delivery of health care, even though few doctors know how to run a business. That is why many states have laws that require nurse practitioners and physician assistants to work under doctors' supervision, laws whose relaxation doctors continue to oppose even though patients' access to needed services would improve.[31] Many states also forbid the corporate practice of medicine, meaning that they won't let Costco or Walmart run hospitals or own other businesses that deliver health care to the public. There is no evidence—zero—that these laws improve the delivery of care. Their real purpose is to stifle competition, thereby enriching physicians and traditional hospitals.

In the crazy world of health care, doctors even set the prices Medicare pays for their services. Everyone else, from accountants to zookeepers, has to compete on price and gets what the market bears. But not physicians. The amounts they receive from Medicare are set, in large part, according to estimates of the time required to perform procedures. The estimates are prepared by a secretive American Medical Association (AMA) committee whose members know that higher estimates mean higher pay. As Tom Scully, a former head of Medicare once observed, "the concept of having the AMA run the process of fixing prices for Medicare was crazy from the beginning . . . . It was a fundamental mistake." [32] That should've been obvious to everyone, but what better way to send doctors lots of money than by letting them set their own rates? Worse, by jacking up the prices Medicare pays, doctors also rig the rest of the market. Private insurers follow Medicare in rough lockstep: a $1 increase in Medicare payments predicts a $1.30 increase in the price paid by private insurers.[33] The uninsured get the shaft because doctors and hospitals charge them inflated "rack rates," collect whatever they can, and ruin the credit ratings of patients who don't pay.

Only in the retail sector do health care providers face pressure to charge less. That's why prices there have held steady or declined, while in the rest of the health care sector they have soared. Americans could save huge amounts of money and receive better-quality treatments by letting retailers expand.

On rushing out of an interview abruptly, Mahatma Gandhi supposedly said, "There goes my people. I must follow them, for I am their leader."[34] Gandhi knew how mass movements work. America's politicians do too. When millions of us take our business to retail medical outlets and tell our elected representatives that we want more freedom to do so, they will be forced to stand up to the health care establishment. And once the norm of buying health care at retail outlets is established, there'll be no turning back.

Lesson #3: To Beat 'Em, Leave 'Em

Providers may enjoy a local monopoly, but beleaguered patients can disrupt their cozy cartel by traveling elsewhere. The field of "medical tourism"

is booming. By flying to other countries to get hip and knee replacements, cardiac surgeries, and other expensive procedures, Americans can save more than enough money to pay for the trip. By having heart surgery at a world-class hospital in India, an average American can save enough money to live on for a year.

For patients who don't want to leave the country, there's still some good news. They can break the stranglehold of local providers by traveling domestically to other cities and states. The average charge for a knee replacement in the United States is about $57,000.[35] But the Surgery Center of Oklahoma (SCO) will perform the operation for only $19,400.[36] Its posted price includes anesthesia, operating room charges, and surgical fees. The artificial joint will cost $4,000–$6,000 more, but the folks at SCO will tell you its price in advance and they will charge you only what it costs them. No absurd markups here. If you like, they will even show you the receipt. With the $31,000 or so that you'd save by having knee replacement surgery done at the SCO, you could fly to Oklahoma City, stay in its fanciest hotel, buy courtside tickets to a Thunder game, and have enough left over to install granite countertops in your house.

SCO's prices for many surgeries are low enough for middle-class people to afford. A mastectomy costs $5,000. A pacemaker implantation runs $11,400, hardware included. A patient with droopy eyelids will spend $4,150 for a blepharoplasty. Although it's never pleasant to write a big check for a medical service (or anything else), these amounts are comparable to the cost of many medium-ticket items that middle-class people save up for. A used car for a kid in high school or a family vacation might cost about as much as a mastectomy or blepharoplasty. To get these prices, though, patients have to schedule their procedures in advance and pay for them themselves. When patients ask SCO to deal with their insurers, it charges more.

And here's the really good news. If you don't want to travel at all, you can probably save a bunch of money right where you are. Just tell the folks at your local hospital that you'll have your knee replacement surgery done at the SCO unless they match its price. You may be pleasantly surprised by the response. When faced with the prospect of losing patients, many hospitals are willing to offer substantial discounts. Although some

patients have adopted these strategies, they will remain at the margins until more consumers begin to control and spend their health care dollars themselves.

Lesson #4: Better Health Care (and Better Health) through Self-Pay

Saving money matters to patients who spend their own dollars. But when Medicare, Medicaid, or private insurers foot the bills, patients have little reason to care. That's a recipe for disaster. If the payment system were designed sensibly, self-pay would be the rule. Health care coverage would be reserved for disasters, just like other forms of insurance. Auto insurance covers major crashes, not small dings and certainly not oil changes. Life insurance kicks in when people die, not when they miss a day at work because of a sore throat. Homeowners' insurance covers damage inflicted by serious fires, water leaks, and windstorms—and it has sizable deductibles, to get homeowners to bear all of the costs of minor problems and to share the costs of major disasters.

Health care coverage should work similarly. Insurers should pay for highly complex and expensive procedures that relatively few people need in any given year. Patients should pay for routine stuff—like check-ups, diabetes monitoring, and allergy medications—just like they pay for gym memberships, running shoes, and other things that contribute to good health.

This will happen naturally if consumers purchase health insurance themselves. We expect the high price of first-dollar coverage will lead most consumers to purchase coverage only for remote health risks that involve expensive treatments. They will not buy comprehensive coverage for their bodies for the same reason they do not buy it for their homes or their cars: such coverage costs more than it is worth to the people who are making the decisions about how they wish to spend their own money. Only people who are unusually risk averse will find the price worth paying, and they will be free to do so if they want. Similarly, people who don't want to spend time shopping for providers may seek out "concierge practices" that offer most services under one roof and help

with referrals when unusual needs arise. These plans resemble insurance but are better described as prepaid service arrangements. Some people will seek out these arrangements, but we expect most consumers spending their own money will want insurance that covers catastrophes and will self-pay for everything else.

One easy way to see the potential benefits of self-pay is to focus on governmental programs, like Medicare. When people think about Medicare, they naturally focus on what the program does. They talk about the millions of seniors it covers, the fact that it now pays for drugs as well as medical services, and so on. But just for a moment consider what Medicare doesn't cover—because the omissions shed light on the program's true purpose and on the advantages of self-pay arrangements. Suppose you are an elderly person with a condition that will probably kill you in a few months. If you want to pull out all the stops in the hope of staving off death for as long as possible, you are in luck. Medicare will pay for unlimited medical treatments during the last days of your life. It will pay an oncology clinic to pump you full of anticancer drugs. It will pay a hospital to prod you and poke you as often as you can stand. It will pay a surgeon to operate on you even though there is little or no chance that you will recover. The people who designed Medicare love to pay for intensive treatments, enabling the program to hand out buckets of money to health care providers.

But suppose that, instead of being injected, prodded, poked, operated upon, and generally made miserable, you would rather spend your final days at home and experience a dignified death surrounded by your family. To make that happen, you would like to make a few modifications to your home—so you can move around in a wheelchair more easily. You would also like to hire a personal assistant to help with bathing, changing clothes, eating, and pain management. Or maybe you would like to check an item off your bucket list by moving to a foreign country and spending your last days on the beach.

Now you are out of luck. Although Medicare has a limited hospice benefit, it will not pay for any of the other possibilities just listed—even though all of them combined would cost substantially less than dying in an intensive care unit after a lengthy hospital stay. To get what you want,

you'll have to buy it yourself. Why does Medicare refuse to pay, even though these alternatives are a comparative bargain? Because the program will only buy something for seniors if the money goes into the pockets of health care providers. It is not set up to help beneficiaries die with dignity in the manner they prefer or to pay for services of any other kind. If you want expensive medical treatments, great. If not, you are on your own.

To really help seniors, Medicare should operate like Social Security. It should give beneficiaries money and let them decide how to spend it. That simple reform would put seniors in the driver's seat. It would also jump-start the bottom-up process of improving the health care system that we discussed above, by creating an army of direct-purchasing seniors who are bent on finding economical health care. What would work for seniors would work for everyone else too—particularly the poor, who are covered by Medicaid.

Government would still play a role by distributing money to persons in need. Recipients could use their stipends to purchase insurance against catastrophes or pay for ordinary care out of pocket. This approach isn't new. Food stamps enable poor people to buy groceries wherever they want, so they can look for the best deals. The Earned Income Tax Credit and the Child Tax Credit give poor people money they can use to pay bills of all types, including bills from health care providers and insurers. Social Security and veterans' disability payments do the same thing.

One source reports that, if all anti-poverty programs were replaced with simple cash transfers, at current spending levels, a poor family of four would receive an annual income near $70,000.[37] And those dollars would go a lot farther than they currently do. Instead of wasting money on a flawed system, people would maximize their bang for the buck by shopping for bargains and forcing health care providers (and other sellers) to compete for their dollars.

In sum, to a distressing degree, American health care looks and acts expensive by design. The payment system behaves as if its objective is to move the largest possible amount of money into the health care sector. It does that job extraordinarily well, and it will do it even better in the future because health care providers use every trick they can think of to make more money. But rising costs and high deductibles have already motivated

many consumers to look for bargains in the retail sector. When it seems as natural to go to a local big box store like Target or Walmart for a medical treatment as it currently does to visit a doctor's office or an emergency room, people may finally see the rest of the medical sector for what it is: a fat and lazy industry that needs a swift kick in the pants.

We expect the health care sector to become more efficient and pro-consumer when and only when it is subjected to the same competitive forces that apply to the rest of the economy. If you want to see why we make such strong claims, read on.

PART 1. MISDIAGNOSIS: THE PROBLEMS OBAMACARE SHOULD HAVE FIXED

The United States is "the most expensive place in the world to get sick."[1] Why? One big reason is that providers routinely game the payment system. Drug companies are experts at this. Chapter 1 describes how they first gain strangleholds on supply. Chapter 2 describes how they then charge whatever they want, knowing the payment system imposes no restraint on prices. Chapter 3 shows that shady conduct occurs at every point in the drug distribution chain and often involves the willing participation of pharmacists and physicians who profit by exploiting existing payment arrangements. It is easy to see why spending on prescription drugs, new and old, has gone through the roof.

Doctors game the payment system too. As Chapters 4 and 5 show, they deliver an ocean of services that patients don't need, such as excessive numbers of stents and cesarean deliveries. Chapter 6 describes how doctors regularly perform treatments that haven't been proven to work, many of which are found to be ineffective or harmful when they are finally studied with care.

Chapter 7 explains how public officials get in on the action. In return for sizable campaign contributions from health care providers and their lobbyists, they let the flow of cash into the health care sector continue and look for ways to increase it. When the campaign contributions are

large enough, elected officials even go to bat for corrupt providers who face fraud investigations.

Some hospitals and doctors aren't satisfied with excess payments for garden-variety overuse and unnecessary care, and they turn to a life of crime—or at least abuse. Chapter 8 explains how hospitals "upcode" treatments, invent secondary conditions that patients don't have, and concoct phony bills. Chapter 9 shows how hospitals also conspire with doctors to maximize their revenues by capturing differences in payments based on the site of service, tacking on absurd charges, and gouging patients who are uninsured or treated by out-of-network physicians at their facilities. Chapter 10 describes how hospices, nursing homes, and home health care services play similar games and frequently charge for services that were never delivered.

Chapter 11 shows how some doctors operate pill mills that supply the street with dangerous drugs—likely contributing to the rising death toll from overuse of prescription narcotics. Ambulance companies and durable medical equipment suppliers cheat the system regularly too, as do domestic and international criminal gangs. As Chapter 12 explains, there are far too many malefactors for the police to catch. For every one police put away, two more pop up. That is why the same types of fraud succeed again and again and again.

Chapter 13 explains that the quality of health care is often dangerously low because the payment system pays providers regardless of how well or poorly their patients fare. In fact, it often doles out more money to providers when patients experience complications than when they get well. Chapter 14 explains how incumbent health care providers have stifled competition so successfully that the government has to pay them extra to improve. In other industries, competition forces existing business to bear the costs of improving their products.

Although there have been repeated attempts to address these problems, all have failed because they have not changed the core incentives driving the system. We address that problem in Part 2.