

Response to Professor Noll  
by Rep. Jim Cooper, November 27, 2007

The prospects for sensible reform of the U.S. health care system are much brighter than Professor Noll indicates. Although he is correct in pointing out that providers have won many protections for their “incomes and autonomy,” he is too quick to be discouraged by “years of frustration in trying to generate more competition and better financial incentives in the health care sector.” (p. 2) I resemble that remark. To quit now, on the verge of victory, would be a tragic mistake. We are better positioned today than ever to pass “managed competition” legislation, like the Wyden bill, after the next election. Since Congress only responds to crisis, the approaching Medicare insolvency helps focus attention on reform. I would share Noll’s depression if the only hope for reform was “creating an agency with a mandate” (p. 1) for command-and-control-type regulation. Fortunately, we are about to do much better than that.

Notice the fragility of the coalition that Noll surrenders to. “This alliance of consumers and suppliers” (p. 2) must be divided, then conquered. Inept suppliers are the only true enemy; fickle consumers can be won over with proof of better value for their dollars.

In my opinion, Noll misreads the largest and most powerful provider group, hospitals, (pp. 15-16) although their share of health care dollars is slowly shrinking. From my experience, hospitals not only still receive over 30% of total health spending (down from 40%), they are the largest employers in every county in America, regardless of industry. With annual health care spending of \$8,000 per capita, even the smallest of America’s 5,000 hospitals vie to capture hundreds of millions of local health spending. Every hospital CEO I know thinks market power is the key to EBITDA margins of over 30%, the usual corporate target. Specialty hospitals are a threat, as are rural hospitals<sup>1</sup> that have not been added to the chains (as Noll correctly notes, whether for-profit or non-profit). Just rationalizing the hospital market would show great progress, and the AHA and Federation of American Hospitals are ready to bargain if we can just give them some relief from specialty hospitals and Grassley’s attempts to remove their charitable status.

Another missed opportunity is rationalizing referral patterns by physicians. Antitrust is a clumsy way of curbing hospitals with excessive market power resulting from cornering the local market in high-referral physicians. Regardless of what the research literature says (hospital companies I know have made billions by throwing you off the scent with stale research data so that they can keep ahead of the hounds), vertically integrated hospitals work beautifully and monopolistically. The reason so many hospital/physician deals have been unwound (p. 18) is fear of federal prosecution, and the sentinel effect of HCA (after its \$2 billion Columbia/HCA fines) choosing to err on the side of not going to prison. Talk to a health care REIT about high prices paid for

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<sup>1</sup> Rural hospitals receive far more federal reimbursement than they should. Because of the political strength of the farm lobby, rural hospitals get extra billions in virtually every health care bill including \$40 billion in the Medicare Modernization Act of 2003, resulting in some of the highest subsidies for the lowest-quality care in America. Low volume alone makes it harder for local physicians to meet standards of excellence.

physician “furniture” or ridiculously low rents for physician suites in new medical office buildings adjacent to hospitals. These have been prosecutions-waiting-to-happen for years now. My favorite solution is to ban physician ownership of any referral entity. Although I am not a big fan of Pete Stark, his famous laws did not go far enough and they do contain too many loopholes. A clean and simple Stark III ban would eliminate the \$8 billion in self-dealing that the new McKinsey study found. After all, there is no shortage of capital. Physicians are troublesome small investors; the only reason entrepreneurs pursue them is for their referral power.

Yielding to consumer ignorance about what makes a good doctor or good insurance company (p. 22) would be foolish. The Surgeon General hasn’t even tried a campaign to educate consumers about medical excellence v. good bedside manner or proper claims-paying. We haven’t allowed most consumers to evaluate physicians on performance simply because the data are so hard to generate and disclose. But try yanking the AMA’s CPT code revenues and you’ll get their undivided attention. Reversing the damage of the backlash against HMOs will be harder, but who wants unmanaged care? The bottom line is that American’s are the best shoppers in the world, when we are allowed to shop. Empower consumers with the tools they need and I think you will be proud of the results.

Is it really true that “no system of health care that is based on private insurance is likely to be very efficient”? (p. 26) I like Enthoven’s latest CED plan, released earlier this month. We should not assume that employer-sponsored coverage is inevitable, that the FEHBP cannot be shared nationwide, or that one-year policies are the only choice.

Don’t give up yet on reforming doctors. Noll “can not imagine that they is any hope of creating an effective system of second-guessing decisions by physicians and enforcing standards through financial incentives that would cause a substantial change in behavior that would be worth the cost if implementing it,” (p. 27) but I can. Start by not second-guessing doctors but getting it right the first time. The motto of Army bomb squads in Iraq is: “Initial Success... or Absolute Failure.” If we drilled the Wennberg/Fisher data down to the individual physician level, doctors would begin to have the tools they need to reform themselves. They are a competitive group. But, as businessmen and women say, if you can’t measure it, you can’t manage it. The Cooper corollary is: If you won’t measure it, you don’t deserve to manage it.

Noll is a brilliant analyst of the crazy world of regulation, but seems less familiar with the even crazier world of health care. I am probably crazier still, but whether reform comes piecemeal, or all at once, it is coming. The urgency of our fiscal crisis alone demands it. Try cutting Medicare benefits by 50% or doubling payroll taxes and you’ll get an entirely new Congress with radically different attitudes. We just have to have the policies ready for them to use. I remember when I offered the first emissions-trading legislation that was included in the 1990 Clean Air Act, at the behest of Dan Dutko of the Environmental Defense Fund. There were plenty of skeptics on the left and right. And it changed the world of regulation, at least for SO<sub>2</sub> from command-and-control to cap-and-trade. The same thing is about to happen with managed competition.\_