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CONSUMER-DIRECTED DOCTORING: THE DOCTOR IS IN, EVEN IF INSURANCE IS OUT

HEARING

BEFORE THE

JOINT ECONOMIC COMMITTEE
CONGRESS OF THE UNITED STATES

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

APRIL 28, 2004

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C O N T E N T S

Opening Statements of Members

	Page
Senator Robert F. Bennett, Chairman	1
Representative Pete Stark, Ranking Minority Member	2

Witnesses

Statement of Dr. Bernard Kaminetsky, M.D., F.A.C.P., Colton and Kaminetsky, Boca Raton, FL	5
Statement of Dr. Robert S. Berry, M.D., PATMOS EmergiClinic, Inc., Greeneville, TN	7
Statement of Dr. Alieta Eck, M.D., Drs. Eck, Apelian and Mathews, Piscataway, NJ; Zarephath Health Center, Zarephath, NJ	9
Statement of Dr. Robert A. Berenson, M.D., Senior Fellow, Health Policy Center, The Urban Institute, Washington, DC	12

Submissions for the Record

Prepared statement of Senator Robert F. Bennett, Chairman	37
Prepared statement of Representative Pete Stark, Ranking Minority Member	39
Prepared statement of Dr. Bernard Kaminetsky, M.D., F.A.C.P., Colton and Kaminetsky, Boca Raton, FL	41
Prepared statement of Dr. Robert S. Berry, M.D., President and CEO of PATMOS EmergiClinic, Inc., Greeneville, TN	57
Prepared statement of Dr. Alieta Eck, M.D., Drs. Eck, Apelian and Mathews, Piscataway, NJ; Co-founder, Zarephath Health Center, Zarephath, NJ	80
Prepared statement of Dr. Robert A. Berenson, M.D., Senior Fellow, Health Policy Center, The Urban Institute, Washington, DC	91

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WEDNESDAY, APRIL 28, 2004

UNITED STATES CONGRESS,
JOINT ECONOMIC COMMITTEE,
Washington, DC.

The Committee met at 10:03 a.m., in Room SD-628 of the Dirksen Senate Office Building, the Honorable Robert F. Bennett, Chairman of the Committee, presiding.

Senators present: Senator Bennett.

Representatives present: Representative Stark.

Staff present: Donald B. Marron, Tom Miller, Leah Uhlmann, Colleen J. Healy, Mike Ashton, Wendell Primus, Deborah Veres.

OPENING STATEMENT OF SENATOR ROBERT F. BENNETT, CHAIRMAN

Chairman Bennett. The hearing will come to order.

I understand that Dr. Berry is in the building and will be with us shortly.

We very much appreciate our witnesses being here this morning. We're here to explore how some doctors are finding alternatives to the traditional third-party payer health care system, and at the same time providing better care for their patients.

Many doctors are frustrated by the state of our current health care system, and their patients are, too. Doctors are continually faced with third-party entities interfering in their practice, pushing them towards a system that focuses on arcane regulations rather than patient care.

Low reimbursement rates require physicians to increase the number of patients they see, while shortening the length of office visits. And they must also shoulder the burdens of increased practice costs, time-consuming paperwork and rising medical liability premiums.

Many patients, particularly those with lower incomes, find it difficult to obtain affordable care and to receive it in a timely manner. They often feel rushed through brief office appointments without having adequate time to address their questions and concerns, or adequate help to navigate the complex medical system.

Today's hearing will examine the experiences of innovative and entrepreneurial doctors who are responding to gaps in the current system by returning to an older style of medical practice—a patient-focused approach that used to be the norm. By adopting these approaches, doctors are finding ways to spend more time with their patients and provide a better quality of care.

We will examine the potential reach of these early trends among innovative physicians who deal more directly with their patients than do physicians relying predominantly on third-party insurance mechanisms.

Now, I recognize that insurance-free medical care may not work for everyone. But early evidence of consumer-directed doctoring suggests that some physicians and patients are reacting favorably to this way of providing care, and in some cases, it has produced lower costs.

In other cases, it has offered a more enhanced level of personal medical service. And on occasion, it has delivered both. In any case, it means providing better value.

By studying how these entrepreneurial physicians are building their practices, we can learn about the strengths and weaknesses of our current health care system and how better to address them. By understanding alternatives to the system, we may be able to improve medical price transparency, help relieve medical liability pressures, and retain highly-trained physicians who are increasingly frustrated by the present system.

We'd like to welcome our panelists today, all of whom have experience delivering health care through innovative or entrepreneurial means, or who have studied the issue in an effort to understand the implications of this emerging trend.

I will wait until after we've heard from Mr. Stark to introduce each of the witnesses. But again, we thank you for being here and look forward to your testimony.

Mr. Stark.

[The prepared statement of Senator Robert F. Bennett appears in the Submissions for the Record on page 37.]

OPENING STATEMENT OF REPRESENTATIVE PETE STARK, RANKING MINORITY MEMBER

Representative Stark. Thank you, Mr. Chairman. Excuse me, but I certainly am in need of treatment today. If I could afford the services of our witnesses, I would probably be better off for it.

This hearing appears to be an installment in your side of the aisle's move towards replacing traditional health insurance with high-deductible health plans and health savings accounts and that sort of thing.

This time the rationale is that doctors provide cheaper health care to patients if we do away with the insurance companies and their pesky paperwork.

Now I'd state right off that I'm certainly not a poster child of insurance companies in this world. But I'm not sure that they don't provide a service to many of us.

The frustrations in dealing with insurers have led some doctors to accept only cash payments. And the doctors claim that they can offer lower prices for office visits and other simple procedures because they reduce overhead from all the paperwork and the insurance reimbursement and so forth.

"Concierge care"—as it's been dubbed—is kind of a new country club for us rich folks. And we pay a big premium just to belong, and then we're guaranteed access. We don't have to sit around with

the riff-raff. But we still have to pay for each service that we receive.

I guess the danger is that if a large number of the doctors open these types of practices, the health care system will move much more quickly into a dual system, with the wealthy paying for exclusive access and the poor taking what's left over—public charity care, whatever.

Having access isn't quite the same as having health insurance. A growing body of literature shows that people without health insurance forego even necessary care and don't have their care properly managed. They incur the risk of serious complications and lower overall quality.

And I'm particularly amused by the concept of "empowering" consumers to make more choices about their health care. The need for health care is unanticipated. We rely on our doctors' expertise, not our own, to guide our decision-making.

As I often say, we may ask questions of our doctor, but we never question our doctor. And the policy of consumer-directed doctoring says, basically, "patient—heal thy self."

I guess I've spent the last 20 years of my congressional career in the health care policy and I've never known so-called "consumer-driven" or "consumer-directed" health care to perform well. It seems to shift costs to consumers who pay more. Then we get to the HSAs and some of these other programs, the high-deductible plans. All I can see is that that's another tax shelter, again, for the rich, and it doesn't do much to help us select.

Now I have a personal disclaimer here.

A number of years ago, I went to Johns Hopkins with prostate problems. And probably one of the leading surgeons in the world was there and he just looked at me and said, "I don't take insurance, fella. If you want me, it's $5,000 up front."

And I said, okay, I wanted him, because as many of you may recognize, this was delicate surgery and I wanted to come out of there with all my moving parts in working order. So I paid it.

Now, I'm not sure that there are a lot of people who could. And I found out why he doesn't take insurance. Blue Cross kicked in $1,300. That's what they would have paid him. And he wanted $5,000.

So there are people—I guess if you want the best and the brightest, you have to pay up for it. Maybe he occasionally did it free, but I'm just suggesting that this does go on. I'm not sure it should, but it does.

So I'll be interested in hearing from our panel today and see what light they can shed on how to help us all, every American resident, receive first-class medical care more equitably.

Thank you.

[The prepared statement of Representative Pete Stark appears in the Submissions for the Record on page 39.]

Chairman Bennett. Thank you very much. I normally do not comment on other Members' comments. But I do feel moved to make this one disclaimer. And maybe it's the fact that I'm in the Senate and Mr. Stark is in the House.

But I can assure you, Mr. Stark, that there is no conspiracy on our side of the aisle to try to undermine the present system.

There is certainly none on my part.

Representative Stark. I'm glad, because I don't like any conspiracy that I'm not a part of, Mr. Chairman.

Chairman Bennett. I see. Okay.

[Laughter.]

Chairman Bennett. These hearings, and we are doing a series of them, are structured simply in an effort to take a fresh look at the entire health care system, a simple desire to say that nothing is beyond examination. At least from my point of view, there are no sacred cows that cannot be looked at.

It stems from my conviction that the present system, however satisfactory it is in many ways, is inadequate, is falling short in a large number of ways. And I want to take a clean sheet of paper look at every aspect in the health care area to see what is working and what isn't, to see if, in the end, we can't make a recommendation to the legislative committees, on which you sit and I don't—maybe that gives me some degree of objectivity, that I'm not on the Finance Committee or the HELP Committee. So I have absolutely no responsibility.

Representative Stark. If you were going to become a Democrat, you wouldn't, either. Okay.

[Laughter.]

Chairman Bennett. That's a step I'm not planning to take.

[Laughter.]

Chairman Bennett. As I think I may have said when I became Chairman of this Committee, Alan Greenspan once said to me: "When Hubert Humphrey was Chairman of the Joint Economic Committee, he made it look as if no other Committee in Congress mattered, because he said, 'you have no legislative mandate. Therefore, you can look at everything.'"

And I corrected him. I said, "No, Alan, we do have a legislative mandate." And he said, "Oh, what is it?"

And I said, "We're required to offer a comment on the annual report of the President's Council of Economic Advisers."

And he said, "As I said, since you have no legislative mandate, you can look at everything."

I don't think that there is anything that is affecting our economy more than rising health care costs. I hear it from corporate executives as their number-one cost problem over and over again, one that they cannot seem to contain.

So I think it appropriate that we look at every conceivable aspect of the system to try to understand it better. And at the end of the day, I hope that we can make some recommendations to the legislative committee.

But may I assuage my Ranking Member's fears that this is not the part of a long-term conspiracy on behalf of the Republicans to try to undermine anything or promote anything other than, I hope, solutions that can be embraced in a bipartisan fashion.

I'm not naive enough to expect that that will really happen, but at least it's a consummation that we can work towards.

If you need an additional rebuttal, I'll be happy to allow you that.

Representative Stark. [Nods in the negative.]

Chairman Bennett. Okay. With that, let us turn to our witnesses, whom I will introduce in the order in which I think we should hear from them.

Dr. Bernard Kaminetsky, from Boca Raton, Florida, operates a practice that specializes in concierge care, or retainer medicine, where patients primarily seek preventive care, get involved with wellness plans and individualized attention and 24-hour access to a personal physician.

And then we'd like to go to Dr. Robert S. Berry, who is here from the PATMOS EmergiClinic in Greeneville, Tennessee. Dr. Berry will talk about his experience building a pay-as-you-go practice. His office fully discloses its prices up front, receives payment at the time of services, and generally does not accept any third-party insurance reimbursements.

Dr. Alieta Eck, a Physician from Piscataway, New Jersey, runs a—did I pronounce that city correctly?

Dr. Eck. "Pis-cat-away."

Chairman Bennett. Piscataway. Okay, I apologize to the Piscatawayans who may be offended.

She runs a charitable care clinic that combines community resources with more efficient methods of health care delivery, to meet the urgent medical needs of the poor and the uninsured.

And then batting clean-up, we will hear from Dr. Robert Berenson, who is an experienced physician, now a Senior Fellow from the Urban Institute here in Washington, DC. He has focused on health care policy, particularly Medicare.

We look forward to each of you.

Dr. Kaminetsky, we will start with you.

STATEMENT OF DR. BERNARD KAMINETSKY, M.D., F.A.C.P., COLTON AND KAMINETSKY, BOCA RATON, FL

Dr. Kaminetsky. Thank you, Mr. Chairman, Mr. Stark.

I am a 51-year-old, board-certified internist presently practicing as an MDVIP-affiliated physician in Boca Raton, Florida. I affiliated with MDVIP because of the inability of the current health care environment to accommodate the necessary emphasis on wellness and prevention that is essential to perform comprehensive preventive care. Instead, current practice, because of time constraints, focuses predominantly on acute care. I am honored to be able to discuss my career, and my decision to provide my patients with the choice to obtain the preventive care and early detection services that they have requested and deserve.

I had always aspired to be a doctor, even from the age of six, as my mother could tell you. I attended Albert Einstein College of Medicine in New York, where I was elected to membership in Alpha Omega Alpha, the national medical honor society. I completed my training at New York University-Bellevue Hospital Center, where I served as chief resident in medicine and was responsible for the continuing medical education of the house staff. My Bellevue experience was certainly unique. I cared for addicted single mothers, Park Avenue matrons, the homeless and suburban entrepreneurs. Following training, I stayed on as a faculty member at the New York University School of Medicine.

During my career, perhaps the greatest change in primary care has resulted from the rapid growth of managed care, especially in the realm of Medicare HMOs. Reimbursement, as we all know, became lower than traditional fee-for-service Medicare, but doctors essentially had no choice.

Capitation—in other words, accepting fixed payment per-patient per-month—held the potential to be very remunerative, because whatever was not spent on the patient accrued to the doctor.

However, such an arrangement was never acceptable to myself or my partners because of the obvious inherent conflict of interest. In that setting, a doctor is incentivized to order as few tests and as little medication as possible in order to improve the bottom line.

Moreover, that approach to care emphasized treatment of acute problems with diminished emphasis on prevention.

Concomitant with declining reimbursement, we faced an increase in our overhead on a continual basis. The health care costs for our employees continually rose. Malpractice insurance has skyrocketed, especially in crisis states such as Florida.

We attempted to cut staff, but that caused untenable delays. And we became more and more constrained in our efforts to be pro-active with regard to health care and became more and more reactive.

It seemed there was only one way a practice could promote prevention and still maintain its financial viability, and that was by seeing more patients. But the reasoning was clearly circular—more patients would mean less time for prevention, while a solution mandated more time, not less.

As a profession, we all had great ideas, but we were lacking in the ability to implement any meaningful change. I was very seriously contemplating leaving clinical medicine.

Last June, the *New England Journal of Medicine* documented that only 55 percent of recommended preventive care is administered. Only 52 percent of recommended screening is performed.

It's been estimated that a doctor with a typical patient load of 2,500 patients, if he were to comply with the recommendations of the U.S. Preventive Services Task Force, he would spend 7.4 hours of each day on prevention only—obviously, only a tiny fraction of the day would then be devoted to acute care.

In a similar vein, if one planned on performing comprehensive preventive exams of even an hour in length for each of the 2,500 patients in a typical practice, that would be 2,500 hours, or one entire year solely for annual exams, with no time whatsoever for acute care.

In contrast, if a practice is limited to 600 patients, such as my current practice, then 12 hours a week, or even 18 hours, is devoted to annual preventive exams with ample time available for routine and urgent care.

Hence, my decision to join MDVIP, a program which is focused on annual preventive care, physical exams, individualized wellness planning tailored specifically to a patient's needs.

I make prevention the foundation of my practice rather than a set of often ignored recommendations. My practice style allows me to dwell on exercise, nutrition, weight loss, smoking cessation, curtailment of alcohol use. I provide detailed analyses for the patients

of their medical and family history, nutritional, psychological and fitness screenings, cardiograms, comprehensive labs, imaging studies.

And all of this is supported with electronic documentation that is given to the patient to carry on a CD in their wallet.

My practice is limited to 600 patients by necessity. In order to offset the decline in revenue associated with the far smaller practice size, the patients pay an annual fee to receive these preventive care services which are not covered by Medicare or commercial insurance.

Early analysis suggests that the scope of care that is delivered in a practice such as mine results in enhanced patient outcomes. Preliminary studies using a modified HEDIS survey of MDVIP-affiliated practices in Florida have yielded results that far exceed the national quality of care averages.

Moreover, these same practices have experienced approximately 30 percent fewer hospitalizations relative to national averages, a highly significant difference.

Who are my patients?

The demographic make-up of my current practice very closely mirrors that of my former practice. My patients range in age from 18 to 101, and come from all socio-economic backgrounds, including patients on fixed incomes and those whose incomes qualify them as upper middle class.

Those patients who chose not to avail themselves of the benefits of the MDVIP prevention program remained in my former practice and a new internist was hired to join the group, take my place, and ensure continuity of care for all patients.

For myself, for my patients, the clock has truly been turned back. The practice environment of the past is like it used to be. I really feel like I'm a doctor again, a confidant, an advisor.

I'm in a position to incorporate the newest recommendations regarding prevention. It's a win for the patients. It's a win for the doctors. It's a win for the insurers because of the reduced hospitalizations.

I can't imagine anything could be better. Thank you.

[The prepared statement of Dr. Kaminetsky appears in Submissions for the Record on page 41.]

Chairman Bennett. Thank you very much. We appreciate that. Dr. Berry.

STATEMENT OF DR. ROBERT S. BERRY, M.D., PATMOS EMERGICLINIC, INC., GREENEVILLE, TN

Dr. Berry. Mr. Chairman, Mr. Stark, thank you for inviting me to testify before this Committee today.

I am grateful that our leaders want to know what is happening at the grassroots level and you are willing to consider a perspective of an ordinary primary care physician like me when deliberating health care policy.

I'm Dr. Robert Berry. My background is primary care internal medicine and emergency medicine. As a physician in a private practice that does not take any insurance, I believe I might be able to offer you fresh insights on some of the seemingly insurmountable problems we face in health care today.

Over three years ago, I left ER medicine to start a clinic primarily for the uninsured in my community. I thought I might be able to help them avoid unnecessary expensive visits to the ER.

My motivation was simply to try and flesh out in my own life an answer to the age-old question—"who is my neighbor?" Of course, I don't refuse other patients willing to do payment at the moment of service. In fact, because this seemed to be the unifying theme of our practice, I chose its acronym—PATMOS—as the name for the clinic.

PATMOS is similar to charity clinics such as Dr. Eck's in that it serves many patients falling through the cracks of our broken health care system, except that we don't receive any taxpayers' funds, either directly as subsidies or indirectly as a tax-exempt organization.

It is similar to boutique clinics such as Dr. Kaminetsky's in that it contracts directly with its patients, except that most of our patients don't have insurance.

The prices for medical services at our clinic are quite reasonable—$35 for a sore throat, $95 for a simple laceration.

I can keep my fees this low and, thus, affordable to the uninsured and patients with high deductibles, because I avoid the crushing overhead and hassles of processing relatively small medical claims, a service from which they clearly do not benefit.

Mine is only one of many non-boutiques, cash-only clinics in this country. There is a growing movement of physicians like me who offer affordable quality medical care by refusing to sign insurance contracts.

We are no longer willing to tolerate anyone intruding into the once-sacred doctor/patient relationship. And the mainstream media is catching on.

Last November, *The Wall Street Journal* featured our clinic on the center of its front page in an article entitled, "Pay As You Go MDs—The Doctor Is In, But Insurance Is Out."

Just several weeks ago, the AP News ran a story on Simple Care, a network of cash-only clinics, which was picked up by CNN and many local media throughout the country.

National news programs have highlighted other cash-only clinics as well. The media is tapping into a rich vein of frustration and fear, frustration with costs escalating and no end in sight, while medical care is becoming less accessible and less personal.

Fear that we might end up with a single-payer system where delays for treatment can be inhumane.

Clinics like ours offer hope that there are doctors out there today who care, and who don't cost an arm and a leg.

In Canada, the median time from a mammogram to a mastectomy is 14 weeks. Personally, I don't think I could look a woman in the eye, inform her that her mammogram was suspicious for cancer, and then have to tell her that the cancer might have spread before she can receive treatment.

Of course, in Canada, I wouldn't be put to that test, because clinics such as mine are currently illegal there.

The issue before you now, it appears, is very simple—who will control health care dollars?

The government? No. Medical decisions are much too complex and personal to entrust to distant bureaucrats, many of whom lack basic medical knowledge.

How about the patients, then?

In my opinion, the most cost effective and humane solution to many of our health care problems is to allow ordinary Americans to manage their own routine medical care by giving them control over health care dollars. They can do this now with pre-taxed, tax-deferred personal and family medical accounts within consumer-driven health plans and spend them at clinics like ours.

It is, after all, their money and their health. They should control both.

Ronald Reagan once again said, "There are no easy solutions—just simple ones." All that is required is being a neighbor.

[The prepared statement of Dr. Berry appears in Submissions for the Record on page 57.]

Chairman Bennett. Thank you very much.

Dr. Eck.

STATEMENT OF DR. ALIETA ECK, M.D., DRS. ECK, APELIAN AND MATHEWS, PISCATAWAY, NJ; ZAREPHATH HEALTH CENTER, ZAREPHATH, NJ

Dr. Eck. Good morning. Thank you for the opportunity to speak before this Committee and share some of my experiences as a private practicing physician, in the trenches, so to speak.

I have prepared a written testimony, which you have. So I'm just going to try to summarize.

Chairman Bennett. It will be part of the record.

Dr. Eck. I was a registered pharmacist before I became a physician. I graduated from St. Louis University School of Medicine, did a residency in internal medicine at Robert Wood Johnson University Hospital in New Jersey. I'm board-certified in internal medicine.

I live and practice in New Jersey, but I participate in a health benefits reform message board. Experts from across the country—we've been discussing the different problems related to health insurance. New Jersey is considered the poster child with what can go wrong with how government can mess things up so badly.

In 1992, they created an individual health coverage program to ensure that people that didn't have private insurance or government-sponsored insurance could purchase insurance. So they standardized plans.

The state was attempting to make it easier for people to understand the plans and comparison shop. But the net effect was a staggering increase in premiums and an equally staggering increase in the number of people who are uninsured.

So New Jersey is really ripe for change.

There were 220,000 individual policies in 1996; 90,000 now, and they're going down quickly.

As you'll look up on the web site, you'll find that an individual policy for $1,000 deductible, 30 percent co-pay, is now about $4,000 a month.

They actually publish these rates in New Jersey.

The reasons are many. But it's government. The government has told people that the insurance companies have to have a community rating. They have guaranteed issue. They have a $300 mandated amount that they have to pay for check-ups. All kinds of government mandates in each insurance policy. They limit the level of the deductible. And there's intense political pressure to avoid change.

I've outlined all of the reasons for this in my prepared comments.

I even asked our Senator, Jon Corzine, I said, please, let us buy health insurance across state lines. But that's not legal in New Jersey, or I don't know if anywhere else. It certainly wouldn't be against the commerce clause of the Constitution and it would allow a lot less people to be uninsured.

Anyway, I have two practices. I have a private practice with four physicians. And there, we have cut things way down so that we have two full-time employees, about six part-time employees. Very efficient. We don't do any HMOs. We don't do any private insurance.

And this keeps our costs way down and our prices are very reasonable there. We earn a living there.

We participated in one non-capitated HMO. But they looked at our charts and decided that we had charged a higher level than we should have. And therefore, they wanted a claw back. They wanted to take back some of the money that they had given us for services that we had rendered.

We got out in a hurry. And that was the last HMO that we were in.

We found that, in a hospital conference, they gave us a graph and they showed us a horizontal line was where how long people stayed in a hospital. And the vertical line was how much we spent.

And they told us if we were in the upper right-hand corner, we were bad doctors. Lower left-hand corner, we were good doctors.

In other words, our whole training was being compromised by how much we spent, and that was really the most important thing, as Dr. Kaminetsky had noted.

Well, there is a problem of access for the poor. So although our prices are reasonable, we also want to help people who are struggling and have nothing.

We have fascinating stories of people that we have helped in the other practice that we have, called the Zarephath Health Center. We've been in existence for 6 months now and we've been able to take care of people in a very personal way. Not a bureaucratic way, not a one-size-fits-all way.

But you get to know these people and you say, well, how can I help? And how can I make a difference?

There's a little building that was given on our church property for us to use. Our overhead is about $500 a month. We have all volunteers taking care of people. And they come in. And I want to tell you about a couple of these people that we've been able to take care of.

A 28-year-old woman came. Her father had died from a long illness. She had been the primary caretaker and became very depressed. She lost her apartment. She had no job and needed $230 worth of medicine.

She went to the local social service agency and they looked at their lines and they filled in what she needed. She said, "You know, the way you could get help is to just get pregnant."

Well, she was smart enough to realize that wouldn't really help her. So she wound up coming to us. We helped her access a pharmaceutical program where she could get $230 worth of this medicine, a three-month supply. And after that, they wouldn't repeat it until she got a letter from the social services agency that said why they had turned her down. They wouldn't write it.

So we just called around. We found out how much the medicine cost, wrote her a check and bought her her medicine.

It's a tax-deductible gift that people had given to us to help take care of the poor. We helped her. Now she's getting a job. She's not going to need us any more. That's the kind of person we're helping.

Another, a 52-year-old woman is taking care of her 54-year-old sister dying of breast cancer. She has no insurance. Her family has no insurance. She went to the local hospital where she thought she could get reasonable care. They charged her $495 for a physical and blood work. They then gave her a prescription for a mammogram.

Now she has no money, no anything. She came to us. We said, wow, we could have done that for a whole lot less. But we gave her the money for a mammogram. And she got it and thankfully, she's okay.

Interestingly, her sister was just told that she can get on to Medicaid as of July 1st. And she'll be dead by then. So she has really no help. We'll help her, too.

The bureaucratic systems just don't really help, when you really get down to the bottom to where people are struggling.

Just to summarize. I love being a physician. It's the most rewarding of professions. But we're struggling because a lot of government mandates—the malpractice situation is extremely difficult. That makes it harder and harder for us to provide reasonably-priced care.

There are 15,000 retired doctors in New Jersey who can't even help in our clinic because they can't buy the mandated health insurance. Or aren't interested in paying a lot for health insurance.

Those doctors——

Chairman Bennett. You mean malpractice insurance, don't you?

Dr. Eck. I'm sorry. Malpractice insurance, yes. That's an army of people who could serve the poor in our very personalized way if they were just freed up from that kind of a liability.

Anyway, we have to hurry because there are a lot of Americans that are being hurt. The obstetricians and neurosurgeons aren't able to do what they do best because of the malpractice situation.

To summarize, that's basically it. We just need less government pressure on us and more freedom to practice the way we were trained.

Thank you.

[The prepared statement of Dr. Eck appears in Submissions for the Record on page 80.]

Chairman Bennett. Thank you very much.

Dr. Berenson.

STATEMENT OF DR. ROBERT A. BERENSON, M.D., SENIOR FELLOW, THE URBAN INSTITUTE, WASHINGTON, DC.

Dr. Berenson. Thank you, Mr. Chairman, Mr. Stark, and the other witnesses. I appreciate the opportunity to speak here today.

I've provided testimony or a statement for the record. I'm going to divert from that because yesterday evening, I had an opportunity to read the testimony of the other witnesses and found it very interesting and wanted to comment briefly on some of what I read and heard this morning.

Chairman Bennett. Your full statement will be included in the record, as is the case with all of the witnesses.

Dr. Berenson. Thank you very much. And I actually found I had a lot to agree with in the testimony and the statements of the other witnesses.

I think, in composite, they are painting a picture of an increasingly dysfunctional health care system, where primary care physicians, in particular—and I guess we're all, I'm an internist, also, a board-certified internist. I think in particular feel that the system is not working very well for ourselves or for our patients.

I certainly think in aggregate, the other witnesses presented a good picture of the symptoms of our current system and I fully understand their responses, how they've tried to cope with the problems in their own way.

I was actually in a similar situation about a decade ago to Dr. Kaminetsky, where I was working harder trying to just stay afloat.

I think the best year I ever had practicing internal medicine was making about $35 an hour on a full-time basis, making $75,000.

I took time with my patients. Insurance didn't reward me for taking time with my patients. And I wound up, instead of doing what Dr. Kaminetsky did, moving on to more of the policy side of health care to try to see what we could do about improving the system.

So I'm quite sympathetic to what they have described.

However, I think I disagree with some of the proposed approaches, or at least where the physicians suggest the solutions lie.

Dr. Berry made some very compelling comments about how a patient has a choice between going to a busy, crowded emergency room, spending hours, getting a huge bill and not terrific service. And he was providing an alternative to that.

And indeed, all of the physicians described sort of the growing impersonality and bureaucracy that characterizes medicine.

Let me briefly tell you a story of my wife, who a few years ago was traveling in a city where she didn't know any physicians. She was on a trip, developed a fever of 103, felt terrible at about 6:30 at night, and decided she needed to get some medical attention.

She went across the street to a pharmacy that was open. Got the name of a physician to call. Called, a man answered. She said, "Can I speak to the physician?" He said, "I'm the physician." She had expected to be going through a whole array of people, actually expected to be talking to an answering service.

Described her problem. The physician said, "I'll be right over."

In half an hour, had seen her, diagnosed her, given her a prescription, and billed her for $40, which she paid on the spot.

That's the way medicine should be practiced.

That was in France. That was not the United States. That was in a social health insurance system. In Belgium, physicians make as many home visits as they do office visits. In other words, just the fact that there is social health insurance does not mean that we have to have a bureaucratic, impersonal, costly health care system.

There are clearly examples of problems. The UK is under-funded. There are long waits. Canada is having a problem. Other systems have problems. But to equate bureaucracy with government, I think, is a mistake.

In my opinion, the kinds of problems that we have don't call for moving towards high deductible plans that put even greater financial burdens on individuals to seek care, but actually should be addressed by dealing with the problems of uninsurance and under-insurance, by the huge waste and inefficiency that we have because of, in particular, the individual and small group insurance market, which does not work very well and extracts 40 cents on every dollar. These dollars are not going to patient care and this insurance market creates some of the confusion that physicians and patients experience.

And I think we have a continuing problem that has not been adequately addressed by the Medicare Resource-Based Relative Value Scale or by private insurance, which tends to follow the RBRBS, in which we over-reward procedures and tests and doing things to patients and under-reward the activities that physicians are trained to do, but are not compensated for doing.

So I think there are lessons in what these doctors have described for changes in public and private insurance companies. But doing away with front-end insurance coverage, I do not think is the solution.

Specifically, on the issue of health savings accounts, I think they actually exacerbate some of the problems. The healthy and wealthy would be able to do reasonably well with high-deductible plans. But those with chronic diseases, which are an increasing percentage of the population, who would immediately go through their deductible and be in the catastrophic part of the insurance, would be worse off because of adverse selection.

And so the premiums would go up more and more for those with illnesses, and those who are healthy and wealthy would be able to essentially opt out of the insurance pool.

Similarly, I would argue that the costs in health care which are driving government budgets and private premiums through the roof, are associated with a small percentage of patients who generate a huge percentage of costs.

Virtually anywhere that you look, whether it's in Medicare or in private insurance plans, about 5 percent of patients generate about 50 percent of the costs.

In Medicare, patients with four or more chronic diseases represent about 79 percent of spending in the Medicare program.

To provide some incentives for people to use their own money to shop more carefully might feel good. It might reduce some marginal, discretionary services. It would not make a dent in what's driving our health care spending, which is really spending for the very sick.

And then the thing that would bother me the most, and picking up on some of the remarks that Dr. Kaminetsky made, is that people with high-deductible plans who are not affluent would be making choices about whether they should forego early prevention and early diagnosis and treatment, which should forestall health problems down the road and reduce spending down the road.

I don't think we have any evidence base to suggest that people, basically being asked to be their own doctor, know how to make those kinds of choices.

I certainly would not go there based on what we know right now.

So let me conclude by saying I look forward to our discussion. I think the physicians are on to something when they describe the problems in the health care system.

I just don't think that moving more towards a market solution is the way we want to go.

Thank you very much.

[The prepared statement of Dr. Berenson appears in Submissions for the Record on page 91.]

Chairman Bennett. Thank you very much. I look forward to discussion with all of you.

If I might, Dr. Berenson, picking up on your example of your wife. If I understood Dr. Eck correctly, the physician in France that you talk about would not be permitted to do that in the State of New Jersey. Is that correct?

Dr. Eck. I don't think he'd be permitted to do that in Canada. But in New Jersey, they could do that. Cash practices are okay in New Jersey.

It's just that if you wanted to have health insurance, the mandates are all in the health insurance policies, which makes the price of the insurance policies go up. But, yes, cash payments are okay in New Jersey.

Dr. Berenson. I'm not aware specifically of New Jersey, but there have been developments of physicians starting activities to do home visits.

I actually think it's sort of a mechanical thing. In some countries, patients pay at the point of service and then get reimbursed from the social security system. In other places, they send the insurance through up front.

I don't think that—we do not have to have all of the overhead associated with the current practice of U.S. medicine in a well-insured health care system, is the point that I want to make.

Chairman Bennett. Yes. And I find agreement there between what you're saying and the experience that's being demonstrated here.

Now, Dr. Kaminetsky, respond to Dr. Berenson. By the way, I never mentioned health savings accounts in establishing this hearing.

It's interesting that that's where the conversation goes because that's where the conversation has been.

As I said in my response to Congressman Stark, I'm not carrying water at this point for any particular solution. We just want to find out what will work to make physicians, as these physicians have indicated, get excited about practicing medicine again.

Increasingly, I hear that physicians want to get out of it, that the bureaucracy, whether it be private or government, is intolerable.

Among physicians, I don't get any division between the bureaucratic heavy hand of an insurance company or the bureaucratic heavy hand of the government. It isn't an anti-government kind of thing.

It's a revolt against the idea that a third party, whoever it may be, is constantly injected into the equation.

So let's go back to understanding where we are.

Now, Dr. Kaminetsky, will you respond to Dr. Berenson and talk about what——

Dr. Kaminetsky. When you raised the point, which is, of course, on the principal reasons we're here, discussing physician dissatisfaction and why doctors have chosen to make changes in the nature of their practice.

The premise underlying the question or the criticism of what I do is the assumption that were I not doing what I'm doing, I would just be back on the treadmill the way I was, seeing 30 people a day, dealing with acute care, but paying little, if any, emphasis to prevention.

That's a flawed premise, because I was certainly on the verge of leaving the practice. I had done enough investigation to actually be very seriously contemplating signing a contract with a pharmaceutical company. And of course, many physicians have, unfortunately, left the profession because of the frustrations involved. And sadly, their skills are being lost.

Concerns—Dr. Berenson touched on many different aspects. What I do is a solution. It's certainly a niche product. To quote from the AMA's report of the Council on Medical Services—"The phenomenon of retainer medicine is inherently self-limiting. The more physicians charge for their services, the smaller the demand for their services. These economic realities limit any potential for widespread adoption of retainer practice."

In terms of access, I also want to emphasize that affording oneself of the opportunity to concentrate on preventive services and, as a patient in a smaller practice, reap the de facto benefits of being a patient in a smaller practice, is a matter of choice.

Certainly, for those patients, of my former patients who were not capable of making the choice because they truly would find that $1,500 prohibitive, those patients are still my patients.

We call them scholarship patients. There's absolutely no differentiation between the preventive services they receive and any other patients.

So, I do not believe that access is limited by the nature of an MDVIP affiliated practice because of it being a niche product, and because those patients who truly are not capable of making the choice are accommodated, nonetheless.

Chairman Bennett. Any other comment before I turn it over to Mr. Stark on this?

[No response.]

Chairman Bennett. Okay. What I'd like to do, Mr. Stark, if it's all right with you, is for you to take a round and then I would hope that the six of us could have a roundtable kind of conversation rather than the traditional your turn, my turn, my time, your time.

Let's interrupt each other and interact with each other, if that's acceptable to you.

Representative Stark. It certainly is. Thank you. That's generous of you, Mr. Chairman.

Like Dr. Berenson, I haven't heard anything this morning that gets me terribly upset. I have to look at the Stark family.

I like the idea of what we call the "boutique." I'm just enough of a snob that I'd just as soon be able to call the doctor at home and do a whole lot of things that—now, the Senator and I have available to us, courtesy of the United States Navy, a whole clinic full of doctors who are available 24/7. And we don't wait. I mean, we really don't. And they're high-class physicians.

And it is a form of medical care delivery that this country could not afford.

But we know what the boutique of the boutiques is like. And it's pretty nice. And I have some of my colleagues who have retired who get out into the real world and miss that very much. They could afford and would go to a physician.

We changed with our three little children pediatricians. Same reason. We just got sick of being shuffled. They ran maybe three offices and had 15 physicians. And that got to be just more than we could deal with until we found a physician who would deal with the children and we could contact her. So I think that's instinctive.

The trouble with it, I suspect, is if everybody went that way, we would get into much more of a two-class system than we have.

Let's assume that the 40 million uninsured are one class and those who enjoy medical payment systems are in another class.

So I have no quarrel there.

Dr. Eck, first of all, you're to be commended for formalizing your commitment to treating people without charge. I have often suspected that when I hear physicians, and I hear a lot of physicians every year, complaining about how poorly Medicare pays them and how much time they spend on pro-bono services, that the only time I think they really mention pro-bono services is when I see them in my office.

But that's a skepticism that you certainly disprove.

As for cash only, I have this experience. Near Annapolis, where we live, there's a doc-in-the-box person who doesn't require an appointment and is near our home. And often, either our nanny or my wife or I will go there when we're pretty sure what we need. We're pretty sure it's an ear infection and we need an antibiotic, or whatever.

And she's very accommodating. She takes cash, but we can send her bill on to Blue Cross. And sometimes they'll pay us some and sometimes they won't, depending on what she writes down that she's done to us. This physician serves a real purpose in our community.

There's a nighttime pediatrics that now takes adults as well. It's a community organization mostly of pediatricians and a couple of family practice physicians. And they're open 6:00 till midnight and Saturday afternoons and some Sundays for the time that children mostly seem to get sick. And they will take adults.

So I had an experience there, and this is what troubles me.

I was waiting to register my son to go in, probably with an earache. A woman was next to me and they were saying how much she had to give them her insurance card or her credit card. They did not take her insurance. She had a young child with her and the child was quite obviously in some pain. They wanted $65.

She had driven, for those of you who know the area, from Kent Island all the way to Annapolis. So this wasn't just in the neighborhood. They made some effort to bring this child some distance. And she couldn't afford the $65.

So she left with the child and hopefully went to the Annapolis Medical Center and waited around the emergency room for a while.

And there are people—and it's hard for many of us who are more comfortable to understand where $65 is a real barrier to getting the kind of attention that we think, as patients, that we'd like at the time. And that's a problem I have.

I wanted to ask because I want to talk about the free market in a minute.

In each of your practices, for the primary care patients—and I don't know how many of you provide other services than primary observation and referral. But give me what you think would be the median dollar amount that your patients spend. Not including your fee.

But what does a patient on your books spending a couple of thousand, three thousand, two thousand, one thousand, what's the median of people who you see?

But before you get to that, my concern is, and I think in your testimony, Dr. Berenson, you presented this to some extent.

I don't think that we as lay people—and the Senator may be better at this than I am—I don't think that we're able to shop for medical care or services.

I can go out and shop, with the help of *Consumer Reports*, for automobiles and tell you how to get the best deal on a Camry or a Lexus or whatever you're looking for, and we know about that.

And my wife can tell you where to go to get the best produce, whether it's best at Fresh Fields or Giant and what days the fish is fresher, where.

But we are absolutely clueless as to what it costs or what kinds of things to go shopping for in terms of medical services.

And I had my staff, just for the heck of it, shop in your hometowns earlier this week. It took four of them about 3 hours apiece. And I would just ask—and it was two things—a head CAT scan and a colonoscopy.

And I don't know if you found a bargain colonoscopy, if you'd like to run out and get one right away. But let me just ask Dr. Berry.

In Greeneville, Tennessee, do you know what the range of colonoscopy charges—now they all said about $2,500 for anesthesiology and the facility fee.

Dr. Berry. Do you want to know the doctor's fee or the hospital's fee?

Representative Stark. What would you guess the range is?

Dr. Berry. The doctor's charges versus what he's reimbursed—the doctor's charges I think run between $600 and $800. The hospital charge to the uninsured——

Representative Stark. We said that we were uninsured.

Dr. Berry. Uninsured.

Representative Stark. The ranges we got were $900 to $1,500.

Dr. Berry. Okay.

Representative Stark. Dr. Eck, what do you think——

Dr. Berry. The hospital, by the way, sir, would be about $1,500 for the uninsured.

I know that because I have a copy of a bill from someone who came in.

Representative Stark. That's okay. I'm just trying to——

Dr. Berry. And his wife's insurance was——

Representative Stark. What do you think they are in Piscataway?

Dr. Eck. Piscataway. It's an Indian name.

Representative Stark. Just the doctor's fee. What do you guess?

Dr. Eck. I'd say about $1,200 to $2,000.

Representative Stark. You'd pay too much. $600 to $1,200 is what we got.

Dr. Kaminetsky, do you want to take my test? What would you guess?

Dr. Kaminetsky. I would hazard a guess of about $800 for the doctor's fee.

Representative Stark. Well, we got $500, $900, $650 and $1,100 in Boca Raton where we called.

So, I guess the only reason I say this is that it took us forever and a day. And if you need a head CAT scan, you're probably not in shape to be spending a couple of hours calling around to get the best price. We don't shop for that. You tell us to take a test. We take it and hope we pass. And we go where you send us.

Dr. Eck. If you're going to save several hundred dollars, you would shop around. That's not that hard.

Representative Stark. Well, Doc, I want to tell you that there are times when various malfunctions hit you and you're in no mood to shop around.

Dr. Eck. Well, that's different.

Representative Stark. And my sense is that——

Dr. Eck. Then what you need is a general contractor who knows the system who can help you out.

Representative Stark. I'd just point out that it's difficult for us——

Dr. Berry. I've done the shopping, Mr. Stark, and I've gotten discounts from hospitals and from other—not for colonoscopies. I've tried. I haven't been able to do that. But for an MRI, for example, cash payment to our clinic would be $530, and that includes the interpretation. If they want to put it on their credit card, $550.

Representative Stark. But you're doing that.

Dr. Berry. I've done that for a lot of tests.

Representative Stark. What I'm suggesting is that that's fine, and that's as it should be.

But we as patients——

Dr. Berry. That's why you come to me.

Representative Stark. Precisely.

Dr. Berry. Because I've done that work.

Representative Stark. And what I'm trying to suggest is that that's what's wrong with these high co-payments—we as patients don't know how to do that. We don't know what we're looking for.

Dr. Berry. Well, what happens out in the real world is that patients talk among themselves and they find out which doctors they can trust.

Chairman Bennett. Right.

Dr. Berry. And that's why more and more patients are coming to me.

Chairman Bennett. Yes. If I can intrude my personal experience in this.

I don't shop for dollars, but I shop for doctors. And if I can give you a somewhat parallel example. You talk about automobiles.

I am as clueless when it comes to car repair as I am medical repair. I have no idea whether I'm getting ripped off by a——

Representative Stark. You are.

Chairman Bennett. Okay.

[Laughter.]

Representative Stark. Go into the repair shop with that in mind and you'll be right.

[Laughter.]

Chairman Bennett. I have found in my lifetime repairmen, auto repairmen who are willing to talk to me. And you spend some time talking to them, they'll tell you who in the community gives you good service and good prices and who doesn't.

And usually, I take the coward's way out and simply take the car back to the dealer, which may or may not be the right thing to do.

But when I'm worried about money and I've got an old car that I've got to deal with, I'll talk to a mechanic who will tell me who the other mechanics are.

Now, do the same thing with doctors. And doctors break the code of silence if you get to know them and they'll say, "the question is, all right, doctor, if you had a problem, where would you go?"

And inevitably, in one area, and I won't identify it, because I don't want anybody listening to this to start to go down the trail. But in one area in my family, we've had a particular problem that has occurred in several members of the family.

We have asked doctors—"Okay, if you had this problem, where would you go?" And the same name has come up every time.

And by careful activity, every member of our family that has had that particular problem has gotten in to see that doctor.

I don't think it's just because I'm a Senator that I can make a phone call and say, "Will you see my grand-daughter?" And have him say "yes."

The network is out there. One of the great frustrations with managed care is that you can't do that. Indeed, when I was CEO of my company picking plans for my employees, I picked the plan that made the most economic sense, which is what the incentive is.

And then when I looked at the particulars, I said, "Wait a minute. I don't want this plan," because the doctor with whom I had a relationship was not on the list of doctors.

I got around it by going to a doctor who was on the list whom I knew and said, "Will you please accept the assignment of my pri-

mary physician and immediately refer me to the doctor that I want?"

And he knew the doctor that I wanted. He agreed with me that it was a very good choice and said, "sure."

So we gamed the system by my signing up with this plan and worked it around so that I never ever saw the doctor who was on the list as my primary care physician.

Dr. Eck. You know, it's interesting. The very best specialists you won't find on any plan because they can name their price.

Chairman Bennett. That was the case with the doctor that I wanted.

Dr. Eck. They can name their price, they're so good. Who do you want to go to when you need that neurosurgery? I'd rather go to the best and pay more than go to the doctor on my plan. That's why I'm not in any plan.

Representative Stark. I just wonder if I could get the numbers real quick and then I'll yield.

Have you guys thought about what the median patient spends for primary care in your practice each year?

Dr. Berry?

Dr. Berry. At my clinic?

Representative Stark. Yes.

Dr. Berry. I know what they spend per visit.

Representative Stark. No. Well, what would you guess they spend in a year?

Dr. Berry. I don't know that, sir, because I don't keep those kinds of records.

But they spend $51 per visit, which includes the professional fee, the labs, whatever tests that I order and whatever medicines I provide there or dispense from the clinic. That's the total visit.

Representative Stark. Any idea, Dr. Eck?

Dr. Eck. The average person? Again, I don't have those kinds of records, either. I'm just imagining.

Some of them like to come a lot. They feel better when they see me a lot. So they might pay $500 or $600 a year, if they're not very, very sick.

Representative Stark. All right.

Dr. Kaminetsky, other than the fee, what's your average?

Dr. Kaminetsky. As Dr. Eck said, a lot of patients like to come a lot. And one of the old complaints about Medicare, of course, is that there's no disincentive for a patient to come for a very trivial complaint.

But I'd say the vast majority of my patients are either paying for their Medicare supplement, which is several thousand dollars a year, plus medications, depending on what their needs may be in terms of relative health.

My non-Medicare patients, their main expense would be the cost of their health insurance, which would vary. I think single with children—for my family of five, I pay $1,300 a month.

Representative Stark. Most of your patients have insurance. And that covers most of what you would bill them for, your procedures.

Dr. Kaminetsky. The vast majority, yes.

Representative Stark. Okay. Thank you.

Dr. Kaminetsky. Can I take the opportunity?

Chairman Bennett. Sure.

Dr. Kaminetsky. I just want to respond to Mr. Stark's anecdote about changing to the pediatrician. And of course, you change because you are frustrated by the lack of access.

Chairman Bennett. You shopped.

Dr. Kaminetsky. The prevention program, the emphasis is truly prevention.

For example, numerous studies have shown that what is most effective in getting patients to stop smoking is doctor-patient intervention. Not Nicorette gum, not nicotine patches, not Welbutrin, but doctor-patient intervention.

When I have a smoker and I'm trying to get him to stop, it's almost like a game. But he knows that a designated day of the week, every week, he's going to get a phone call.

That's prevention.

With 2,500 patients, I couldn't possibly do it. Now it is true, again, a de facto benefit of being in a smaller practice, as when you're competing with 600 people for an appointment versus competing with 2,500. It's different. But the emphasis in the program is prevention.

And as far as the concern about creating tiers, well, medicine is tiers. We've got HMOs. We've got PPOs. A Medicaid patient can't see a doctor who is not a participant in Medicaid. And a Medicare HMO patient cannot see a doctor who is not a participant in that HMO.

This is another product in a very pluralistic market which offers many different options for patients. And the AMA's Council on Ethical and Judicial Affairs, specifically referring to retainer practices, has endorsed the concept that, "the patient has the freedom to select their health care on the basis of what appears to them to be an acceptable trade-off between quality and cost."

Representative Stark. I have no quarrel with it at all. I am a little uncertain as to how it deals with extra billing relative to Medicare. But that's a very technical problem for another day. But other than that——

Dr. Berry. To answer your question, though, all you have to do is multiply, say, the patient sees me 4 times a year for hypertension. That would be about $200.

Representative Stark. One of the problems we have, and then I'll get out of this, what I was leading up to is that, on average, and averages are bad. We spend $7,000 a year on a Medicare patient.

Now, most of that is spent on those beneficiaries who are very much older than I am. But nonetheless——

Chairman Bennett. And in the last 30 days, isn't it?

Representative Stark. Yes. But I think even if you took the 20 percent at the right hand of the curve and lopped it off, we'd still be at $2,000 or $3,000, anyway that would be spent, again, on average, by these 40 million Medicare beneficiaries.

And I don't know that they could get insurance, absent community rating and forced across the country and a whole lot of other things that they could afford if we didn't have it.

Now you may not like it as the best system, but many of us think it's pretty efficient. And prior to 1965, I was active in finding insurance for my grandparents and my parents and it was impossible.

So for those people who remember back that far, it was a great burden that was removed from the worries of seniors as to what they were going to do about paying for health care.

And in those days, it wasn't as expensive. There weren't as many sophisticated techniques and tests and things to pay for. But it was still a concern for people.

Dr. Eck. Do you remember what the cost of a hospital bed was per day back in 1965?

Chairman Bennett. It's under a $100.

Representative Stark. I'm going to guess, in the neighborhood of $100 and change.

Dr. Eck. In New Jersey, it was $39. But once all those dollars came infusing in, that was part of the reason for the medical inflation that has occurred.

Representative Stark. You could buy a Mercedes for $2,000 in 1965, too.

Chairman Bennett. A Mustang, maybe.

Representative Stark. A Mercedes.

[Laughter.]

Representative Stark. A Mustang was $900.

Dr. Eck. Medical inflation is higher than Mercedes inflation.

Chairman Bennett. Yes.

Dr. Berenson, get into this.

Is there any evidence that concierge care or insurance-free medicine of the kind that we're talking about here which Mr. Stark has endorsed as something he'd like to see survive—the Canadian system clearly says, no, we will not allow this to survive.

Is there any evidence that this has contributed significantly to the escalating health care costs? Hasn't the orthodox insurance and medical practice been able to escalate entirely on its own without any help or upward pressure from this kind of thing?

Or is, in fact, this a threat to the now more traditional kind of financing?

Dr. Berenson. I guess a couple of responses.

First, we're combining to some extent apples and oranges here, because as I understand what Dr. Kaminetsky is doing is he's got a separate subscription for a certain kind of additional service.

Chairman Bennett. We deliberately tried to get three different kinds of examples instead of the same one all 3 times.

Dr. Berenson. So, in a sense, I think people are paying extra out of their pocket, without tax-subsidization for this special attention. And it probably marginally increases overall costs. But it's so small, that I don't think it's anything to worry about.

And it might actually have benefits, as he points out, in promoting early diagnosis and treatment.

Again, these other approaches, whether it's having special, cash-only emergi-clinics or physicians who are starting home visit services and getting paid, that's not where the money is in the health care system. And so——

Chairman Bennett. When you say the money, you mean the costs.

Dr. Berenson. The costs. I mean, that's not what's driving health care costs.

So, again, as sort of niche activities, certainly a free clinic is a worthwhile activity that's taking care of uninsured. So I don't think what we're talking about today as sort of niche activities is a threat or driving up health care costs.

What I get concerned about is seeing this become part of a philosophy of moving away from the important social role of insurance pooling risk. To think that we can take these few examples and build it into something bigger is what bothers me.

Chairman Bennett. Well, let's pursue that. Let's not talk about philosophy. Let's just talk about the market.

Suppose this catches on and a lot of people decide they want to do it. You consider—in other words, there's a threshold, if I understand what you're saying—as long as they remain small and scattered and not very many, you're not going to worry about it.

But is there a threshold at which point the Dr. Berrys and the Dr. Ecks and the Dr. Kaminetskies multiply where you say, "Wait a minute, this does become a threat." And at that point, you're going to come to the Congress and say, "You've got to take action to stop it."

Dr. Berenson. I guess my concern is, if we develop—if at some point we're developing specialized services that attract the healthy and the affluent into a separate sort of risk pool that they benefit from, we just drive up the risks for those who have no choice but to have comprehensive insurance.

And so, we may save a few dollars on some reduced discretionary services—if somebody doesn't need an MRI because they're a weekend tennis player and they're going to have to pay out of pocket and they make a decision not to have it, that might reduce some expenses, if it's purely discretionary and it's something that somebody doesn't want to pay for out of pocket.

But the problems created for those who are in the basic comprehensive insurance pool, I think, are not worth that sort of marginal savings.

Chairman Bennett. So there is a point at which you would draw the line and say, by government fiat, we're going to say "no more?"

Dr. Berenson. I'm not sure that I know where that line is, because these are very diverse kinds of activities.

Chairman Bennett. Well, I'm not looking for the line. But philosophically——

Dr. Berenson. Philosophically, I think that's right. I think we don't want to go too far down this road.

Chairman Bennett. Okay.

Dr. Eck, do you serve the wealthy and draw people away from insurance?

Dr. Eck. No, I believe in insurance. I just believe that the insurance model has to be correct.

I believe in high deductible insurance. I don't want people trying to run through their deductibles so that they can get into insurance where everything is covered and then over-spend.

So that's why I like the idea of high deductible and then paying for their services via health savings accounts for the lower things.

Representative Stark. Can I add to that?

Chairman Bennett. Sure.

Representative Stark. I would assume that all four of you feel that whatever the plan, at some amount, $2,000 or $3,000, there ought to be a catastrophic benefit for people who need surgery or severe—do all of you feel like that?

Dr. Berry. I have that kind of insurance.

Representative Stark. Yes.

Chairman Bennett. And I agree with that, too.

Representative Stark. Just the first thousand or two. And beyond that, whoever they are, they ought to have some coverage.

Dr. Eck. It just has to be properly designed. My family, since 1997, has not had health insurance, and I'll tell you why.

Because we live in New Jersey, it was way too expensive and it's not worth the money.

But we were able to get into a Faith Christian group where they could put restrictions on our behavior that would lower the cost of health care for all. And therefore, we pay $215 a month to be covered for catastrophic events that exceed $900. And it's extremely reasonable, and it works, and it's covered. It's not insurance. Therefore, it doesn't get under the department's banking and insurance.

Representative Stark. Do they provide that for warlocks? Have you ever heard?

[Laughter.]

Dr. Eck. They'd have to have their own.

[Laughter.]

Representative Stark. I can't find any. That's why I ask.

[Laughter.]

Dr. Berry. That's because their behavior is so high risk.

[Laughter.]

Dr. Kaminetsky. My practice is entirely compatible with insurance. It does not supplant insurance in any way. And certainly, my patients are far from being cherry-picked as being healthy and wealthy.

It's because of the nature that many of them have chronic illnesses and they would like to forestall getting more seriously ill, that they put the emphasis on our preventive products.

So, certainly, if anything, though it's a small sample, our preliminary data, as I said, shows a 30 percent reduction in hospitalization rate. I am convinced that we are saving insurance companies money.

Chairman Bennett. But your comment there seems to be counter to what Dr. Berenson says, because you say that you're getting the sicker rather than—that is, people who have chronic problems that they want to deal with.

Dr. Kaminetsky. No, I have an entire spectrum.

Chairman Bennett. Okay.

Dr. Kaminetsky. The point I was trying to make is that it's not just getting young, affluent, healthy people who want to live longer than 50.

Chairman Bennett. Okay. In other words, there is no adverse selection.

Dr. Kaminetsky. Absolutely.

Chairman Bennett. All right.

Dr. Berenson, you want to say something?

Dr. Berenson. Well, simply that they have their full insurance coverage. And in addition, they are purchasing some additional services. I think we should actually do the study that's implied here.

A lot of the best physicians I know in Washington where I practiced for many years, and from what I understand from around the country, practice a different style, which is spending lots more time with their patients—these are primary care physicians, often internists. And because they are doing that, they believe that they are reducing unnecessary referrals to other specialists. They think they are reducing tests and procedures and saving money.

This should be subjected to some real testing, and if it demonstrates, in fact, that that's what the effect is, I don't know why insurance companies within their insurance products are not rewarding Dr. Kaminetsky for doing exactly that kind of thing.

I don't know why we have to have this to be extra insurance, I guess is what I'm saying. Why shouldn't Medicare, as I've suggested, and other payers, actually pay additional fees for the coordination activity that primary care physicians should be doing, but don't have time to do for their patients who may have seven doctors and take 35 medications in a year. They're not paying for any of that kind of coordination. And so important care falls through the cracks.

So I guess what I'm saying is I haven't heard anything here today that's not compatible with insurance products, whether public or private. I think there have been some misguided decisions by insurance companies, public and private, about what they're paying for.

Chairman Bennett. Okay. That's getting——

Dr. Berry. May I say something here?

Chairman Bennett. Sure.

Dr. Berry. I think that actually the low co-pay, low deductible so-called "insurance," which is not really insurance at all, is, in fact, increasing the cost of care for a number of reasons. And I don't think that the government should encourage that with their tax policy, because right now, it's open-ended. A company can write as an expense $10,000, $20,000. And the rest of the country is paying for that, including the uninsured.

They're effectively subsidizing these low co-pay, low-deductible insurance policies.

What I'm for is payment at time of service for routine health care. And he says that it's not going to reduce costs much. I don't know. But there are about a half billion patient-doctor interactions or encounters per year in primary care.

Now you change the mindset of people. Instead of their asking, "Doc, don't you think I need that MRI or some blood work on this?"—they will be asking, "Doc, do you really think I need to have that test done?"

Let me tell you, that changes the whole equation. And I suspect that once you translate that cost savings per encounter, you would see significant cost savings. I don't know what the numbers are. Policy people can probably churn those out. But you don't get visits

at $51, including all that I provide, without doing some penny-pinching.

Chairman Bennett. Dr. Eck.

Dr. Eck. In May, we're going to have "Cover The Uninsured Week." That's a big publicity event where I think what we're saying is that people who have no money, somehow we have to come and cover them. And by covering them, we have to buy them health insurance.

I would disagree with that, because the whole idea of health insurance is not necessarily health care and it's phenomenally expensive.

There's a little center in New Jersey that is a lot like ours, only it is 4 years old. It sees 6,000 people a year who have no money, and it's all volunteers. It's a lot like what we do, volunteer doctors and physicians. Their budget is $500,000 a year for 6,000 people. That translates to $83 a year per person.

Now these people get health care. So do they have coverage? No. But they get health care. They get referred. The hospital takes care of them if there's a problem. The community that's working that's getting health care to people.

Everybody's happy. Patients love it. They get personal care. The doctors feel good. They're volunteering their time. It's not a big, expensive, bureaucratic—actually, it was covered on "20/20," and I think it's a real solution to take care of the poor.

Is it a two-tiered system? I suppose. They're not paying. But it's getting the job done. And I think that we should look into that as a way to get health care to the poor rather than the big government programs.

Chairman Bennett. Mr. Stark.

Representative Stark. Well, I think we're—let me just try this. We don't think boutique medicine is inherently bad. All of us——

Chairman Bennett. Say that again. I didn't hear you.

Representative Stark. We do not think——

Chairman Bennett. You do not think. Okay.

Representative Stark. We don't think it's inherently bad.

Chairman Bennett. You said it quickly enough that I heard, "we all think."

Representative Stark. Now all of us want better access. But not everyone has the type of access that we are able, either as professionals or politicians or wealthy people—we're in a class distinct from, say, the family of four with $25,000 of income or less, they don't have the advantage.

Chairman Bennett. Unless they live in Dr. Eck's neighborhood, and then they do.

Representative Stark. They may. But they don't as a matter of practice. So, obviously, there are perverse incentives in the fee-for-service area to do more to get paid more. That's an incentive that we've had to deal with a lot, and I'm sure the physicians recognize.

But there's also the reverse of that incentive, is when you don't have any insurance. There's a big of an incentive to postpone perhaps getting treatment because your tolerance for pain may go up as your pocketbook gets thinner.

And I think if we could figure out somewhere in between, Mr. Chairman, how we can be sure that the person who has to come up out of pocket—now in Dr. Eck's area, there are non-governmental organizations that provide. There aren't in a lot of areas. I mean, your neighborhood—and your neighbors are to be commended—but that doesn't exist universally.

So if we could be sure that the people at the lowest income scale, let's just suggest, had access as any of you would suggest they need for either primary care, for preventive care, to do all the things that you'd recommend, and also then, for those of us at the other end, are somehow prevented from abusing the system by over-indulging our whims to chat with you nice professionals whenever we get the urge or sneeze, that's the middle ground that perhaps we're all pushing towards. I don't know what the answer is. There may be different approaches.

Dr. Berry. I think part of the answer is doing payment at the time of service for routine health care.

Representative Stark. What if you don't have any money?

Dr. Berry. The administrative overhead for doing——

Representative Stark. What if you're homeless and don't have any money? How do you pay at the time of service?

Dr. Berry. That's a separate and small issue, I will admit. There's no question about that.

But let me say this, that when I was working in the ER, 80 percent of TennCare patients who came, adult TennCare patients, smoked cigarettes.

Assuming $1,000 a year, that would be 20 office visits at my clinic. They need to be made accountable as well. They need to be acting neighborly as well. And they don't need to be driving Toyota Sequoias. They don't need to own vast tracts of land. Some of the people's net worth on TennCare is much higher than mine will ever be. So there's something wrong with that.

Representative Stark. I think you're quite right. I just think that we don't have a system—I noticed in Colorado recently, it was in the press yesterday or the day before, the emergency rooms are, many of them, trying to triage now to keep the burden of unnecessary visits——

Dr. Berry. They could come to our clinic.

Representative Stark. I beg your pardon?

Dr. Berry. Our clinic is ideal for that. And they're not willing to forego a $1,000-a-year cigarette habit——

Representative Stark. If they have any money.

Dr. Berry. Their problem is with priority, not with my price.

Dr. Eck. There are 32 volunteers in medicine clinics across the country.

Representative Stark. You have a clinic that can handle it.

Dr. Eck. There are 32. And they just need to be encouraged. And I think that army of retired physicians that I was speaking about, if we could relieve them of the malpractice burden so that if they donate their time, they're not liable for anything that might have a bad outcome, we can make a big difference.

Representative Stark. You're getting close, Doc. If we relieve them of the malpractice burden and maybe the tax burden, we're really paying you. And I have no quarrel——

In other words——

Dr. Eck. They're not getting paid. These doctors aren't getting paid. They wouldn't be getting paid. They would be giving free service. You take care of the poor. Just relieve them of the malpractice burden so that they're free to do this.

Representative Stark. What do we do in areas where there aren't any nice guys like that?

Dr. Eck. They're all over the country. There are 15,000 in New Jersey.

Representative Stark. Send everybody who can't afford to New Jersey.

[Laughter.]

Chairman Bennett. No, let's not send them to New Jersey.

[Laughter.]

Dr. Eck. So there must be a lot in other states. That's what I'm extrapolating.

Chairman Bennett. One of the issues that this panel has highlighted that gets ignored a great deal in the discussion of health care is the number of doctors who are voting with their feet and walking away from medicine.

And that has to say to us that there's something wrong with the current system if it is driving away its most qualified practitioners.

At the risk of opening another area, and I'll shut it off very quickly if indeed this does inflame a lot of comment:

When I got involved in looking at education, I discovered a very interesting thing. Education is the only area where people will accept a lower price for the privilege of not teaching in public schools.

Private schools pay lower salaries than public schools and teachers will voluntarily walk out of the public school for the privilege of teaching in an environment that they consider more conducive to education.

Now I'll quickly shut that door, having opened it.

But it does represent a signal that there's something wrong that has to be dealt with. And we find some of the best teachers refuse to go into public education, and they go elsewhere.

I know that because I used to run a company that was basically an education company and we had wonderful teachers, none of whom would have any interest in teaching in public schools, and the public schools were the poorer for that.

So if we are in fact seeing "hamster health care," which is the phrase I use with physicians on the treadmill all the time, and therefore, physician satisfaction going down, and as I've talked to physicians and I think what you're saying here, it's not financial. It's not because they're not earning enough money that they decide that they have to get out of medicine because they can make more money someplace else.

It's what you have said here, they are feeling that they cannot perform what they were trained to do, and so they're leaving health care.

Dr. Eck. A lot of them are leaving the HMOs and that frees them up.

Chairman Bennett. Okay.

Dr. Eck. That frees them up tremendously. And I think most of us sitting here enjoy practicing medicine.

Dr. Kaminetsky. But the problem you just touched on is a very serious one. I don't know if anyone might have seen, not this past Sunday, but the week before, *The New York Times Sunday Magazine*, Lisa Sanders at Yale, a primary care professor talking about the declining applications every year to primary care.

We're all primary care-givers. And the national residency match program, every year there's been a decline in internal medicine and family practice.

So with the numbers of primary care-givers going down, at the same time that the population is getting older and demographically, the need for internists is going up. Furthermore, there are more reasons to see a doctor now.

For instance, as an example, someone who might have had congestive heart failure 10 or 15 years ago would have been treated with just Digoxin and a diuretic.

Now there are many other modalities of therapy. There are many new drugs. There are inhibitors, ARBs, and so forth. There's more reason to see the doctor. There's an older population and there are fewer primary care-givers.

Now part of the problem realistically is not because—you're right. I agree with you. It's about being a doctor and giving care.

However, when you graduate with $175,000 of debt, you're not immune to a respected mentor saying, "You know what? Don't go into medicine."

So one of the potential solutions is maybe there needs to be more government intervention and subsidizing private medical school education in return for encouraging people to go into primary care subsequently.

Dr. Berry. I'm not so sure about that. But it seems that society doesn't value the services of a physician today quite so much.

Had I graduated from the University of North Carolina business school in 1992 instead of graduating from the medical school in 1989, I would be making more than I would be if I were still practicing emergency medicine, a considerable sum.

So that shows—if you're a senior or junior college student and trying to decide what you're going to do with your life, why would you go into medicine? You're going to get paid less. You have long hours. You've got incredible risk. People's lives are in your hands. Why do it? I think that that's a legitimate question to be asking.

Dr. Berenson. I'd like to add, I think we sometimes lump all docs together. And what's I think the serious problem right now is the lack of training in the primary care fields. In the same article that Dr. Sanders wrote in *The Times*, there was a reference to Alan Goroll, who is a professor at Harvard who is a friend of mine. I was in his class at college.

He told me that last year's graduating class at Harvard Medical School, of about 160 graduates, 20 were going into internal medicine. But of those 20, 15 were going into cardiology and gastroenterology and perhaps 5 were becoming the kinds of doctors that you call at 2:00 in the morning.

That's something we haven't talked about, everybody getting a doctor with whom we can have a relationship as the way to get their basic primary care.

There was another article I saw in *The Times* surveying graduates of some medical school. 40 percent of them wanted to go into dermatology because the pay was better, the hours were better, there was no night call. I don't think they're so unhappy, frankly, the dermatologists of the world. I do think that practicing primary care right now is very difficult. And a lot of doctors I know are giving up HMOs. They're giving up Medicare.

Medicare patients are complicated. They have four, five or six problems and many medications and it's hard work. And we're not rewarding them and compensating them appropriately or giving them sort of the kind of nonrenumerative support that I think they need.

And I would offer a policy opinion on this one. Because in the Medicare statute, we have control over expenditures for physicians, the Congress, CMS, Medpac, don't look at where we're spending that money because we control expenses.

So the fact that we are sending huge signals about what specialties to go into, and those signals are don't go into primary care, is not anything that has gotten policy-makers' attention. I think it needs to be focused there.

Representative Stark. Are you familiar with the German system? Do you like it?

The only people on fee-for-service in Germany are the primary care docs. You go to the hospital and it's a flat-rate per day, whether you've got a plantar wart to be removed or a heart transplant, the same amount. And all hospital-based physicians, which are all surgeons, are paid a salary, except if you're the chairman of a department at a university. Then you can charge a fee on top. And it just turns our system on its head.

In other words, you maybe get three pfennings for a Xerox, but you get a long Chinese menu of things that you can charge as a primary care doc. And they do much better than their counterparts, unless they happen to head a department.

Dr. Berry. Well, I think I would be doing much better if I could see, instead of three patients an hour, four patients an hour. I would be almost making as much as that MBA from Carolina.

The problem is that, besides the government subsidizing low copay, low-deductible insurance, they make it very difficult for doctors to do this kind of practice. They require basically doctors to opt out of Medicare. If I did not opt-out of Medicare, I would have to refuse Medicare beneficiaries showing up at my clinic asking to be seen, willing to pay me $35 out of pocket. Quite frankly, I'm not willing to discriminate against Medicare beneficiaries in my community.

So that is one policy that you could look at, is to roll back this crazy opt-out clause, because I can't find physician coverage for my clinic. I had to shut down the clinic today. Nobody's going to work at my clinic because everybody still takes Medicare. I've opted out.

Chairman Bennett. Any other comment on that?

[No response.]

Chairman Bennett. Well, let's wrap this up. This has been enormously helpful, and I'm very grateful to the four of you.

Dr. Eck. Can I just say one more topic we haven't touched on? And that is the plight of the uninsured.

In New Jersey, I know, they get charged 300 percent of what Medicare pays for a hospital visit. If a hospital visit costs $10,000, the uninsured get charged $30,000. Tremendous. And these are the people who presumably really can't afford it. And so then liens get put on their house and the whole thing.

What we have found out is that if you go to a little island in the Caribbean that is not the United States, there are little hospitals there that can take out a gall bladder and they would charge $1,000.

Compare that with $30,000 in New Jersey, $1,000 in the Caribbean.

And so we're looking into that. And we're just saying, what would happen if Americans came down and had an operation done there? Maybe we could even bring our surgeons down. And they're very positive. The surgeons are saying, "Hey, we would do that. We would do it for free if you gave us a week in the Caribbean." So we're looking into it and I'll keep you posted.

Dr. Berry. Well, the front page of *The Wall Street Journal* shows a Canadian citizen going to India to pay for a hip replacement that costs about $5,000. He would have had to have waited a year-and-a-half for it in Canada. And the $5,000 is about a quarter of what he would have been charged in the United States.

Dr. Berenson. If I could, I think, though, that Dr. Eck's comment is something that I wanted to address about sort of this alternative approach of low-cost, often what has been called "charity" care. I worked in a free clinic. I also saw patients who didn't have insurance. I'm sure all of these physicians provide uncompensated care.

But I remember an experience I had. I had a patient I was seeing for nothing who needed a chest x-ray. So I called the head of my hospital where I admitted and said, "Can I get a free chest x-ray?" And the guy said, "I'd love to help you out, but I don't have anything to do with the x-ray department. That's owned by somebody else, a separate radiologist company."

The point is that medicine, health care is a very complex—there are many people who have to provide services. So the physicians providing cut-rate and good services perhaps, but the hospital is then charging 3 times more for that same patient or the radiology group is not discounting their MRI rates or might actually be price discriminating more against the person who has poor insurance or no insurance. And so, I commend approaches to fill gaps and to provide some services in a lower cost way.

But I think it's pretty clear from the studies that are being done by—some by my colleagues at the Urban Institute—that people do better with insurance. It does drive up costs some, but their health care is better. And there are some cost offsets.

And an alternative of non-insurance, second-class, "we do the best we can for you," I don't think is something that we as the United States should be looking to as the major way we provide health care to the uninsured.

Chairman Bennett. I haven't heard anybody here say this morning that we should get rid of insurance.

My concern is that insurance ought to be insurance. Now I've used this before and it's an imperfect analogy, like every analogy is, but I use it again to make the case.

I have homeowner's insurance. I would be foolish not to have homeowner's insurance. It's a wonderful policy. If the house burns down, they not only replace the house. They replace the paintings on the wall. They replace the carpets on the floor. They replace the silverware in the drawer in the kitchen and the clothes in the closet. Everything.

It's just terrific.

But try as I might and read the fine print as often as I can, I can't find anything in the insurance policy that will reimburse me for mowing the lawn or painting the front door when the dog scratches it, which the dog does quite often. Or used to when we had a dog.

Insurance is for the issues that I cannot handle in the every day experience. And I pay to have the lawn mowed. I pay because I'm in Washington and can't be there, the guy who mows the lawn, also takes care of the garden. And that's just part of the expense of having to maintain two homes.

I guess when we live there, we'll plant our own tulips. But at the moment, my wife likes to go home to see tulips and I pay for that. I cannot file an insurance claim to pay for the tulips.

Dr. Kaminetsky. By way of analogy, if the branch falls on your roof and it's damaged and the adjuster comes and says, "Well, we're going to fix this area over here," you're not in a position to say, "Well, you know, that's really not going to look nice. I want the whole roof."

By way of analogy, there is no reason why an adult child can't say with regard to their 92-year-old mother with metastatic carcinoma, "I want her in the ICU, doctor."

I'm not proposing more bureaucratic oversight of Medicare. But these are types of real-life issues that come up every day where, as we all know, half the Medicare dollars are spent in the last 6 months of life, and there's essentially no oversight about appropriateness of care and whether the dollars should perhaps be reapportioned, which is obviously a very weighty issue with a lot of ethical and moral considerations, but one which has been too long ignored.

Chairman Bennett. Thank you for that addition. I'll use it from now on.

[Laughter.]

Chairman Bennett. This is the point. If we can, in fact, make insurance truly insurance by incentivizing people to be in the businesses that these three are in, I think it's absolutely inevitable that the cost of insurance will come down and come down quite dramatically. Particularly if they practice the kind of medicine that Dr. Kaminetsky focuses on, and I assume the other two do as well, which is the way to keep costs down is to keep people healthy.

There is no incentive in a pure insurance program to keep anybody healthy. It's all focused on acute care and not focused on prevention.

And there have been fairly significant studies, case studies of folks who spent a whole lot more time on prevention, having pro-

duced the enviable result of having lower costs and higher satisfaction on the part of the people that are in the insurance pool. We've had testimony on that in previous hearings.

So the problem with the poor is a clear problem. But, quite frankly, the insurance system, whether it's government or private, is part of the problem.

And I now repeat to you a conversation I had with a woman in Utah who heard me give a brilliant luncheon speech on this subject and came up afterwards and said, Senator, you haven't the slightest idea what you're talking about.

And I said, Okay. Teach me.

And she's a woman who spends almost all of her time dealing with the homeless and the poor. And she said, the primary problem with the homeless and the poor is not that they don't have any money. And it's not that they don't have access.

They cannot navigate the system.

The rules are so overwhelming, the bureaucracy is so daunting, that they can't navigate the system. And she said, you should be spending more time on community health centers—and I've been to the community health center in Salt Lake, where, when you walk in, the first thing that happens to you is somebody approaches you and becomes your navigator and says, Okay, this is where you can go. This is where you can go.

Medicaid, charitable activity, the Shriners Hospital, whatever it might be, there is a mentor or navigator that knows about those things, which the person on the street who is homeless has no clue. Even though in the law he may have access to or eligibility for, in his own capability, he can't navigate the system.

So I want to encourage community health centers of that kind that will help the poor and the homeless with their real problems rather than their perceived problems as we sit behind this dais and make judgments about them.

We are spending as a society plenty of money on health care. But, in the language of the west, we are not seeing the water get to the end of the ditch.

There's plenty of water in the irrigation reservoir. But when we pull up the gates, the water is not getting to the end of the ditch. And we've got to do something to see to it that the percentage of GDP that we are spending on health in this country produces the kind of result that that money could, in fact, buy.

Dr. Berenson, I'm not sure that there is a level where I would cut off what these people are doing. I would hope that we could devise some kind of a system, and the government's got to do it, because the tax code drives the health care system. The tax code drives what employers do. And then the government steps in with Medicare and Medicaid and that's, what, 40 percent of the dollars.

I end with the way I began. I'm hoping that we can find a clean sheet of paper solution that takes the very best of these entrepreneurial activities that are producing at least in the populations that they serve better health care at a lower price with, if Dr. Kaminetsky is correct, an impact on the insurance system because it makes fewer demands on the hospital structure and other things that the insurance system is using.

This is not an either/or. This is not "we want to kill the insurance system by a purely market system." But at the same time, we don't want to kill the market entrepreneur system by the Canadian model that says, you've got to do it our way or you can't practice medicine.

Okay. That's the end of my oration.

Representative Stark. I'm just curious. In thinking about the problems of primary care, do any of the three of you have a code—Medicare doesn't quite cover it yet—for what I would call disease management?

You come close, Dr. Kaminetsky, in your practice. But let's say that a diabetic comes in. Would you charge them $100 a month or $50 a month and say, "I'll send you out for the tests?" Do any of you have that?

Dr. Berry. Well, if somebody wants, say, 30 minutes of my time, that would probably cost $100, if they really wanted to sit down——

Representative Stark. No. But would you proactively say, "I'll call you. I'll be after you." You talk about it in maybe stopping people from smoking. One of you mentioned that.

But we're looking at disease management as a procedure, if you will, for primary care docs to be the interlocutory between a variety of providers and the patient. And I just wondered if any of you were doing that in your practices now?

Dr. Eck. Diabetes a great example. It's very education-intensive. People just have to understand their disease and be reminded and don't do this and do this and check your sugars. It's very complicated.

You try to make them make a little list of their sugars and what they ate and that type of thing. I like to see diabetics once a month. But some of them are very, very smart and very good at it and they don't need to be seen that often.

It depends on the person. It's not a one-size-fits-all type of management.

I don't do insurance. So if it's a long visit and if they're high-maintenance, they get charged more.

Representative Stark. But you don't set up an annual program where you would get after them.

Dr. Eck. I don't tell them. Every year you check their——

Dr. Berry. They've got to see an ophthalmologist.

Dr. Eck. Yes.

Representative Stark. Pardon?

Dr. Berry. They've got to see an ophthalmologist every year, make sure you're looking at their feet.

Dr. Eck. There are certain things that you make them do routinely—check their eyes, check their micro-albumin, the urine. See if they're developing that. A good foot exam.

Those type of things, we just do without telling them. But this is part of their program.

Representative Stark. Thank you, Mr. Chairman.

Chairman Bennett. The kind of thing that the Capitol physician does for you and me.

Representative Stark. Gets after us.

[Laughter.]

Chairman Bennett. And we pay for it.

Representative Stark. Yes, we do.

Chairman Bennett. Anybody else have a last burning comment you want to make before we leave? We've held you here all morning.

Representative Stark. Thank you.

Dr. Berry. Let insurance manage risk and patients manage care.

Chairman Bennett. That's a pretty good bumper sticker.

[Laughter.]

Dr. Eck. There you go. The real answer is to allow individuals to deduct the health insurance just as the employers do.

And therefore, the employers should be relieved of having to buy the health insurance policy. Just like the employers don't buy our car insurance policy, our homeowners insurance.

That would make a phenomenal difference.

And then I think if people were spending their own money, they wouldn't pay for HMOs, and that would be the end.

Chairman Bennett. Well, if they were, the HMOs would change dramatically.

Dr. Eck. Absolutely. If people had to buy their own insurance, they'd really buy it in value.

Chairman Bennett. Again, I'm sorry. But my market orientation comes in here. If I go to an HMO and I get treated badly, I get disrespected, I get shuffled off, I have to wait a lot, and I control the money that's paying for that HMO, and I can say, "Look, if I don't see the doctor in another 5 minutes, I am out of here and my money is out of here with me. I'm going down the road to another HMO that's run by Dr. Eck." The HMO concept is not a bad concept, except as it is run for the economic and financial benefit of the people who own it because their customer is the third party who doesn't care how I get treated.

Dr. Eck. That's right.

Chairman Bennett. But if the person who is running the HMO is dependent upon my patronage, just the way that the person who is running any other business is dependent on my patronage, why, the waiting times will go down, all kinds of marvelous things will happen.

I don't want to leave it just that we trash HMOs and we want to eliminate HMOs. But if we give the customer the economic power to determine what's going to happen in the HMOs, I think the three of you, and maybe if you can lure Dr. Berenson back into the practice of medicine, the four of you, might some day open an HMO based on the concepts that you're practicing here.

Thank you very much. The hearing is adjourned.

[Whereupon, at 11:55 a.m., the hearing was adjourned.]

Submissions for the Record

JOINT ECONOMIC COMMITTEE
ROBERT F. BENNETT, CHAIRMAN

For Immediate Release:
April 28, 2004

Contact: Rebecca Wilder (202) 224-0379

Chairman's Opening Statement

Senator Robert F. Bennett

Hearing of the Joint Economic Committee
"Consumer-Directed Doctoring: The Doctor Is In, Even If Insurance Is Out"
April 28, 2004

Good morning and welcome to today's hearing. Today we're here to explore how some doctors are finding alternatives to the traditional third-party payer health care system, and at the same time providing better care for their patients.

Many doctors are frustrated by the state of our current health care system, and their patients are too. Doctors are continually faced with third-party entities interfering in their practice, pushing them toward a system that focuses on arcane regulations, not on patient care. Low reimbursement rates require physicians to increase the number of patients they see and shorten the length of office visits. They must also shoulder the burdens of increased practice costs, time-consuming paperwork, and rising medical liability premiums.

Many patients, particularly those with lower incomes, find it difficult to obtain affordable care and to receive it in a timely manner. They often feel rushed through brief office appointments, without having adequate time to address their questions and concerns or adequate help to navigate the complex medical system.

Today's hearing will examine the experiences of innovative and entrepreneurial doctors who are responding to gaps in the current system by returning to an older style of medical practice, a patient-focused approach that used to be the norm. By adopting these approaches, doctors are finding ways to spend more time with their patients, and to provide a better quality of care. We will examine the potential reach of these early trends among innovative physicians, who deal more directly with their patients than physicians relying predominantly on third-party insurance payment mechanisms.

While insurance-free medical care may not work for everyone, early evidence of consumer-directed doctoring suggests that some physicians and patients are reacting favorably to this way of providing care. In some cases, it has produced lower costs. In others, it has offered a more enhanced level of personal medical services. On occasion, it has delivered both. In any case, it means providing better value.

By studying how these entrepreneurial physicians are building their practices, we can learn about the strengths and weaknesses of our current health care system and how better to address them. By understanding alternatives to the system, we may also be able to improve medical price transparency, help relieve medical liability pressures, and retain highly-trained physicians who are increasingly frustrated by the current system.

We'd like to welcome our panelists today who all have their own experience delivering health care through innovative and entrepreneurial means.

Dr. Robert S. Berry is here from the PATMOS EmergiClinic in Greenville, Tennessee. Dr. Berry will talk about his experience building a pay-as-you-go practice. His office fully discloses its prices up front, receives payment at the time of service, and generally does not accept any third-party insurance reimbursements.

Dr. Bernard Kaminetsky from Boca Raton, Florida operates a practice that specializes in "concierge care" or "retainer medicine," where patients primarily seek preventive care, wellness plans, individualized attention, and 24-hour access to a personal physician.

Dr. Alieta Eck, a physician from Piscataway, New Jersey runs a charitable care clinic that combines community resources with more efficient methods of health care delivery to meet the urgent medical needs of the poor and the uninsured.

We'll also hear from Dr. Robert Berenson, an experienced physician, who is now a Senior Fellow from The Urban Institute here in Washington, DC. His work focuses on health care policy, particularly Medicare.

We look forward to hearing them describe their unique approaches to build a medical practice without the bureaucracy of the health insurance system.

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REP. PETE STARK (CA)
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Congress of the United States
Joint Economic Committee
Democrats

108TH CONGRESS

804 HART SENATE OFFICE BUILDING
WASHINGTON, DC 20510-6602
202-224-0372
FAX 202-224-5568
www.senate.gov/~jec/democrats

WENDELL PRIMUS
STAFF DIRECTOR

Opening Statement
Representative Pete Stark
Joint Economic Committee Hearing
April 28, 2004

Thank you, Chairman Bennett. Today's hearing appears to be the next installment in the Republicans' push toward replacing traditional health insurance with high-deductible health plans, also known as Health Savings Accounts (HSAs). This time the rationale for HSAs is that doctors can provide cheaper health care to patients if we do away with the insurance companies and their pesky paperwork.

Frustrations dealing with insurers have led some doctors to accept only cash payments from patients. Physicians claim that they can offer lower prices for office visits and other simple medical procedures, because they can reduce the overhead from filing paperwork and obtaining insurance reimbursement.

"Concierge care" – as it has been dubbed – is like a new country club for the rich, since members pay a hefty premium just to join. But in this case the only thing that club membership guarantees is access – the opportunity to call on a doctor – since members are still required to pay for each medical service they receive.

The danger is that if a large number of doctors choose to open up these types of practices, the health care system will become even more inequitable than it is today. The wealthy will pay for exclusive access to quality care, and everyone else will continue to have inferior access to primary care physicians, specialists, and basic medical advice.

Having access to a physician is not the same as having health insurance. A growing body of literature shows that people without health insurance forego even necessary care and do not have their care properly managed, thereby increasing the risk of serious complications and lowering the quality of overall care.

The concept of "empowering" consumers to make more responsible choices about their health care decisions is misleading rhetoric. Health care needs are often unanticipated and patients rely on their doctors' expertise – not their own – to guide medical decision-making. A policy of consumer-directed doctoring says, "patient – heal thy self."

Having spent much of my Congressional career in health care policy, I have never known so-called "consumer-driven" or "consumer-directed" health care to perform well or to have much potential. These high-deductible plans are not consumer-driven, nor do they offer much choice. Instead, they simply shift costs to so-called "consumers" who pay more and

more out-of-pocket, making it difficult for patients to get the care they need. Furthermore, high-deductible plans would likely undermine coverage that people receive through their jobs, as employers looking to cut their costs look more and more to HSAs.

HSAs are yet another tax shelter for the rich, who have no trouble affording insurance or quality health care. The President has now proposed to spend $41 billion on HSAs and high deductible plans, which will at best extend health insurance to a tiny fraction of the 44 million who don't have coverage today. The Administration's policies are not directed toward insuring the uninsured. Instead, their policies attempt to insert more "cost consciousness" into the system to reduce consumption, but fail to meet even that objective.

High-deductible plans are unlikely to alter the overall level of spending on health, but would undoubtedly shift more costs to people who can barely afford their current obligations. In all likelihood, these plans could have the perverse effect of increasing overall spending as people delay care until their treatment is even more costly than it would have been if treated early.

If Republicans were really interested in controlling costs, they would have given the Secretary of Health and Human Services authority to negotiate prescription drug discounts in the Medicare program, but that's a topic for another hearing.

High-deductible plans don't reduce costs or increase health coverage, they simply discourage people from using health care services.

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Testimony of Bernard Kaminetsky, M.D., F.A.C.P.

Joint Economic Committee

United States Congress

April 28, 2004

I. Introduction

I am a 51-year-old board certified internist, presently practicing as an MDVIP affiliated physician in Boca Raton, Florida. I affiliated with MDVIP in order to provide my patients with comprehensive preventive care services that unfortunately can no longer be offered in a traditional primary care setting. This decision was prompted by the inability of the current healthcare environment to accommodate the necessary emphasis on wellness and prevention that I believe is essential for comprehensive preventive care. Instead, current practice, because of time constraints, focuses predominantly on acute care. I am honored to be able to discuss my career, and my decision to provide my patients with the attention to prevention and early detection that they have requested and deserve.

II. My Background

Choosing a career was a simple choice, inasmuch as I'd always aspired to be a doctor, even from the age of six. I attended Albert Einstein College of Medicine in New York, where I was elected to membership in Alpha Omega Alpha, the national medical honor society. Following graduation, I completed my training at New York University-Bellevue Hospital Center, where I served as chief resident in medicine and was responsible for the continuing medical education of the medical staff. My experience as

intern and resident was fulfilling, enlightening, and, because of the nature of medicine, with its unforeseen outcomes and complications, humbling. I believed that my intensive training, at one of the country's biggest and busiest urban medical centers, prepared me to be a consummate physician. I was trained to be academically proficient, empathetic and socially conscious. My Bellevue experience was unique. I cared for Park Avenue matrons and addicted single mothers, suburban entrepreneurs and the homeless. At the conclusion of my residency, I believed I was ready for the real world.

Following training, I stayed on as a junior faculty member at New York University School of Medicine. My position combined teaching with practice, an arrangement I considered optimal. Practicing in an academic environment allowed me to stay current and to apply what I learned to my practice.

About eight years into practice, in 1992, I encountered a situation that was new to me. A patient called and asked if I was on the panel of the insurance company that her employer was switching to. Until then, a patient's insurance carrier had never been a concern. If the patient had Medicare, I accepted assignment. When the patient was younger, insurance typically paid eighty percent of my fee, and the patient paid the balance. If the patient didn't have insurance, we made other arrangements. I now discovered that whether a patient saw me was no longer dependent on his preference, or trust in my skill, but rather on whether I was on his plan. At first, I considered this an isolated phenomenon, but it soon became clear that, unless I too joined the panels, my practice was at risk of becoming financially unsustainable.

Coincident with these changes, academia also began to change. The practicing faculty began to feel more pressured by declining reimbursement. With less time

available, it became increasingly difficult to volunteer uncompensated hours for teaching. Formerly, the attending staff had very generously donated their time.

Bowing to legislative constraints, residents in New York State changed from an every third to an every fourth night schedule. In addition, residents were no longer on call all night. They went home at midnight, without regard to whether a patient was stable or decompensating. This was implemented to mitigate the effects of stress and sleep deprivation. An unintended consequence of this change was the adoption of a more time clock oriented approach to healthcare. An intern no longer went home when his or her work was done. They went home when the "shift" was over. Faculty members were criticized for being "overly academic," and teaching rounds were sometimes perceived as keeping staff from getting their work done. Moreover, the spectrum of pathology previously seen at Bellevue had narrowed. In the years prior to the advent of highly active antiretroviral therapy, most admissions were due to HIV related disease, and the residents became less interested in an atmosphere that was increasingly oriented toward less time with patients. The gratification from teaching is understandably diminished in such a setting.

At that time, South Florida had a reputation as possessing a burgeoning population and an inadequate number of rigorously trained physicians. Some of my New York patients, who wintered in Florida, suggested that I would do well there. I made the move.

Perhaps it was naive to think that the changes in medicine wouldn't become universal. What I had not anticipated was the rapidity with which managed care, particularly in the realm of Medicare HMO's, would take hold. Because of the generous

pharmacy benefit which was then offered, these plans held great attraction for patients. Of course, the reimbursement was lower than traditional fee for service Medicare but doctors had no choice. The alternative Medicare HMO model, called "capitation", i.e. accepting a fixed payment per patient per month, held the potential to be very remunerative. Whatever was not spent on the patient accrued to the doctor. However, such an arrangement was never acceptable to myself and my partners because of the obvious inherent conflict of interest. The doctor is incentivized to order as few tests, and as little medication, as possible in order to improve his or her bottom line. Such an arrangement was not suitable to us. Moreover, the approach to care emphasized treatment of acute problems with diminished emphasis on prevention. Quantitatively, the time for preventive care was simply not there.

Concomitant with declining reimbursement, overhead continued to increase. Healthcare costs for employees rose. Malpractice insurance skyrocketed, especially in crisis states such as Florida. We attempted to cut staff but untenable delays occurred. We became more and more constrained in our efforts to be *pro*active with regard to healthcare, and were far more *re*active. It was apparent that there was only one way a practice could promote prevention and still maintain its financial viability: by seeing more patients! But the reasoning was circular. More patients meant less time, so how could a physician implement prevention? A solution would necessitate ***more*** time, not less.

III. My Decision to Fundamentally Re-orient My Practice to Emphasize Preventive Care

The need for primary care is growing. Changing demographics, characterized by growth of the elderly as a percentage of the population, is not a problem confined to Social Security planning and Medicare budgeting. As the population ages, the number of primary care providers must expand accordingly. However, what is happening economically to practitioners of internal medicine is not lost on today's medical students. Average debt upon graduation is currently $110,000. I've spoken to a student who has incurred $175,000 of debt. Respected teachers, who were once role models, now advise students to consider seriously dermatology or the more lucrative surgical subspecialties. Each year the national residency-matching program documents a decline in applications for internal medicine and family practice programs. The American College of Physicians has been forced to launch an initiative program to try to attract students to primary care. I have been present at gatherings of internists where the question has been posited, "Who would encourage their child to go into internal medicine?" Not a hand goes up. Doctors are concerned that their children will not be able to attain the professional gratification that makes practicing medicine a joyful pursuit.

Declining reimbursement and more elderly patients equals more visits. But, is that a viable or sustainable model? The Annals of Internal Medicine has pointed out that as newer technologies are developed, physicians are less and less able to find the time to incorporate these changes into their practice. ("General Internal Medicine at the Crossroads of Prosperity and Despair: Caring for Patients with Chronic Diseases in an

Aging Society," *Ann Intern Med* 2001; 134: 997-1000). Whereas before, a patient with congestive heart failure may have been treated with just diuretics and digoxin, now one must consider ACE inhibitors, beta-blockers and aldosterone antagonists. How many additional visits will this entail? Where does one find the time for them? Patient education is, and should be, time consuming. The days of the paternalistic physician, who freely prescribes without offering an explanation, are long gone. Suppose a diabetic patient is well controlled. Her blood tests document that the standard of care is being met. But a newer insulin might work just as well and may be given only once per day instead of three times. It might not be an advantage medically, but it will improve the patient's lifestyle tremendously. Of course, the patient will need to come in frequently during the transition. It is horrific that a physician must even consider such matters.

Last June, the New England Journal of Medicine documented that only 55% of recommended preventive care is administered, and only 52% of recommended screening is performed. It has been estimated that if a doctor, with a typical patient load of 2500 patients, complied with the recommendations of the U.S. Preventive Services Task Force, he would spend 7.4 hours a day on prevention. Only a tiny fraction of the day could then be devoted to acute care.

The above scenario describes what my day had become. I was on a treadmill, running at an ever-accelerating pace, desperately trying to do the best for patients with a limited resource, i.e. time. I was essentially putting out the fires of acute problems and was frustrated by my inability to place appropriate emphasis on prevention and wellness. I was disappointed professionally and missed the gratification that had always been inherent in physician-patient interaction. Patients, too, were becoming increasingly

unhappy. While they were sympathetic to the time constraints I labored under, they read about, and wanted, more preventive care. Patient dissatisfaction was particularly irksome and frightening, since studies have demonstrated that malpractice is often not the product of malfeasance, but, rather, is due to poor communication between doctors and patients. Yet, how can that dynamic be altered when numerous surveys report that patients routinely feel that they are not getting enough face time with their physician?

In early 2001, it became apparent that I was no longer the physician I had trained to be. I was always frenetic. I treated heart disease while desperately trying to devote attention to nutrition and exercise. I treated emphysema but lacked the time to consistently call each patient regularly and encourage him or her not to smoke. Sometimes that's what it takes - direct engagement rather than technologically based intervention.

What was I looking for? A way to make prevention the foundation of my practice rather than an often ignored recommendation. A practice style that would allow me to dwell on exercise and nutrition, weight loss, smoking cessation and curtailment of alcohol use. A method to provide patients with electronic tools that would guarantee timely transfer of clinical data between providers. Planners have been talking for years about the need for a dramatic change in the delivery of primary care, but I knew of no feasible solution. Similarly, in regard to technology, smart cards, containing digitized patient data, had been regularly touted. I'd yet to see one. As a profession, we were awash in well-intentioned ideas, but lacking in the ability to implement meaningful change. I was ready to abandon clinical medicine. It was a most propitious confluence of

events that MDVIP came on the scene just as I was on the verge of leaving clinical medicine.

In a typical practice of 2,500 patients, if one worked 50 weeks a year and planned on performing a comprehensive preventive exam of even an hour in length for each patient, then 50 hours a week would be devoted to annual physical exams. Of course, that leaves no time whatsoever for acute care. In contrast, if a practice is limited to 600 patients, such as in my current practice, then 12 hours a week, or even 18 hours, can be devoted to annual preventive exams, with adequate time still available for routine and urgent care.

Hence my decision to join MDVIP, a program focused on an annual preventive care physical examination and related wellness planning, individually tailored to a patient's needs. This includes detailed analysis of medical and family history, nutritional, psychological and fitness screenings, EKG's, and comprehensive lab and imaging studies. In order to offset the decline in revenue associated with the far smaller practice size, patients pay an annual fee to receive these preventive care services. MDVIP provides me, and other physicians located in eight states, with the operational, technological, and administrative support required to effectively establish a preventive care based practice.

What does it mean to patients who are members of a practice limited to 600 patients? It means they know that when I talk about diet and exercise I really mean it. I will urge them repeatedly, and be able to assist them throughout the year, to be more compliant with proactive preventive care initiatives. It means they will travel with a pocket CD which contains a comprehensive summary of their history, physical exam,

medications, allergies, EKG tracing, x-ray findings and digitized images. I could offer you many anecdotes, but here's just one. A patient had her CD with her when she was hospitalized in Beijing, and it made an incalculable difference in her care. Her physician called me from Beijing, late at night, to discuss the information on her CD, which was essential to his treatment decisions. With a practice limited to 600 patients, I was able to recall details even when at home, and without access to the chart, and actively participate and assist in the care of my patient in another part of the world. How could I ever commit to memory the details of 2,500 patients, or have the ability to offer this level of involvement consistently to each of 2,500 patients? Logistically, it could not be possible.

My patients are thrilled. I've rediscovered the intimacy that traditionally had been part of the doctor patient relationship. Soon after starting my new practice, I realized that patients would share with me stories that they had never told me before. For instance, one woman tearfully related that she had never told me that she had been an abused wife and was seriously injured. I asked her why she had never shared that with me. As similar stories have surfaced, I have come to realize that the reason I now knew was because of the changing dynamic of our relationship. I have become a friend, a confidant—a real doctor, just like Sinclair Lewis' Dr. Arrowsmith. It is gratifying beyond description.

The emphasis on prevention mandates that the practice be kept small. Otherwise, there wouldn't be enough time to perform a comprehensive exam and implement wellness plans for each patient. The *de facto* benefit of being a patient in a smaller practice is that the ambiance of the office is less harried; the tenor of the office staff is calmer. Patients exhibit relaxed body language. Calls are returned promptly. Patents reach me by e-mail. No phone tag. Again, these are *de facto* benefits of being in a smaller

practice. They are simply reflections of how I run my practice. When a patient calls and tells my assistant that his oncologist hasn't gotten back to him about his CAT scan results and he is nervous, we assuage the concern by obtaining the results, even though we haven't ordered the test. When a patient asks me to tell her a little about her *sister's* rare illness (and her sister is not a patient!), I am able to oblige. When I reassure my patients, when I address their fears, I'm being a doctor again. Would a busy physician taking care of 2500 to 3000 patients reasonably be able to research a matter totally devoid of any relevance to their patient's care? Despite the best of intentions, it would be very difficult.

I've frequently been asked how an MDVIP practice is received by the specialists I work with. Actually, specialists enjoy seeing my patients. Quite often, a patient will appear for a consultation without the reason for the consultation being clearly documented. This can be frustrating to the specialist who asks the patient, "why are you here?", and gets a blank look in response. In contrast, before my patient sees the consultant all pertinent records, x-rays, labs, etc., will have already been faxed. Furthermore, the software tracking that MDVIP has provided advises me that the patient has seen a specialist and prompts me to speak with the specialist regarding the visit. If a patient comes in and advises me that they had an appointment with a consultant that was arranged through other auspices, my office makes sure to get a record of the visit. Since elderly patients will often see several consultants, the only way to prevent potentially harmful drug interactions is to make a determined effort to keep abreast of any medication changes instituted by a physician other than myself.

MDVIP has assisted me in establishing benchmarks for preventive services. Our patient satisfaction scores are extraordinary, and the membership renewal rate exceeds

95%. Not surprisingly, our hospital admission rates are unusually low. Because our practice is small, a patient with swelling of the ankles or shortness of breath is invariably seen the same day. The patient is therefore treated when his or her congestive heart failure is incipient, and presentation to the emergency room in the middle of the night is avoided.

Our attentiveness to an old fashioned style of care, with emphasis on prevention, results in significant savings to insurance providers. I listen to patients -- literally. Much has been written about the increasing reliance of practitioners on technology, to the exclusion of a careful physical exam. My utilization is lower because I rely less on expensive imaging studies and more on careful scrutiny of physical findings. I *listen* to the heart and lungs carefully, as I was taught in medical school. I'm judicious with my use of tests. Sometimes, careful auscultation with a stethoscope obviates the need for an expensive echocardiogram.

My relationship with my patients is special. I am their "doctor". I am not a provider chosen from an insurance company roster. My patients trust me. Many physicians typically must order an excessive number of tests to protect themselves from the threat of malpractice. Because of the time I now have for preventive care, and the trust engendered, I am not subject to that fear. My patients and I recognize that whatever the outcome, I gave them my best.

Who are my patients? The demographic makeup of my current practice very closely mirrors that of my former practice. My patients range in age from 18 to 101, and come from all socioeconomic backgrounds, including patients on fixed incomes, and those whose incomes qualify them as upper middle class. Those patients who ***chose*** not

to avail themselves of the benefits of the MDVIP prevention program remained in my former practice and a new internist joined the group to take my place and ***insure continuity of care for all such patients***. I use the word "chose" advisedly. For the vast majority of patients, joining my new practice was a matter of choice. The financial foundation for this dramatically smaller practice setting is largely based upon an annual fee of $1,500. Such an amount is certainly significant. However, $125 per month to maintain one's health is certainly no less important than a cell phone and cable bill, which cost more.

Nonetheless, for those patients for whom it was not a choice, for those who truly could not afford the membership fee, the fee was waived. Those patients are full members and reap the benefits of the prevention program. Absolutely no distinction is made between the paying and the "scholarship" patients.

IV. The Role of Preventive Care Based Programs Such as MDVIP

In order to fully understand my practice, it is essential to recognize that the preventive services I provide to patients are not covered by Medicare or by commercial insurance. Perhaps the most striking, and least understood, aspect of the Medicare program, from the perspective of patients, is that Medicare is designed to cover only a portion of the healthcare expenses of seniors. Indeed, annual preventive care physical examinations are specifically excluded from coverage under Medicare.[1] Similarly, these services are beyond the scope of care that is covered under commercial insurance. Accordingly, patients who desire such services must obtain them using personal funds.

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[1] The recent Medicare Modernization Act of 2003 established a limited one-time preventive care examination available only during the first six months of Medicare eligibility

Clearly, I am not suggesting that my practice is an option for all patients, as there cannot be a single healthcare alternative for all segments of society. I firmly believe, however, that my practice offers a compelling and viable choice for many patients who seek services that are not available in traditional primary care practices.

The national media has described my MDVIP practice, and other efforts by physicians who incorporate annual fees in their practices, as "retainer" or "concierge" based medicine. Although initially the subject of some controversy, this approach, when properly implemented, is now acknowledged by both the Federal government and the American Medical Association as an appropriate and innovative option for patients.

Charges in excess of the Medicare fee schedule for covered services are, of course, contrary to law. However, in a May 1, 2002 letter to Rep. Henry Waxman, Secretary of Health and Human Services Tommy Thompson specifically confirmed that as long as a charge, such as the fee associated with my practice, is solely for non-covered services, such fee is consistent with Medicare law. The HHS Office of the Inspector General recently reaffirmed this determination in an alert dated March 31, 2004. As stated in the OIG Alert, "Medicare participating providers can charge Medicare beneficiaries extra for items that are not covered by Medicare."

The American Medical Association has considered retainer medicine and supports such practices. In its Report of the Council on Medical Services issued in June 2002, the AMA found that

> ". . . retainer practices ***are consistent with long standing AMA policy*** in support of pluralism in the delivery and financing of health care. . .The success of retainer practices in the market ***is the best evidence that these practices fill a market need.*** There are several factors that explain the successful proliferation

> of this model to date . . . first, these practices fill otherwise unmet market demand . . second, retainer practices may lead to market driven improvement in quality . . . third, the practices have great appeal to physicians and their patients. ***Instead of spending a few minutes with each patient, physicians are at liberty to spend as much time as needed with each patient, which may result in higher patient satisfaction, higher physician satisfaction, and better outcomes for the patient. (emphasis added)***"[2]

The suggestion that such practices will deny access to care is misplaced. As found by the AMA, retainer practices are:

> "a growing but small-scale market phenomenon that seem to have sparked a disproportionate share of media attention . . . The phenomenon of retainer medicine is inherently self-limiting. The more physicians charge for their services, the smaller the demand for their services . . . ***These economic realities limit any potential for widespread adoption of retainer practice and any potential growth in retainer practice to adversely impact patient access to care. . . The Council currently finds no evidence that special retainer agreements adversely impact the quality of patients' care or the access of any group of patients to care. (emphasis added)***"

Although there is no factual basis to suggest that MDVIP, or similar programs, would diminish availability of physicians, MDVIP nonetheless requires all affiliated physicians to provide for continuity of care for ***all*** patients that elect not to become MDVIP members. This is done to insure that patient care is not interrupted when a patient chooses to not remain with a physician who begins an MDVIP affiliated practice, and this policy formed the basis for the establishment of my practice.

MDVIP provides a niche service. It meets the needs of patients who desire these services but would not otherwise receive them because they are not covered by insurance, and therefore are not provided. In parallel fashion, it meets the needs of those physicians who seek to employ a methodology that emphasizes prevention and wellness. The sentiment has been expressed that patients should not be allowed to receive these services

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[2] The AMA Council on Ethical and Judicial Affairs also determined in June 2003 that "retainer" practices are consistent with ethical guidelines and recommended policies to ensure appropriate transition to, and operation of, such practices.

at a time when tens of millions are uninsured. However, that notion is flawed because the presence or absence of preventive services has no discernible impact on the plight of the uninsured. Those who may believe that physicians should not run MDVIP affiliated practices assume that, were I not doing what I am presently doing, I would still be on the treadmill, seeing 30 patients a day. That assumption is incorrect. As I related earlier, I was on the verge of leaving clinical medicine and would have done so if not for MDVIP. In fact, many fine physicians, frustrated and overburdened by a system that does not place the physician-patient relationship at the forefront, have left the profession, and, sadly, their skills are being wasted. In any case, even if I were still in my old practice, would that ameliorate the plight of the uninsured? From a purely logical standpoint, causality cannot be inferred.

It appears that the quality of care that I am able to provide may be enhanced as well, as suggested by the AMA position statement of June 2002. Preliminary analysis, using a modified HEDIS survey of MDVIP affiliated practices located in Florida, yielded results that far exceeded national averages.[3] These same practices were also surveyed to

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[3] In 1990 the National Committee for Quality Assurance (NCQA) was founded. NCQA is a private not-for-profit organization that measures the quality performance of over 90% of all health plans. NCQA developed a series of measurements known as HEDIS, the Health Plan Employer Data Information Set. HEDIS is a tool that uses more than 60 different measures to evaluate the care and service performed by health plans. HEDIS makes it possible for consumers and employers to compare the performance of health care plans on an "apples-to-apples" basis, something not previously possible. The HEDIS criteria include the evaluation of preventive measures, such as the percentage of female patients receiving mammograms. It also includes treatment data, such as the successful management of high blood pressure and elevated cholesterol. These are just some of the treatment aspects evaluated by HEDIS. Although MDVIP practices are not health plans, the use of HEDIS data allowed for a preliminary assessment of the care provided to MDVIP patients. The MDVIP physicians surveyed had superlative HEDIS scores, which cumulatively approached an average of 90% compliance against a sample of HEDIS criteria. While each individual HEDIS evaluation has its own numerical score, the range of national compliance generally runs from 40% on the low side to 77% or 80% as a high score on some measures. Most health plans achieve compliance in the 60% to 70% range when all HEDIS scores are averaged. These numbers have real life significance. For example, raising the compliance numbers for blood pressure treatment from 40% to 68% could potentially save an estimated 28,000 lives in a population of 100,000.

determine the average number of patients admitted to hospitals throughout the year. This is not only of importance in regard to patient health, but also in the context of the dramatic expense associated with hospitalization. Significantly, the results showed approximately 30% fewer hospitalizations relative to national averages compiled by Milliman and Robertson, a leading national actuarial consulting firm. This applied across all age ranges, even though MDVIP participation is skewed to an older patient base. Admittedly, these results are preliminary since they are derived from a small number of practices and in one locale. It is noteworthy, however, that the locale is an area known to have one of the highest hospitalization rates in the nation. Early analysis nonetheless suggests that the scope of care that can be delivered in an MDVIP affiliated practice such as mine can result in enhanced patient outcomes.

V. Conclusion

I was quite idealistic when I started practicing medicine. The bond of trust that I had with my patients was of paramount importance to me. For a while I loved being a doctor. Then, the dynamic began to change and gradually eroded. My "customer," if you will, was no longer the patient. It was the insurance company. The patient paid the insurance company, and the insurance company, in turn, paid me. There was no transaction utility between the patient and me. Now, with great appreciation for the fortunate position I find myself in, I can proudly say I'm a doctor again. I treat people, not clients. I am their healer, their friend, their confidant. This is how it was when I was a child in the early 60's. For myself and my patients, the clock has been turned back, and the practice environment of yore has been restored. Doctors are now in a position to incorporate into their practices the newest recommendations regarding prevention. It's a win for patients, a win for doctors and a win for insurers who save money. What could be better?

Joint Economic Committee of Congress

Testimony of

Robert S. Berry, M.D.
President & CEO of PATMOS EmergiClinic, Inc.
Greeneville, TN

April 28, 2004

Good morning. Thank you for inviting me to speak with you today.

My name is Dr. Robert Berry. I graduated from the University of North Carolina Medical School in 1989 and did my residency in Primary Care Internal Medicine at the University of Alabama Hospitals in Birmingham. I became board certified in Internal Medicine in 1992, scoring at the 99th percentile on the exam's "core component" – a measure of competency in General Internal Medicine. Up until I started this clinic over three years ago, I practiced Internal Medicine for six months and Emergency Medicine for the balance. I became boarded in Emergency Medicine in 2003.

I represent a growing movement in cash only practices and the patients who use them. Yet our clinic is a little different in that we center medical services around the unique needs of the uninsured. They are the most cost effective healthcare consumers, and we all could learn something from them.

Our clinic is similar to charity clinics in that it serves patients falling through the cracks of our broken healthcare system - except we don't receive any taxpayers' funds either directly as subsidies or indirectly as a tax-exempt 501c3 corporation. It is similar to boutique clinics in that it contracts directly with its patients - except that most of our patients don't have insurance.

How and why I started an insurance-free medical clinic

In January 2001 I left ER medicine to start a clinic primarily for the uninsured of my community as an attempt to flesh out in my own life an answer to the age-old question, "Who is my neighbor?" Of course, I don't refuse other patients willing to do "**P**ayment **A**t **T**he **M**oment **O**f **S**ervice." In fact, because this seemed to be the unifying theme of our practice, I chose its acronym PATMOS as the name for the clinic.

As an ER physician, I knew the people the charts classified as "self-pays." In a small community such as ours, I purchase goods and services from many of them. They are all in a real sense my neighbors – too poor for $10 co-pay insurance and too rich for Medicaid. Like the political prisoners Rome used to banish to Patmos Island, they are effectively political exiles within our healthcare system.

Most doctors refuse to see them. In fact, one of our uninsured patients mentioned at the beginning of a front and center article in the Wall Street Journal last November that he had been refused care by every primary care doctor he called in a nearby town before coming to us. For practices set up for insurance, the uninsured tend to disrupt patient flow. Many cannot pay for tests and procedures sometimes needed to exclude potentially litigable misdiagnoses. The uninsured simply take too much time with too much risk for uncertain payment. No wonder physicians turn them away and refer them to the ER.

But the ER, as we all know, isn't an appropriate place for these patients either. Charges are higher, work-ups much more expensive, and few physicians are willing to see them in follow-up. Although one Princeton healthcare expert referred to them in *Newsweek* as "expendable people – mostly low-income, hard-working stiffs, socially and politically marginal," I had learned from my work in the ER that they are neither destitute nor derelict. In our community they are farmers, construction workers, stone masons, Hispanics, Mennonite families, beauticians, cleaning ladies, small business owners and their employees – hard working folk who pay their bills. They told me they didn't have the time to wait at government clinics and did not like the quality of care they received there.

They urged me to start a practice and promised that they would come see me if I did. I thought that maybe over time this clinic might replace my income from the ER with the hope that I could jettison increasingly wasteful, irrational, and dehumanizing bureaucracies as much as possible from my practice and from my life.

Because of the charitable nature of the clinic, I had considered making it a non-profit to take advantage of tax breaks and to raise money for my own salary. After several discussions with my attorney, I had pretty much decided against it. He pointed out that dealing with a board would probably be about as frustrating as every other bureaucracy I had encountered since my residency. In addition, even though I would be the one building the patient base, the board could dismiss me whenever it wished, and the years I would have invested might well end in futility and bitterness. Since the sick and injured we will always have with us, I reasoned that it was more prudent in the long run to depend on them for my income rather than on fickle donors and ever-changing tax laws. The long-term risks did not appear to be worth the short-term financial security a non-profit might offer.

The idea of making the clinic non-profit became academic very quickly as my plans to make the clinic full time were realized sooner than I had expected. For various reasons, the president of the hospital where I worked had my ER contract terminated abruptly. I simply did not have time to start a practice and raise money too. Had I pursued the non-profit option, the idea of this clinic might still be in committee. At that point, I had to make a decision – either obtain ER work at another hospital or start the clinic full time. For better or worse I stepped out in faith and decided on the latter. The clinic was up and running within two weeks of my dismissal.

A visit to the clinic

In general we are a walk-in clinic for routine minor illnesses and injuries – I would characterize us as a high capability urgent care. We are open every morning Monday through Saturday for walk-ins and some afternoons by

appointment. Sometimes I treat established patients over the phone and charge their credit card.

So let's suppose that you are a patient coming to the clinic for the first time – what would you see and experience?

As you walk up to the clinic, you will see a large sign that has information about the cost for various medical problems. Poison ivy - $25. Sore throat - $35. Simple lacerations - $95. A doctor who actually enjoys practicing medicine today – priceless (and we do take Mastercard). These fees, which are about 50% of the Medicare Allowable, are listed on the brochure I brought with me and should be available to you.

The only way that I can keep my prices so low is by avoiding the crushing overhead and hassles that other physicians allow third party payers to impose on their practices. I even don't take Medicare, a potential source of a great number of patients, because doing so would force the uninsured to pay for the cost of processing other patients' medical claims – a service from which they clearly do not benefit. Forcing me to hire more staff to bill on behalf of Medicare beneficiaries would defeat the purpose of my clinic. From day one, the clinic has centered care around the uninsured and patients with high deductibles, even if it meant seeing fewer patients and thus receiving a lower income.

Contracting with a third party payer obligates a physician to some extent to the one paying the bills. This would force me into a conflict of interest I am not willing to accept. I recoil at the thought of being anything less than completely transparent, putting before each patient my best recommendations and their estimated costs. This is exactly how I would like to be treated if I were in their shoes. This engenders a trust not currently present when a bureaucrat is allowed to intrude into the doctor-patient relationship – one that many Americans today still consider second in importance only to family.

Advertising my fees and qualifications, by the way, initially ran counter to my ideas of medical professionalism. I realized I had to overcome this professional arrogance if my core clientele – the uninsured and people with high

deductibles – were to learn about the cost breaks of a clinic not taking insurance. Such advertising is permitted within the by-laws of our state medical board.

We have worked out discounts with various other providers in the area so that a cholesterol panel is $20 to the patient; a complete chemistry is $25; X-ray's with a radiologist's interpretation at Takoma Adventist Hospital are $70. Some patients choose to pay one of the chiropractors near the clinic $35 for an extremity X-ray and bring the film back to me for an interpretation and treatment. Costs to the patient here are about 60% those of other physicians' offices, 40% of the local urgent care, and 10 to 20% of the local ER's.

Upon entering the clinic, you see to your immediate right my board certification diplomas in Internal Medicine and Emergency Medicine, my Internal Medicine residency certificate from the University of Alabama Hospitals, my medical school diploma, and state license. You decide, perhaps, that I'm not some sort of quack after all and proceed to sign in at the desk where my fee schedule is posted. Everything is up front and honest.

My office assistant realizes that you have not been here before. She offers you a patient information sheet that usually takes less than 5 minutes to fill out. Since we fit under the Country Doctor exemption, there are no long HIPAA confidentiality agreements to pore over and sign. In fact, I have had some insured patients who have transferred their care to my clinic because they refused to sign these incomprehensible forms at their former physician's office.

The intake sheet explains a little about our clinic – that we don't take insurance and expect payment at the time of service. It also says that if you do have commercial insurance we can forward the claim to a billing service for a $10 surcharge, but there is no guarantee that you will be reimbursed.

Since the majority of our patients don't have insurance, they are delighted to learn about our service. Some bemoan that they had wished they had known about us before they incurred their $1000 bill at the ER. It is personally very gratifying to be appreciated by the lower middle class folk who form the economic backbone of this country and whom I have the privilege of calling my friends and neighbors.

Being in this type of practice gives me, I believe, a unique perspective on the mindset of Americans who are used to low co-pay, low deductible insurance. Every day presents me with new lessons in human behavior. It can be quite amusing, for example, to observe their responses to my intake sheet – they're kind of like Pavlov's dogs – except rather than salivating in anticipation of a delicious meal they are conditioned to expect healthcare on the cheap (if not entirely free). You can see the wheels churning as they try to process this new thing confronting them.

For example, after reading our intake sheet one Sunday afternoon, one very wealthy, prominent member of our community developed a puzzled look and in all sincerity asked me if my clinic were legal. I responded, "For now, but if we adopt single payer healthcare like Canada's, it won't. Then you will have to wait in the ER all afternoon."

Others have walked out in disgust announcing to everyone in the waiting room that they were off to see a real doctor. One teenage boy ran into the clinic to ask how much it would cost to treat him for a sore throat. "Thirty-five dollars," my assistant replied. He ran back to the front seat passenger side of his family's Lexus and informed his mother. She shook her head in disgust and peeled off.

With some it seems I'm the last stop in their desperate attempt to find a doctor without having to resort to the ER. After trying their regular doctor (2 weeks for the next appointment - sorry), and the local urgent care where waits can be on the order of hours not minutes, they rush in here delighted to find they will be seen quickly. Their countenance changes when they find out we don't take third party payment.

They can be heard agonizing, "But I have good insurance – just a $10 co-pay - see it says so right here on my card." I examine the card and, well, the information on it is all very interesting but I have to tell them that it has no currency at our clinic. I simply state the obvious - that health insurance does not equal health care (as many patients are quickly coming to realize).

Sometimes I'll press the point and ask if they have insurance for routine car maintenance to which, of course, they reply no. Then I ask, "If you don't

have insurance for routine car maintenance, they why have it for routine medical care since fees at our clinic run anywhere between an oil change and a brake job." A lot of time this comparison gets through to them. If still not convinced, I just tell them they have a decision to make about the value of their time and health.

It's obvious that we have a lot of re-educating to do of the commercially insured population. But mark my word, as their co-pays and deductibles are increasing, you wouldn't believe how quickly they are learning. One company just raised its co-pay to $35, and I am seeing many more of its employees at the clinic. Price when not adulterated by government subsidies can be a wonderful educator of value.

Getting back to the patient: While you are filling out your intake sheet you happen to overhear typical conversations my office assistant has with people calling on the phone. "No, we don't take insurance. The average fee is between $35 and $50." It seems if they were so discriminating when it came to spending their insurer's money, we wouldn't have a healthcare crisis on our hands.

Anyway, you filled out your sheet and are brought back by my office assistant to an exam room. She serves as a combination receptionist / lab tech / and nursing assistant. She takes your vitals and pulse ox with one of those machines you see in ER's while jotting down your chief complaint. She carries the phone with her, and if it rings will answer, "Can you hold, please?" until she finishes with the patient, or if she's real busy I will take the call. The patients in the clinic get first priority. When the clinic is busy, I will take the vital signs myself with the machine and usually by the time it has finished I have pretty well completed the history as well.

Let's say you have the stomach bug of the month, and I determine you aren't dehydrated and are able to keep pills down. I dispense 12 Promethazine 25mg pills prepackaged from our little dispensary for your nausea so you don't have to stop by a pharmacy on the way home. I show you the instructions on the label, write them on the discharge instructions, and give you our handout sheet on clear liquid diets, and you are out the door for $40.

If you are dehydrated, I'll recommend an IV, and if you agree, I will administer 2 liters of IV fluids over about an hour, give Promethazine IV if you have a driver, and before you leave dispense Promethazine gel with instructions about how to apply it on the inside of your forearm. You go from feeling like a withered plant to bursting with life again – all for only $130. In the ER this can run over $1,000.

Do the prices seem a little low to you? They probably are. However, I would much prefer a modest income and the freedom to take care of appreciative patients than being rich and forced by government mandate to take care of patients who feel they are somehow entitled to my services.

Clinic Results

PATMOS is located in a village of 16,000, in a county of 60,000, in a state where only 10% are without insurance (one of the least in the nation) and 25% have Medicaid (one of the highest in the nation). In addition, there is a government run clinic in town, two others within 15 miles of town, and a charity clinic in a town 25 miles away. No large company in our community to my knowledge has yet to adopt a consumer driven health plan such as an HRA or an HSA where employees are motivated to find low-cost healthcare. I compete daily against 10 to 20 dollar co-pays.

Given a market so stacked against us, how have we been able to survive these last three years? By providing value and service at fair and honest prices as any other successful small business does. We have nearly 5000 patient charts with (at last count) approximately 51% uninsured, 38% commercially insured, 8% Medicaid recipients, and 3% percent Medicare. The clinic has added 800 new patients in the last six months.

My break-even volume is about 1.2 patients an hour. My average volume over the last 6 months has been about 3 patients an hour, which makes my net income before taxes a little less than what I was making in the local ER. At 4 patients an hour, I would be making about 50% more than I was making in the

ER. The average cost per visit over the last six months including the professional fee, tests, and medicines has been $51.53 per patient.

To put this in more concrete terms, an uninsured patient came to us last week from the local urgent care after refusing to pay the $105 they required up front to be seen for a sore throat. She paid us $35 after the visit.

Other PATMOS-type clinics

I am not alone in this effort. There are many other physicians in this country currently doing low-cost, non-boutique cash-only clinics, and they are gaining increasing media exposure. They are filling real needs in this country, especially for the uninsured.

The largest such network of clinics is SimpleCare, founded in 1998 by two family physicians in Seattle, WA. According to Vern Cherewatenko, MD, there are now over 2000 healthcare providers who are members of their organization (including me). They started their cash only clinic out of financial necessity. Their managed care market was squeezing them so severely by increasing overhead and hassles while cutting their reimbursement that they actually began losing money.

They had five clinics in an IPA and were billing $10 million per year, but were losing $80,000 per month, despite doing everything to cut expenses to the bone. Their average reimbursement per patient visit was $43 while the average cost per patient visit was $50 ($20 of which was incurred in billing). The overhead was so bad that he remarks, "At one time we needed six medical records clerks…just to photocopy the records of patients who, on a monthly basis, transferred in and out of our care on these various managed care plans."

Dr. Cherewatenko is the most prominent leader in the direct payment movement. He appeared on the cover of the April 2002 issue of U.S News & World Report, on NBC news and PBS, as well as in the Wall Street Journal, USA Today, and Forbes Magazine. On April 4th, his organization received national exposure through the AP News service, which was then picked up by CNN and many local media throughout the country. Within three days, his website had

over 25,000 hits with the average time per hit being over 40 minutes. He had interviews taped last week with both the NBC Nightly News and CNN Financial News.

The co-founder of SimpleCare, David MacDonald, D.O, has gone on to start Liberty Health Group, "a medical consulting company with a special focus on the Consumer Directed Health Care Model."

California family physician Tom Lagrelius helped start INDOC – Independent Doctors of the South Bay – in 1997 and is currently listed among its directors. It "was created and serves as a nonprofit patient-oriented doctor referral network that is committed to advancing personalize, private, 'unmanaged' healthcare." The INDOC website contends that "third-party interference between patient and doctor should have no place in the practice of medicine."

CashCare America in Warrenton, VA "is building a nationwide network of physicians, dentists, pharmacies, and hospitals that have pledged to charge you the discounted rate offered to managed care insurance companies if you pay cash rather than rely on insurance reimbursement."

Several religious medical cost sharing plans offer a non-insurance alternative where members share expenses to a large deductible and the risk is reinsured beyond that. Amounts of the monthly "share" tend to run a fraction of the cost of most health insurance premiums. Brochures for two such plans, Samaritan Ministries and Medi-Share, are available in our clinic's waiting room.

Todd Coulter, MD, a black internist from Mississippi, has had a cash only practice for 2 years. He charges a flat rate of $40 per visit. Head of the AMA's young members section, he advises other physicians to "get off the Medicare plantation." His clinic has been featured on the CBS Evening News.

Mike Harris, MD, a urologist from Michigan, got rid of all his third party contracts several years ago. Herb Rubin, a gastroenterologist from California, has been doing direct payment for a number of years and decries "the coarsening and commoditization of our once noble profession" at the hands of managed care. Curtis Harris, M.D., J.D., an endocrinologist from Oklahoma, started doing cash only about 5 years ago. He is on the board of the Christian Medical & Dental

Association and recently submitted an article concerning cash only clinics to be printed in the next issue of the CMDA magazine *Today's Christian Doctor*. Lawrence Huntoon, MD, a neurologist from New York, just recently gave up his last insurance contract as a non-participating provider with Medicare.

The week after I gave a talk to a medical organization last fall, an attendee called me to say he had decided to drop all insurance contracts and start a cash-only practice. The April 23rd issue of Medical Economics contained an article entitled, "No coding, no insurers – no kidding," featuring not only SimpleCare but many other physicians throughout the country whom I had never heard of starting cash only practices on their own just as I have.

It appears that we are tapping into a wellspring of patient and physician dissatisfaction with costly, inefficient, paternalistic, and impersonal bureaucratic medicine. People today want control over their non-catastrophic medical care – and they want it right now, from someone they trust, and at fair and honest prices. With the advent of consumer-driven health plans empowering Americans with pre-tax, tax-deferred savings accounts to spend at clinics like these, we are poised, I believe, to see a grassroots revolution in the delivery of routine medical care.

Over a year ago, Tennessee Representative Zach Wamp in an editorial entitled "Is Healthcare Facing a 'Perfect Storm'?" identified many factors converging together threatening to sink our healthcare system. He warned us then that a federal government takeover of medicine might be imminent. It appears now that consumer-driven health plans together with these direct payment clinics that are spontaneously and simultaneously starting nationwide might well prove to be the twin engines propelling us out of this "perfect storm."

An op ed in the Wall Street Journal by economist Alan Enthoven once asked, "Where are Healthcare's New Honda's?" With more clinics like these offering services costing between an oil change and a brake job, my answer is that they are just arriving – and they are patient driven.

How cash only clinics reduce costs

Cash only clinics can reduce cost substantially. Operating expenses for a family physician vary from practice to practice depending on the locale, the extent of services that are offered, the equipment, etc. Some have their own lab and X-ray machines – many do not. According to the Medical Group Management Association, the average family physician's take home income is about $150,000 per year. Overhead is typically around 65% or $250,000.

One physician contemplating quitting medicine was quoted in last summer's *Time* magazine issue, "The Doctor is Out," as saying, "Our income is completely controlled by the government but we have no control on our expenses." In contrast, I rely on appreciative neighbors for my income, and by avoiding contracts with third party payers I have a handle on cost. My overhead is about one-third that of the typical family practice which in absolute dollar terms is over $150,000 per year – more than the typical family physician's take home pay.

According to MGMA, the average number of FTE's per family physician is about 4.4 and the annual personnel cost is about $150,000. Mine are 1.2 and $30,000, respectively. As I mentioned earlier but is worth repeating, the average cost per visit over the last six months including the professional fee, tests, and medicines has been $51.53 per patient.

If we could suspend political reality for a moment and imagine that all 300,000 primary care physicians did direct payment, the national cost savings would translate roughly into $50 billion savings on the doctor's end alone. This excludes the savings to the insurers.

If there were more reasonably priced clinics like ours around, the uninsured would not have to use ER's for their medical care and Medicaid programs could stop paying for routine medical care for many of their recipients. This would decrease pressure on ER's and would free them up to do what they do best – care for emergencies. It would also decrease Medicaid costs, which are busting many state budgets – including Tennessee's.

The biggest savings, I believe, would come from changing the consumer mindset. Instead of shielding consumers from the true cost of routine medical care with low co-pays and low deductibles, if average Americans had to pay everything up to a fixed, meaningful amount, they would be more cost conscious. My uninsured and high deductible patients feel the full cost of their routine healthcare decisions and find the best value for their dollar as they do with any other economic decision affecting their households. Many ask me to quote a fee before agreeing to be seen. Then they insist that I provide a thorough justification for the diagnostic strategies and treatment I recommend. In a sense, the uninsured and those who have high deductibles are the prototypes for consumer-driven healthcare. Applying the sum of all of these savings to the nearly half billion primary care doctor-patient encounters each year could significantly curb the cost of healthcare for everyone and make it more available and affordable for the uninsured.

I once saved an observation about reasons for waste in bureaucratic medicine (I have since lost the reference). Its *modus operandi* contrasts starkly with the lean operations of these new direct payment clinics.

> "The great Toyota production engineer, Taiichi Ohno, referred to any activity that adds cost but does not add value as **muda**. There are seven categories of **muda.** As applied to healthcare, they are as follow:
>
> • **Delay**: Idle time waiting for pre-certification for hospitals, consultations, tests.
>
> • **Movement**: Unnecessary physician visits for referrals and lab tests.
>
> • **Oversight**: Having one worker watch another worker as in utilization review.
>
> • **Inspection**: Having one worker inspect the work of another worker after it has been completed as in HCFA retrospective case review.
>
> • **Rework**: Performing the same task twice as in second opinions or refiling claims.

> • **Overproduction**: Requiring unnecessary products as in defensive medicine or processing unnecessary information, e.g. as required by HIPAA.
>
> • **Poor or Defective Design**: Design goods that do not meet customer needs, such as HMOs, Government or Employer-sponsored health care, and requiring RBRVS, CPT, DRG, and ICD-9 coding schemes."

One of the biggest savings might not be financial. According to the American Hospital Association's *TrendWatch*, over 120,000 nurses are currently needed to fill vacancies in our nation's hospitals. According to a JAMA study, there will be a shortage of 400,000 nurses by the year 2020. Again, suspending political realities to make a point, if all primary care physicians could reduce their staff by three employees, there would be 900,000 more healthcare workers who would be available for direct patient care rather than wasting time pushing paper.

Maybe it *is* time to change the political reality. After all, John F. Kennedy once said:

> "The problems of the world cannot be solved by the skeptics or the cynics, whose horizons are limited by the obvious realities. We need people who dream of things that never were."

Now we can talk about healthcare

On April 18th, the New York Times carried a thoughtful article by Senator Clinton entitled, "Now Can We Talk About Healthcare?" As a frontline physician, I believe she is right when she says, "We need care to focus on the patient" because "studies show that when patients have a greater stake in their own health, they make better choices." I too believe that "the present system is unsustainable."

However, I would have to disagree with her that "every other industrialized nation has…health care that's always available for every citizen." The evidence shows instead that universal health coverage does not universally guarantee timely, quality medical care. Although beautiful, egalitarian, and

noble in aspiration, universal health insurance has proved ugly, elitist, and ultimately inhumane in practice.

According to an article from London's Sunday Times, over one million Brits are awaiting elective surgery, despite its National Health Service having so many workers that it is the third largest employer in the world. There is such a backlog of surgeries that the government is subcontracting the work out to other European nations. The National Health Service, however, insists it's making improvements, stating on its website, "Already more than three out of four inpatients are admitted within *three months* (emphasis mine) of seeing their GP, dentist, or optician." Soothing words perhaps for the Brits, but with delays of this magnitude we Americans would be suing for malpractice.

The following quote (again from its own website) is even more incredible. "If you are suffering from chest pain for the first time and your GP thinks this might be due to angina, you will be assessed in a specialist chest pain clinic within two weeks." Faced with a potentially fatal medical condition, Americans would never tolerate such delays in care.

Despite many Americans' infatuation with Canada's system, it appears to be no better than Britain's. Canada's own National Post has reported median waits for a CAT scan of 5.2 weeks, for an MRI 12.4 weeks, and for an ultrasound 3.2 weeks. The average time it takes for a Canadian GP to refer a patient to an ophthalmologist is 15.8 weeks with another 10.8 weeks elapsing before the eye specialist actually initiates treatment. According to the Canadian Medical Association Journal, the median time from a mammogram to a mastectomy is about 14 weeks, long enough for a localized cancer to metastasize.

By comparison, just before Labor Day last summer an uninsured patient of mine came in with a worrisome cough. We obtained a chest X-ray that day which showed a shadow on the periphery of his right lung – potentially a curable lesion if cancerous. A diagnosis was made, and the patient was referred to a thoracic surgeon, who removed the cancer 4 ½ weeks from his visit to my clinic. I still see him periodically, and there is no evidence yet of recurrence or spread of the tumor.

Our own Tenncare system, often touted as a model in Medicaid efficiency, is about to bankrupt the state. It costs approximately $5,500 per person or $22,000 for a family of four. In a February 2004 Johnson City Press editorial, I made the following observations.

> "Many Tenncare patients tell me they choose our clinic because either their assigned providers don't have any openings for several weeks or they don't have a provider at all. Should we be surprised considering the pittance Tenncare pays physicians?
>
> To pay for all the overhead insurance and government impose on their practices, physicians have to stack their schedules with frequent visits from patients with simple chronic problems.
>
> So much is wasted in this petty political game of 'you pretend to pay us and we pretend to care,' that there is little left over to pay specialists for the really sick. One of my patients with severe rheumatoid arthritis cannot get an appointment with a rheumatologist who accepts Tenncare until August.
>
> In addition, about as many dollars are spent settling the small claims for routine office visits as the doctor receives for his time."

Several weeks later, Governor Bredesen in his State of the State address announced a fundamental shift in policy by introducing greater accountability at the point-of-care. He was quoted as saying, "the only way you manage utilization effectively is to have some economic skin in the game at the point of sale," calling on "able-bodied adults…to pay something." The consulting group McKinsey & Company has proposed increasing physician visit co-pays up to $32 for this "able-bodied" population – a little less than the average visit at PATMOS.

It seems that centralized bureaucracies simply cannot manage healthcare. Medical decisions are much too complex and personal to entrust to distant bureaucrats many of whom lack basic medical knowledge. The most efficient and humane solution is to allow ordinary Americans to manage their own care by giving them control over their healthcare dollars. It is, after all, their money and their health. They *should* control both.

Senator Clinton goes on to say, "It will…take the whole village to finance an affordable and accountable health system." The "villages" of Great Britain, Canada, and Tennessee might have the power to set prices and thus make healthcare more "affordable," but they cannot contain the costs. Markets, even in healthcare, will not be mocked, and costs will be extracted in terms of longer and potentially fatal delays and fewer innovations. Already more physicians at the height of their careers are choosing early retirement and fewer of our brightest students are selecting medicine as a vocation.

To whom would you rather entrust your care – a heart surgeon who is angry that his (or her) talents were commandeered in mid-career or one willing to acquiesce to the bureaucracy? Without caregivers, there can be no care – irrespective of village mandates. For no one - not even Representatives or Senators - can coerce talented and medically skilled citizens to care.

From my experience with Tenncare, there seems to be little accountability with government run healthcare. While working in a Tennessee ER for 4 years, I noted that over 80% of adult Tenncare patients smoke cigarettes. Given that a pack-a-day habit costs roughly $1,000 per year, these Tennesseans could pay for about 20 visits to our clinic with the money they would save from quitting. Indeed, any objections to paying for their own routine medical care at clinics such as ours could be seen more as a problem with their priorities than with the price.

One 40-year-old nurse with a heart attack I cared for opted for a higher paying job without insurance than one with insurance because he knew that if he did have a catastrophe he would immediately be placed on Tenncare. He was right. I happen to know that his family still owns 70 acres of land outright. I have observed some Tenncare recipients driving late model vehicles to my clinic such as Toyota Sequoias and Honda Accords. I have no problem with their smoking cigarettes or owning vast tracts of land or expensive vehicles – just not at taxpayer expense.

Corruption and waste seem to be endemic in villages, but not at neighborhood cash clinics such as ours that don't presume upon other taxpayers. Every day I am repeatedly and directly accountable to my patients. If they don't

value my service, they go elsewhere. In Canada, that "elsewhere" happens to be the United States.

What government can do to assist development of PATMOS-type practices

If policies promoted the development of direct payment clinics instead of hindering them, the current grassroots movement in low-cost clinics would probably spread like wildfire. I might then be able to find another physician to join me and thus extend the clinic's hours to my community. Then my patients wouldn't have to complain about getting charged $750 by the ER for repairing a laceration that I would have repaired for about $200 – or getting charged $400 by the ER to X-ray a boy's arm to tell him that a BB easily palpable near the skin was indeed located in his arm, when I removed it the next day for $100 (which included the price of the antibiotics). If physicians weren't so afraid of running afoul of arcane and capriciously enforced Medicare regulations, many more, I believe, would start similar clinics.

So what can you as Congressmen and Senators do?

First, you can change Medicare's "opt out" clause. Medicare regulations make physician coverage for my practice practically impossible. In order to care for the uninsured cost-effectively, I had to "opt out" of Medicare. Otherwise, I would have to turn away any Medicare patients willing to pay me directly for my services. No other physician in my area with skills compatible with mine has "opted out" of Medicare. Therefore, I cannot be available to my patients beyond office hours (otherwise I would be on call 24/7, 365 days a year), and I have to shut the clinic down completely when I take a vacation or attend meetings like this one.

Two weeks ago an emergency physician from Georgia spent the day at PATMOS trying to get an idea what it will take for him to get started part time in a practice similar to this. He still wants to continue practicing ER medicine until the practice can sustain his income needs. In order to do that, I advised him to turn away all Medicare beneficiaries, because according to Medicare's "opt out"

clause, he cannot both bill Medicare in the ER and contract privately with Medicare beneficiaries in his clinic.

Medicare law insists that a new patient with an "urgent" condition be turned away from the clinic. Over a year ago a Medicare beneficiary who did not have a primary care physician came to our clinic with a one-month history of weight loss and cough. Had I referred him to the ER, they would have found the mass on chest X-ray but would not have been able to evaluate it more fully. They would have given him the names of doctors with whom he could follow-up, which would have just delayed his care. As it was, the patient was diagnosed with small cell cancer and within about 2 weeks began chemotherapy. I'm not sure if Medicare would consider his condition" urgent." But how could I turn him away because of a Medicare regulation I don't understand? I had to do the neighborly thing. Otherwise, the patient might not have had a few more good months and enjoy his last Christmas with his family.

Medicare patients who want to be treated at direct payment facilities because they are unable to obtain an appointment in a timely fashion with their regular physician might either wait until their condition becomes so severe that they require costly in-patient care or resort to the emergency department earlier in their illness than is really justified. The latter option would be unnecessary for a routine problem, many times more expensive than my clinic, and inordinately time consuming for the patient.

In order to prevent treating a Medicare beneficiary by mistake and risk a fine or imprisonment, such a physician has to require all patients to sign an appropriate document stating that they are neither Medicare beneficiaries nor Medicare eligible at the time of the visit. This is an excessive burden to the clinic and inconvenience to its patients.

Quitting emergency medicine so as to "opt out" of Medicare is certainly not desirable for most emergency physicians. Even those who want to cut back on hours in the ER would like to do so slowly. We enjoy the challenges and rewards of the specialty and more would probably extend their careers substantially if it weren't for the "opt out" clause. In addition, the measure

requiring a two-year hiatus for all who dare to "opt out" is certainly a draconian disincentive to test the waters of caring for the medically uninsured.

Second, curtail the tax exemption for low co-pay, low deductible insurance. If companies want to purchase these for their employees that is fine, just not at other taxpayers' expense. Holman Jenkins of the Wall Street Journal perhaps has said it best:

> "The average family of four now pays about $1600 a year in taxes to cover the cost of a health-insurance subsidy to *itself*. No real gain to anybody occurs: We just push checks around to conceal from people the true cost of their healthcare. How bad this has become is lost on most Americans .... It is also grossly regressive: A family earning $100,000 a year gets $2357 to help pay for medical insurance; a family earning $15,000 gets only $71.... The only reform that stands a chance is one that dismantles the nutty system of tax subsidies that fuel health care inflation by commanding an unnatural urge to channel every ache, pain and prescription through a third party payment bureaucracy."

Third, allow Americans to roll over other assets such as IRA's into their Health Savings Accounts to provide immediate coverage for the high deductibles.

Fourth, promote transparency in pricing by hospitals, especially if they are non-profit. Two non-profit hospitals in Urbana recently lost their tax-exempt status because townspeople were able to demonstrate price gouging of the uninsured and draconian collection practices. The hospital nearest our clinic charged an uninsured patient of mine for a colonoscopy twice what they charged the insurance company of his wife. A patient I diagnosed with appendicitis and referred directly to the surgeon (as opposed to the ER where he would have incurred an even higher bill) was charged $5,500 by this hospital even though he went home the same day as his surgery. I suspect Medicare and Tenncare pay considerably less for the same treatment. Although this hospital is non-profit, it refused to discuss discounting rates for the uninsured at our clinic.

Extending care to all direct payers (including the uninsured)

A business sketch

There is a niche somewhere in between urgent and emergent care that is particularly attractive to emergency physicians whose careers on average cover less than a decade (due to the phenomenon many call "burnout"). It could allow us to use most of our skills and experience under less duress and without doing graveyard shifts. Originally, my clinic started this way, but financial limitations and time constraints forced me to scale back my services. Such an option would extend ER docs' careers by providing an opportunity to use most of our skills and knowledge more fully than most other options currently available.

There is probably no other group of physicians today more qualified to take care of the medically uninsured than ER docs. We provide a broader range of medical care than any other specialty. We are able to treat from the very young to the very old, from head to toe, from the chronic to the acute, from routine ailments such as ankle sprains and sore throats to emergencies such as major trauma and heart attacks. We are part anesthesiologist, part dermatologist, part gynecologist, part internist, part neurologist, part ophthalmologist, part orthopedist, part otorhinolaryngologist, part pediatrician, part psychiatrist, and part surgeon. After about a decade of practice, there are few diseases within medicine that ER physicians haven't treated and, short of major surgery and skills reserved for other specialists, few procedures that we haven't performed. Yet after the first decade of our careers, many are ready to call it quits. Most find less stressful jobs that do little justice to their unique experience and skill.

I believe that this talent could be better employed in fully equipped urgent care centers that approximate small rural ER departments in capabilities. I have worked in small, rural ER's as well as large urban ones that treat major trauma. I understand first hand the capabilities of both. In my opinion, establishing this type of facility throughout the country is an idea whose time has come, especially considering the ever-increasing cost of medical care and the 44 million uninsured. Indeed, four similar facilities (albeit hospital-associated) are already operating in New Jersey.

I predict that there would be a ready supply of physicians for facilities such as the ones that I envision. I believe that near-burned-out and burned-out emergency physicians would be willing to contribute their skill and knowledge in less stressful settings that don't require 24 hour a day, 7 day per week coverage. The burden on urban ER's would be reduced. Rural hospitals could replace much of their ER coverage with hospitalists capable of covering the whole hospital 24/7. And best of all, more urgent and semi-emergent conditions could be treated skillfully and definitively. Should true emergencies happen upon the premises (ambulances would not be allowed to transport emergency cases to such facilities), they could be adequately stabilized and sent by critical care transport to an appropriate hospital.

This presents a win-win-win situation for everyone. Seasoned emergency physicians would not waste their talent. Hospitals could use their resources more efficiently. And most importantly, patients, especially the uninsured, would be able to take advantage of the comprehensive skill of a retired or semi-retired emergency physician in a more cost-effective setting.

I have sketched out a plan for such a clinic in a market larger than Greeneville. A clinic such as ours initially requires only one trained clerical person besides the physician. At between 3 and 4 patients an hour, it becomes cost effective to hire an office assistant. It would require one other physician with a background similar to mine to alternate 12 hour days. We could also take appointments on our days off within a small space in the clinic. Neither an X-ray machine nor a lab would be necessary. In fact, there is a strip mall in a nearby town with a chiropractor willing to take X-rays for us and with a satellite draw station for a regional lab company. Only about 1600 square feet would be necessary. Much of the office equipment could be purchased second-hand at low prices as I did when I started PATMOS.

Given this, I would estimate that start-up costs would be between $150,000 and $200,000 and within 6 months the clinic would be self-sustaining. This assumes a generous amount for advertising, initial office costs, and a reasonable

income for physicians and staff. The clinic would be self-sustaining around 1.5 patients per hour.

The government would not need to foot the bill for any of this. I suspect that there are plenty of wealthy stakeholders with enough of an interest in preserving private medicine who would be willing to capitalize such a venture reasonably if not generously once they have learned of its potential. Perhaps clinics such as these are what Harvard Business School professor Clay Christensen had in mind when he coined the phrase "disruptive innovation." They are indeed a cheaper, more efficient way of providing professional services initially directed at low-end users that will likely catch on soon in the mainstream and eventually come to dominate the primary medical care market.

Direct payment primary care practices like these are pretty simple, really. But then, as President Reagan once said, "There are no easy solutions. Just simple ones."

All they require is being a neighbor.

Testimony of

Alieta Eck, MD

Physician in private practice in Internal Medicine, Piscataway, NJ,
and Co-Founder, Zarephath Health Center, Zarephath, NJ
732-463-0303; zhcenter@aol.com

"Rethinking Insurance"

Before The

Joint Economic Committee

Of The

U.S. Congress

April 28, 2004

Good morning. Thank you for this opportunity to come before this Committee to share some of my experiences as a physician in private practice. After 15 years of watching my profession go through profound changes, I would like to share some insights.

In 1965, a friend of mine was volunteering in a New Jersey hospital. She remembers that, at that time, a day in the hospital was billed at $39. 1965 was the year that government entered into the payment of medical bills, for it was the year that the two huge government programs, Medicare and Medicaid, were begun. This was also the year that medical inflation began, caused by an enormous infusion of federal dollars, resulting in today's sad statistic that a day in the hospital in New Jersey is billed anywhere between $3000 and $5000. My name is Dr. Alieta Eck. I was a registered pharmacist before going to medical school. I graduated from St. Louis University School of Medicine and then did a residency in Internal Medicine at Robert Wood Johnson University Hospital in New Brunswick, NJ. I am Board Certified in Internal Medicine and am part of a four physician multi-specialty practice.

Special Challenges in New Jersey

I live and practice in New Jersey. I participate in a Health Benefits Reform message board, and experts from all over the country shake their heads in awe at how a state government could mess things up so thoroughly. In 1992, New Jersey created the Individual Health Coverage Program to ensure that people without access to employer or government sponsored health care programs could purchase health coverage from a variety of carriers. All plans were standardized, and any attempt to alter the plans to satisfy consumer demands became illegal. Insurance companies were told exactly what had to be covered, what the maximum deductibles could be, and who would be eligible to enroll.

The state was attempting to make it easier for NJ citizens to understand the plans and comparison shop for the best rates. But the net effect was a staggering increase in premiums, and an equally staggering increase in the number of uninsured citizens. 220,000 individual state-approved health insurance policies were obtained in NJ in 1996. This number has dropped to 90,000 and the number is falling quickly. Anyone can pull up ehealthinsurance.com, type in a New Jersey zip code and view rates that are laughable. For example, the March, 2004 quote for a single person, "Plan C," with a 30% co-pay and a $1000 deductible, is an astounding $4419 per MONTH as quoted for all to see, by the Celtic Insurance Company. The *least* expensive plan, which still allows the patient to choose his own physicians, is offered by Oxford, at a rate of $912.20 per month for a single person. These astronomical rates can be explained by six NJ laws and facts that cause insurance rates to rise.

1. **COMMUNITY RATING**-- Charging the same whether one is male or female, 18 or 64. The healthy 18-year-olds are not willing to pay the rates needed by the sicker 64 year olds, so they drop out. This leads to more uninsured New Jerseyans and higher rates for those left in the system.

2. **GUARANTEED ISSUE**- People can avoid purchasing insurance until they feel they have a good reason. They can wait until they have symptoms, purchase health insurance, and, after the one year obligatory

waiting period for pre-existing conditions, be covered for everything. One can find he has contracted Hepatitis C, wait the one year period, and then be covered for some very expensive medicines. Less healthy people in the pool increases the cost of health insurance for all.

3. **$300 MANDATED ALLOWANCE FOR CHECK-UPS**- This actually costs $500 when you consider the bureaucratic paperwork to process the claims. Health insurance costs rise.

4. **GOVERNMENT MANDATES**- Every time we turn around, our legislature is satisfying another special interest group, mandating that all health insurance policies cover another service—in vitro fertilization was added last year. These mandates cause health insurance rates to rise and more people to drop out.

5. **LIMITING THE LEVEL OF THE DEDUCTIBLE**- In an effort to find lower cost insurance, people are asking for higher deductibles. This would lower the premiums and protect the assets of those who own a home. Individual policies with a deductible greater than $2500 are illegal in NJ.

6. **INTENSE POLITICAL PRESSURE TO AVOID CHANGE**- There are currently separate laws for Blue plans, commercial carriers, HMO's, small groups, large groups and individual plans. A "divide and conquer" mentality allows the legislature to write laws that satisfy special interests but do not apply to enough people to cause a massive protest. Regulation should focus on solvency and disclosure, applying to all plans across the board. The rest should be left to the marketplace.

Because of all the mandates, New Jersey is being left in the dust when it comes to the establishment of the newly enacted Health Savings Accounts. One insurance agent told me that there are 2300 open questions concerning the structure of these plans and the legalities of implementing them with the existing New Jersey laws.

At a recent conference I suggested to our own Senator Jon Corzine that there was one law that he, as a US Senator, could support, that would cut the number of uninsured in NJ in half. That would be *to allow us to purchase health insurance across state lines.* The internet provides a perfect vehicle, and Washington could help undo the extensive damage done by legislators in states like New Jersey. This would be entirely consistent with the Commerce clause in the US Constitution. His answer was completely unsatisfactory. He thought that this would result in insurance companies "cherry

picking" only healthy people. I countered, rather, that this would result in more people being insured, avoiding the risk of bankruptcy by owning affordable health insurance.

The Problem with HMOs and Government Run Health Insurance

Early on, in our practice, we avoided enrolling as physicians in the HMOs, unwilling to sign contracts that tied our hands while paying us some un-negotiated fee. We were being asked to swear our allegiance to the HMO, while pretending to care about our patients. I remember attending a hospital Grand Rounds where we were shown a graph with the horizontal axis being our patient's length of stay and the vertical axis being the amount spent on the patient's care. We were told that BAD doctors had patients in the upper right hand corner while GOOD doctors had patients who fell into the lower left hand corner. In other words, we were "good" or "bad" depending on how much money our patients cost the system. There was no mention about how sick the patient was, how much pain and suffering the patient endured, how kind we were, how complicated the diagnosis was to make, or how well we implemented treatment. The heart of our medical training was being undermined, and we were being taught to consider the bottom line above all else.

For several years we participated in one "non-capitated" HMO, but dropped out when the company representatives read some of our charts and determined that we had spent too much time with the patients. If we billed for a "level 3" visit, and they decided it should have been "level 2," they asked for a refund. We got out in a hurry. We wrote to our patients, explaining that we wanted to be their doctors, not the servants of their insurance company. In the letter, I included a quote from Atlas Shrugged, written in 1957, by Ayn Rand:

> "I quit when medicine was placed under State control, some years ago," said Dr. Hendricks. "Do you know what it takes to perform a brain operation? Do you know the kind of skill it demands, and the years of passionate, merciless, excruciating devotion that go to acquire that skill? THAT was what I would not place at the disposal of men whose sole qualification to rule me was their capacity to spout the fraudulent generalities that got them elected to the privilege of enforcing their wishes. I would not let them dictate the purpose for which my years of study had been spent, or the conditions of my work, or my choice of patients, or the amount of my reward. I observed that in all the discussion that preceded the enslavement of medicine, men discussed everything – except the desires of the doctors. I have often wondered at the smugness with which people answer

> their right to control my work, to force my will, to violate my conscience, to stifle my mind – yet what is it that they expect to depend on, when they lie on an operating table under my hands? Let them discover what kind of doctors that their system will now produce. Let them discover, in their operating rooms and hospital wards that it is not safe to place their lives in the hands of a doctor whose livelihood they have throttled. It is not safe, if he is the sort of doctor who resents it – and still less safe if he is the sort who does not."

Many patients left our practice, and went looking for a "$10 doctor" who would only charge them the co-pay, but many have returned, seeing a big difference in the care they receive. They now see us "out of network."

So now we do not participate in any insurance scheme, though we do continue to see patients in the Medicare program. We do not "participate" in Medicare and most of our patients pay the government determined "limiting fee," at the time of service. We dutifully send in the claims electronically, abiding by the Medicare laws. The patients get reimbursed. We do not know how much longer we will do this, as Medicare is becoming more and more intrusive, demanding and punitive—all while lowering its fee schedules. The only reason we remain in the program is the fact that senior citizens are not given any alternative. People over 65 cannot purchase health insurance outside of the Medicare system.

Our practice is very efficient. Our four doctors function well with one full time employee, one bookkeeper and six part time nurses and receptionists. No one needs to spend valuable time asking permission of the insurance companies to do tests. We negotiate directly with each patient, discussing the costs as well as the benefits of any tests we recommend. We have many patients who are uninsured, so we are very careful to order medications that are the most cost-effective. We are free to spend as much time as is needed for each patient and have a loyal following.

Caring for the Poor and Uninsured

Early on in our practice, we learned the folly of getting involved in any government program for the poor. Something seemed disingenuous in government officials promising *they* would provide free health care for the poor, and then expecting *us* to foot the bill. The reimbursement is so ridiculously low, and that comes six months after the

visit. Taking on many Medicaid patients would jeopardize our survival, so we choose to screen them ourselves, and treat the poor for free.

We began to study the root causes of poverty, and were heavily influenced by Marvin Olasky's book, The Tragedy of American Compassion (c. 1992 by Marvin Olasky, published by Crossway Books). The government looks on poverty as a simple lack of funds, and has a hard time categorizing the poor. Indeed, the government is criticized heavily when it attempts to distinguish between the "worthy" poor, those who are poor through no fault of their own, and the poor who should not be given money-- those who have a lack of funds due to bad choices and bad behavior. Both may need help, but the kind of help needs to be very different. Olasky teaches the "ABC's of Compassion," and recommends that successful people personally reach out to those who are poor. A brief summary of his seven principles of compassion is as follows:

- **Assertive**- Actively seeking ways to meet needs, fight social ills, and care.
- **Basic**- Look for people closest to the individual to meet the needs—first the family, then the community, and finally the local and state governments. This describes "subsidiarity," where those nearest the problem are most responsible, and are *subsidized* by the next level of caring commitment. Subsidiarity represents the most efficient way to care and is the least subject to fraud and wastefulness.
- **Challenging**- Gently pressure people to make changes, instead of pampering them. Help develop character traits that lead to more self-sufficiency and growth.
- **Diverse**- Treat each person as an individual, without a one-size-fits-all approach. Each is an individual made in the image of God.
- **Effective**- Try to avoid being bureaucratic and unchallenging. Utilize volunteers with their unique gifts and capabilities. The bottom line is changing lives, not counting the numbers of people treated.
- **Faith-Based**- Well managed Christ-centered charities are more effective at fighting poverty and changing lives than their non-religious counterparts.

- **Gradual**- Continually re-evaluate and check the results of the program. Gradual sustained results, tested at each step of the way, will make helping the poor most successful and sustained.

We were fortunate to belong to a church that had a building that was not in use. It had been devastated by Hurricane Floyd in 1999 and was sitting dormant. A lot of fundraising and volunteer work led to the complete renovation of the building and the emergence of the new Zarephath Health Center. (www.zhcenter.org.) Employing the principles laid out above, we began operation in September of 2003, and have been seeing and caring for the poor and uninsured ever since. Here are a few of the people our physicians, nurses and support volunteers have helped:

- A 28-year-old woman came to us six months after her father had died from a long illness. She had been his primary caretaker while holding down a job in a drugstore. When she became depressed, she lost her job and her apartment. When she applied for financial aid from the state, she was told by the caseworker that, in order to qualify for funds, she needed to get pregnant. She needed medicine that cost $230 per month. We helped her access a program designed by the pharmaceutical companies, allowing her to receive a three month supply for free. The program refused to give her more unless she had a letter from the state agency explaining their denial of aid. They would not write it. So we priced around several stores and bought her medicine to carry her over. She is getting back on her feet, has enrolled in a course to become a phlebotomist, and will be on her own by the end of the summer. She will not need us any more.

- A 20-year-old just graduated from college and was removed from her parents' insurance. She stayed at home for several months, caring for her sickly grandmother who was bedridden with advanced Alzheimer's disease and eventually died. With no paycheck and no insurance, we were able to take care of this young woman's simple illness at no cost to her. She is now at work and does not need us any more.

- A 52-year-old woman stays home with her 54 year old sister, who is dying of metastatic breast cancer. Her husband's paycheck can keep the household going, but no one in the house has health insurance. She herself is at high risk of getting breast cancer, but had not had a mammogram in 5 years. She went to the local, state-subsidized hospital, hoping to get low-cost medical care. The physicians there did a physical exam and blood work, charging her $495. Then they handed her a prescription for a mammogram. When she came to us, we checked around

for the best price, and the Zarephath Health Center gave her a check to pay for her mammogram. She recently told me that her dying sister was told that she will qualify for Medicaid on July 1, two and a half months from now. This very sick sister will likely not live that long.

- A 49-year-old is disabled with complicated diabetes. His disability income is $1000 and his rent is $725. While he is on Medicare and the state-run prescription plan for the poor, he cannot even afford the $5 co-pay. We set up an account in his name, at the local pharmacy, to draw down each time he fills a prescription. The local food stamp office told him that he qualified for only $10 per month in food stamps, so his church supplies him with gift certificates to the local grocery store. Many hands are helping this man maintain his dignity and get the health care and other support he needs.

- A 28-year-old man was terrified that he was dying. He could not hold down a job. He made several visits to the emergency room, and tests all came back normal. He had $30,000 credit card debt and was paralyzed with fear. We spent a lot of time with him, mostly in phone calls, three times a week for several months. Each time we saw him we reassured him of his good health and placed him on medicine that seemed to help. We never charged him, but, each time, we encouraged him to find work. He finally enrolled in a truck driving school and called on the Saturday morning he passed the driving test. He now has a good job, is convinced that he is healthy, and no longer needs us. His mother is eternally grateful.

People ask why we started the Zarephath Health Center for the poor and uninsured, and we reply by telling the story of the Good Samaritan. It is a story that Jesus told, about a man who was lying by the side of the road, injured and bleeding. A minister walked by quickly, thinking that he had to hurry to preach his sermon. Then a Bible teacher came by, and also felt that he did not have the time to stop and help. Finally, a Samaritan, a religious outcast, saw the man, stopped to help, and gave of his own time and resources to see that the man got cared for.

We have determined to live out our faith by following the example of the Good Samaritan. When we see people in need, we are not going to demand another government program, but rather we will use our own time and resources, and find others willing to help us do the same. We are looking for physicians and support people to donate four hours per month. We believe that there is a God in heaven, and that He would have us show compassion by meeting the physical, emotional, spiritual and

relational needs of people with whom we come in contact. We do not shove religion down anyone's throat, but we are ready to give an answer if anyone asks why we have an enthusiastic optimism about the future. We are free to tell them how a relationship with God provided the missing link in our lives and how it can be the same for them.

There is another non-profit health center, the Parker Health Center, in Red Bank, NJ. In its four years of existence, this Center has reached a point where the physicians cared for 6,000 people, with 20,000 visits last year. All the doctors and most of the staff are volunteers. They have a budget of $500,000, which computes to $83 per person per year. I would like to challenge the government to demonstrate any program that delivers care with more efficiency, patient and physician satisfaction, and quality.

One additional concern of ours, as champions of the uninsured, is the tremendous cost differential between what Medicare pays and what the uninsured are billed for a hospital visit. In New Jersey, the uninsured are billed 300% of the cost of their stay. If their stay costs the hospital $10,000, they are billed $30,000. The uninsured have no clout, and if they happen to own a house, a lien is placed on their property. We have done some investigating and discovered that a patient can have his gallbladder removed in a nice little clean hospital on a Caribbean island, for less than $1000. Compare that with the $30,000 bill we saw from one of our patients at a hospital in New Jersey. After travel, lodging, and paying the surgeons and anesthesiologist, plus a week recovering in paradise, the total bill for a cholecystectomy would not be greater than $5000 in that island hospital. The Zarephath Health Center is looking into facilitating such medical tourism for those who are interested.

We have many options—but we simply ask the government to step aside and allow the free market to lower medical expenses for all. Food, clothing, and shelter are greater necessities than health care, yet we have a largely free market in these needs, and inflation in these necessities is kept lower than in health care. As Peter Drucker said in the Wall Street Journal in December, 1991:

> "The government has proved incompetent at solving social problems. Virtually every success we have scored has been achieved by nonprofits." He adds, "Increasingly, these volunteers (in non-profits) do not look upon their work as charity; they see it as a parallel career to their paid jobs and insist on being trained, on being held accountable for results and performance, and on career opportunities for advancement to professional and managerial—though still unpaid—positions in the non-profit. Above all, they see in volunteer work access to achievement, to effectiveness, to self-fulfillment, indeed to meaningful citizenship."

Our Zarephath Health Center could do much more, at no cost to the taxpayer, if there were tort reform that would allow retired physicians to volunteer without fear of being sued. New Jersey has 15,000 retired physicians many of whom would love to provide meaningful aid to those in need. The physicians working for the medical schools have caps on malpractice claims, as well as state-covered malpractice premiums. Why not have a similar arrangement for those physicians who would donate their time to clinics for the poor? This would alleviate the tremendous burden on hospital emergency rooms, lessen the burden of the welfare system, and provide more comprehensive help to those without insurance. It is time that we roll up our sleeves and tackle these problems in a more reasonable way.

The Only True Insurance

- If you get insurance through your employer, *you are really not insured.* If you get too sick to work, you will lose your job. You will not be able to afford COBRA.

- If you are self-employed and buy your own insurance, *you are really not insured.* When you get too sick to work, you might not be able to afford your premiums.

- If you work for a big company and get insurance through it, *you are really not insured.* The company can get downsized, lay you off, or go bankrupt.

- If you work for the government, *you are only insured while you are employed.* If you get too sick to work, you lose your job and your insurance.

- If you count on Medicare, be careful. It will go bankrupt in 15 or so years. The next generation might have little patience with you when you are old and infirm. You certainly will not be in a position to demand more health care.

- If you count on Medicaid, you will find that access to care is severely compromised, as the bureaucrats are paid before the caregivers.

- The only real insurance is the kindness of our families, our churches, and our communities. This is true charity, a synonym for love. We had better be setting up institutions that are very inexpensive to run. We had better be figuring out ways to lower the costs and reduce government mandates. The market works best when it is un-coerced, unregulated, and rewarded. Likewise, charity works best when it is given and accepted freely.

In 1997, my husband, our five children, and I dropped our own health insurance. We were unwilling to pay those inflated New Jersey insurance rates, and we chose to join a faith-based medical cost sharing program. It is not "insurance," but a commitment to "bear one another's burdens and thus fulfill the law of Christ," as stated in the Bible. We pay $215 per month to help others in the program, and they in turn are committed to helping us if any medical event exceeds $911. They hold us accountable for healthy behavior. We cannot smoke, cannot drink alcohol to excess, must attend church, and must avoid sex outside of marriage. This is how the monthly contributions can be kept so low.

I love being a physician. It is the most rewarding of professions. I want my son to become a doctor. But unless we give our physicians the respect and freedom they need to practice the compassionate medicine for which they were trained, we will watch the deterioration of the greatest health care delivered anywhere in the world. Give individuals the freedom to purchase the health coverage they want, opening up insurance opportunities across state lines. Allow people to choose the best physicians, not just those on the list provided by their insurance company. Enact true tort reform, where patients are compensated, but are not awarded jack-pot judgments for "pain and suffering" for bad outcomes. We need tort reform, with relief from skyrocketing medical malpractice premiums, or the best and the brightest will no longer be attracted to the healing professions. And we must hurry—before more Americans are harmed by the diminishing numbers of neurosurgeons and obstetricians who are willing to take risks and use their superb skills to save them. Thank you.

Consumer-Directed Doctoring: The Doctor Is In, Even If Insurance Is Out

Statement of

Robert A. Berenson, M.D.

Senior Fellow, Health Policy Center
The Urban Institute

Joint Economic Committee

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Mr. Chairman, Mr. Stark, and distinguished members of the Committee: Thank you for inviting me to share my views on the growing phenomenon of physicians providing care outside of insurance. This is a timely hearing and I hope to bring a different perspective to the Committee's consideration of the crucial role of health insurance in protecting Americans' health and financial well-being. The views I express are mine alone and should not be attributed to the Urban Institute or any of its sponsors.

In the March/April 2004 issue of *Health Affairs*, colleagues from the Center for Studying Health System Change and I published an article titled "Financial Pressures Spur Physician Entrepreneurialism," which was based upon dozens of interviews we made with physicians and others in 12 metropolitan areas as part of the ongoing Community Tracking Study.[1] The study documented that physicians are experiencing pressures on their practices from a combination of factors, including reduced reimbursement rates, increased overhead costs, and higher premiums for liability insurance. It is not surprising, therefore, that physicians are looking for alternative revenue sources beyond what they earn for insured services. Unfortunately, we concluded that physicians' business practices are actually contributing to rising service use and, as a result, hindering cost containment efforts, the combination of which could exacerbate current problems with access to services for the uninsured and underinsured.

A particular problem we identified was the continued spread of physician investments in ancillary services and, as the ultimate manifestation of entrepreneurialism, the ownership of specialty facilities to which physicians refer their patients. We found that concierge care and similar approaches that permit and encourage patients to obtain services outside of insurance were not yet widespread. In the communities we researched, at most a handful of physicians were engaged in this form of boutique medicine. More recently, there has been a new development of "pay-as-you-go," cash-only medical care –

[1] Pham, Hongmai H., Kelly J. Devers, Jessica H. May, and Robert Berenson, "Financial Pressures Spur Physician Entrepreneurialism," *Health Affairs*, Vol. 23(2), 2004.

purportedly a lower cost alternative for patients without good health insurance, a possibly new approach which is being presented at this hearing

Some Physician Frustrations with Insurance Are Well-Founded

As physicians grow frustrated with the rising administrative costs and complexity of running a practice, the hassles associated with network contracting, and payment systems that have not kept up with the changing nature of medical practice, many believe that the health care system and the doctor-patient relationship would be better off if more care were provided outside of insurance, which would be reserved only for catastrophic expenses. The frustrations are real, as are the problems that produce them. Some responses, including those being discussed at this hearing, I believe, are meant to improve physicians' ability to provide care and to provide an alternative for patients who face escalating health insurance premiums and increasing cost-sharing as part of their insurance packages. These physicians understandably have an impulse to get out from under the rules and regulations associated with public and private insurance and to have more control over their own working conditions.

While these physician-initiated alternatives to the standard insurance-based systems may have some limited application, I think they represent symptoms of a system lacking universal, comprehensive health care insurance. Again, the oft-quoted H.L. Mencken line is applies, "There is always an easy solution to every human problem – neat, plausible, and wrong."

Clearly, there is a market for affluent patients and an elite tier of mostly primary care physicians supplementing the regular system of care based, necessarily, in comprehensive health insurance. However, the market receptivity of those able to afford concierge care and other, less dramatic approaches to providing "subscription services," e.g., communication via e-mail as an alternative to office visits, suggests that public and private payers can and should reform their payment approaches. Similarly, individuals and small employers, in particular, face exorbitant administrative costs that divert crucial

dollars from patient care.[2] Of course, physicians object to the gross inefficiencies and patient indignities associated with the individual and small-group insurance markets.

There are numerous lessons in these physician-sponsored initiatives that offer the possibility for major improvement in the operation of health insurance, private and public. For example, within insured products, we can be more creative in the use of tiered cost-sharing, modeled on triple-tiered pricing for prescription drugs, to try to influence patient behavior and have the patient bear more of the costs of truly extravagant choices. Similarly, those who provide concierge care maintain that having sufficient time to conscientiously attend to patients' concerns and needs forestalls expensive specialty care that time-pressured primary care physicians resort to. Based on my experience practicing general internal medicine for over twenty years, I concur that current fee-for-service reimbursement methods emphasize quick, face-to-face physician-patient encounters, while discouraging other important activities, such as reviewing records, coordinating care with other professionals, and communicating by telephone and e-mail.[3]

Yet, at its best, providing substantial health care services for much of the population outside of insurance is an elitist notion. It perhaps has a role for those affluent individuals willing to pay out of their own pocket, not subsidized by taxpayers, for special attention that a few physicians, frustrated with the rules imposed by insurance programs, want to offer. I do not criticize those who provide concierge care, although it is unfortunate that these physicians have felt the need to opt out.

Medical Care Has Unique Attributes that Do Not Conform to Normal Markets

For many reasons, these cash-based, extra-insurance models do not deserve broad application as a substitute for comprehensive health insurance. All developed countries

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[2] Blumberg, Linda J. and Len M. Nichols. 2004. "Why Are So Many Americans Uninsured?" *Health Policy and the Uninsured,* Catherine G. McLauglin, ed. Washington, DC: Urban Institute Press.
[3] Larson, Eric B., for the Society of General Internal Medicine Task Force on the Domain of General Internal Medicine. "Health Care System Chaos Should Spur Innovation: Summary of a Report of the Society of General Internal Medicine Task Force on the Domain of General Internal Medicine," *Annals of Internal Medicine,* 140(8), 2004.

besides the United States are able to provide universal, comprehensive insurance coverage to their populations at levels of a half to two-thirds of what the United States spends, whether calculated as per capita spending or as a percentage of the gross domestic product. These countries accomplish this either through social health insurance programs or national health systems that face similar theoretical problems associated with the moral hazard of third-party, insurance payment. But only in the United States do we seriously discuss endorsing an approach that would parcel out health care by the ability of patients to pay.

Forty years ago, on the eve of passage of Medicare and Medicaid, Nobel laureate Kenneth Arrow turned his attention to how medical care differs from most other sectors of the economy in a landmark article that is as relevant today as then.[4] Among the unique attributes of the medical care system, he pointed to the asymmetry of information possessed by buyers and sellers. "Because medical knowledge is so complicated, the information possessed by the physician as to the consequences and possibilities of treatment is necessarily very much greater than that of the patient, or at least so it is believed by both parties."

Arrow further explained at length that uncertainty, that is, the reality that the need for medical care is irregular and unpredictable, characterizes the nature of the service the professional is giving. The buyer-patient depends upon the seller–physician for a trusting professional relationship to help address the inherent uncertainty that underlies much medical care. The pervasiveness of uncertainty and the asymmetry of information lead to a relationship of trust and confidence, which is not present in a pure, market-based relationship. Thus, he concludes, "Purely arms-length bargaining behavior would be incompatible, not logically, but surely psychologically, with the trust relationship."

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[4] Arrow, Kenneth J., "Uncertainty and the Welfare Economics of Medical Care," *The American Economic Review,* 53(5), 1963.

The Problems Presented by Health Savings Accounts

Some approaches you will hear about today actually assume the desirability of arms-length bargaining between patient and physician. To further their adoption, many now promote insurance products featuring high deductibles and only catastrophic insurance coverage, such as Health Savings Accounts (HSAs).

However, as I have followed the debate, I have found the logic of high deductible plans is usually supported by simplistic clinical examples that ignore the prevalence of uncertainty and information asymmetry that Arrow described. We often hear of the patient with a straight-forward clinical problem, such as an upper respiratory infection, who can avoid insurance, long waits and paper work by paying, say, $50 directly to a doctor in a clinic. We do not hear about the patient with an upper respiratory infection who also is a diabetic on insulin and has renal failure and hypertension. For such a patient, the $50 cash payment might become hundreds of dollars for a proper evaluation, especially if carried out by a physician who does not know the patient and does not have the patient's medical records. Perhaps this approach would be less costly than care in a hospital emergency department, but the goal should be that every American has a primary care physician responsible for providing ongoing care and coordinating the care provided by specialist physicians and other providers.

Another typical example used to promote HSAs is the middle-aged, weekend tennis player with knee pain whose sports medicine orthopedist recommends an MRI scan of the knee. With a high deductible plan, the theory goes, the patient who now has to pay out of pocket might challenge the need for the MRI and would then search out a facility with lower prices. The decision to proceed would be made as other marketplace transactions are.

Now to the real world. A friend of mine, with good insurance, recently had knee pain. Only it did not interfere with his tennis game, but rather with his occupation – he is a carpenter, and the knee pain was interfering with his ability to work. On the

recommendation of the sports medicine orthopedist, he had an MRI. And unexpectedly it showed a "hole" in one of the bones around the knee. Although it was interpreted as likely to be a cyst, his physician wanted him to see an orthopedic oncologist to evaluate the radiological finding. That physician concurred that it most likely was a benign cyst but strongly recommended a follow-up MRI scan six months later to make sure there was no change. The concern here was the slight chance that the abnormality represented cancer.

As it turned out, the abnormality proved benign. Two expensive MRIs were performed, and they were performed based on expert clinical judgment and at facilities selected by the physicians. Expecting patients to become not only marketplace consumers but, in effect, clinicians able to grapple with scientific uncertainty and to gamble with their own health, in this case, with the specter of cancer, is inappropriate and unfair. Again, there may be some role in insurance products for applying variable patient cost-sharing to try to influence patient decisions, perhaps to select higher quality and more efficient professionals and providers. But expecting patients to make important medical decisions without the fundamental financial protection provided by health insurance is not in the best interest of patients, physicians, or the public.

At a practical level, moving the system to large deductible plans with pure catastrophic coverage, the Health Savings Account model, would disrupt insurance markets and would not likely reduce health care spending enough to be worth the threat that this approach represents.

First, it is likely that relatively healthy, affluent individuals would be the group most likely to opt out of comprehensive insurance products, leading to high insurance costs for those whose health problems give them no choice but to remain in the basic health insurance pool. As healthier families and individuals opt out of traditional insurance coverage, those remaining in comprehensive health plans would be more expensive to insure. This will lead to destructive market segmentation, driving up premiums for traditional coverage even further and setting off a spiral of adverse selection. The

comprehensive health insurance option would become unaffordable precisely for those who need its protection.

Second, most of the costs that drive inflationary health care spending are associated with a small percentage of patients who have very large health expenditures. In most health insurance systems, private and public, with minor variations, about 5 percent of patients are responsible for about half of the expenditures. Because most health spending is attributable to the small share of individuals with very large medical expenses, increasing deductibles far above current levels will not result in much savings, even if care-seeking behavior for those with the deductibles changes marginally. Although some physicians might reasonably believe that high-deductible plans were changing patient desire to have certain discretionary services, for the system as a whole, the cost containing potential of HSAs would be illusory.

Third, by requiring individuals to pay for medical expenses up to the high-deductible amounts, starting at $1,000 for single and $2,000 for family policies, high-deductible insurance would surely discourage low- and moderate-income individuals and families from receiving preventive care and the early diagnosis and treatment needed to head off costly illnesses and complications. With all the progress made in medicine, medical care is still based on substantial clinical uncertainty, an asymmetry of information and the need for a physician-patient relationship rooted in trust. Patients correctly are risk-averse and unreasonable financial barriers to care will surely lead to adverse health consequences.

Health Care Markets Remain Unique

We can agree that forty years after Arrow's commentary things have changed in a number of ways. We now have the Internet, where some patients can gain information about details of diagnosis and treatment that even expert physicians do not immediately know. However, even with this information aide, medicine has become that much more

complex. Asymmetry of information between the seller and the buyer has not diminished. And in many ways the clinical stakes are higher.

Since 1963, we have accepted that patients should not be passive, merely accepting a paternalistic physician's diagnosis and treatment recommendations. Patient preferences for alternative treatment options and their personal values on matters of life and death need to be respected and, often, deferred to. In the area of chronic care management, it has been shown that patients can improve their own health and well-being by becoming better educated and motivated to take responsibility for directing important aspects of their own care. However, we should not confuse activating patients to take greater control over their own care with turning them into consumers able to engage the health care system as if they were buying an airline ticket on the Internet.

And physicians need to remember they are professionals, one of whose important precepts is that they should be acting in the best interests of their patients. In the *Health Affairs* article referenced earlier, we expressed the concern that, in the era of managed care, physicians sometimes felt they compromised their professional agency relationship with patients by becoming, in effect, "double agents," with potentially conflicting responsibilities to patients and the insurance companies with which they did business. We then wrote, "In the post-managed care era, physicians have responded to mounting financial pressures with a range and intensity of activities that evoke images of 'free agents' defending their own financial interests and challenging established professional norms."[5] Although the activities described in this hearing do respond to real problems spawned by practices of insurance companies, I remain concerned that the responses presented by the other physicians at this hearing would, if broadly implemented, threaten the important role of public and private insurance and further compromise the physician-patient relationship.

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[5] Pham, *Health Affairs*.

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