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4 hidden costs of health care

If you're going to fix the system, start with the problems that make it so expensive in the first place.

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NEW YORK (Fortune) -- *This is the fourth installment in a series of health-care columns by Fortune's Shawn Tully.*

Health care is by far the most cartelized, anti-competitive big business in America. The market is crippled by a web of quotas, entry barriers, monopolistic licensing laws, and discount limits that wouldn't be tolerated in any other industry.

There is a rationale for this maze of restrictions. It holds that the supply of virtually everything in medicine must be strongly constrained or costs will explode. But really, tightly regulating the system inflates prices and enriches insurers, drugmakers, and other providers.

Yet none of the health-care "reform" bills on the table today address the restrictions that magnify costs today and could bring rationing tomorrow. Before the Obama administration can craft a plan to get insurance to the masses, it needs to remove some key obstructions.

So let's examine the Big Four supply-side barriers in medicine:

Health insurance: Low-dose competition

In most cities or regions, the health insurance market is dominated by one or two giant carriers, the biggest being the Blue Cross/Blue Shield plans. A recent study by the American Medical Association found that in 56% of America's 314 urban areas, a single insurer held over half the market.

The prices these gigantic players charge are soaring: A General Accounting Office study found that over the past ten years, premiums have risen 120%, compared with inflation of 44% and wage growth of 29%. "Profits in the industry are as high as we've ever seen," says John Sheils of the Lewin Group, a health care consulting and research firm.

So why does the health insurance industry offer consumers few choices and slack price competition? The reason is two-fold. First, a law dating from World War II bars insurers in one state from offering the same plans in another state. The law was set up to give states more control over insurers, but now it essentially protects the companies from inter-state competition. A Pennsylvania insurer may offer plans in New York, but that would be too

expensive, since they must include vastly different services.

"It also takes two to three years for an out-of-state insurer to get a plan approved in another state," says Chandler Rapson, CEO of FSAI, a benefits administrator for health plans in Florida. Hence, insurers can't generate the economies of scale in marketing and back office operations available in any other business, and consumers pay the price in higher premiums.

Second, the Blue Cross/Blue Shield plans that dominate most markets are strongly entrenched. In the 1960s, they received all kinds of special treatment from state governments, which frequently waived policy tax and loss reserve requirements. The Blues built giant networks, and in most states, Blue Cross and Blue Shield plans merged. Their market shares are immense: They write 60% of policies in New Jersey, 66% in Washington, 70% in Massachusetts, and 90% in Kentucky.

How do the Blues manage to remain so powerful? Each Blue typically agrees not to cross state lines to challenge another Blue. They're also masters at requiring contracts that ward off small and large invaders alike.

The shield that protects their market share, and pricing, is their standard contract with hospitals. "Those contracts mean that competitors often can't make a dent in the Blues' business," says Ted Frech, professor at the University of California at Santa Barbara. The Blues, and other dominant insurers, demand that hospitals agree to what's known in the trade as "most favored nation" clauses.

Say a new insurer pledges to steer 1000 new patients a year to a hospital in exchange for a deep discount. That sounds great for the hospital and lowering patients' premiums. But then the new insurer runs into the "most favored nation" clause.

If the insurer's discount is bigger than what the Blue gets, the hospital has to match it. The rub is that the cost of getting the new patients just rose dramatically, and the hospital now has to give the Blue a bigger discount without the promise of any more patients. The hospital is forced to turn down the new insurer's offer, and premiums stay high.

The best solution is the simplest: Allow insurers to sell their policies across state lines. That would greatly reduce the giant price differences across states. Today, a healthy 30 year old pays $960 a year in Kentucky versus $5,860 in New Jersey for full coverage.

Big associations of restaurants and other small employers could buy inexpensive policies nationwide, greatly lowering costs to employees. Strong anti-trust scrutiny of "most favored nation" is also needed to ensure that the new out-of-state competitors can win deep discounts for consumers.

Certificate of need laws: Rationing goods and services

One of the most damaging and obsolete -- but stubbornly pervasive -- restrictions on the supply of medical goods and services is the Certificate of Need Law.

The regulations under its umbrella require hospitals, clinics and physician groups to obtain permission from state planning boards if they want to add new facilities from hospital beds to a new ambulatory surgical center. The rules were originally set up to control supply in the hopes of eliminating duplication and waste.

The federal government required all states to enact these laws in 1974. But in the mid-80s under President Reagan, the CONs were made voluntary. Many states including California and Pennsylvania have dropped the laws, but they're still extremely powerful in 36 other states, including New York and New Jersey.

The laws make it impossible for the numbers of hospitals and diagnostic centers to grow naturally with rising patient demand. Instead, they create artificial shortages as entrenched providers lobby state governments tirelessly to prevent competitors from entering their markets with sorely needed state-of-the art equipment.

"The laws are meant to restrict competition, and that's exactly what they do," says Thomas Barry, an investment banker in the hospital industry at the firm Cain Brothers.

Compare the shortages in Michigan, a strong CON state, with the robust expansion in Ohio, which junked the law. In Detroit, patients wait 7 weeks for a PET scan for cancer or lung problems, and then often get scheduled for 1 or 3 a.m.

By contrast, Ohio reaped a multi-billion dollar investment boom after eliminating its CON in the late 1990s. Since then, it's added 71 dialysis centers, and 202 MRIs -- about 50% more MRIs per capita than Michigan. Tired of waiting weeks, Michigan residents are flooding across the border to get their diagnostic tests in Toledo's fast-growing medical corridor.

Another simple solution: Get rid of CON laws across the nation.

Acute pain: America's doctor shortage

The essential raw material needed to treat the tens of millions of new patients is our supply of physicians. Today, America is suffering from a painful doctor shortage that is another legacy of poor regulation. And it will get worse. The population of new doctors who go into practice each year is governed by the number of residency slots in America's teaching hospitals. Incredibly, those positions have been frozen for 25 years at around 25,000 as demand has soared.

The reason the residency positions haven't grown with the market is that they're funded by Medicare, which has decided it's good public policy to keep the supply of new doctors essentially fixed. The theory is that adding to their numbers would increase costs, since more doctors artificially increase demand by ordering more tests and procedures.

That policy has clearly failed. Only around 6,000 generalists, otherwise known as family doctors, enter the workforce each year -- half the number of the late 90s. And don't blame the old adage that America has created a surplus of specialists. Merritt Hawkins, a leading medical recruitment firm, is flooded with assignments to find gastroenterologists, urologists, general surgeons and specialists in geriatrics.

"We do have a shortage and it will become more acute," says Dr. Toby Cosgrove, chief of the Cleveland Clinic. "We've never trained enough physicians, even including doctors from abroad. And the shortages aren't just in primary care, but many specialties."

One solution is to rapidly increase the number of residency positions, which is not part of the Obama plan. To be sure, it takes many years to build new medical schools, so the additional positions should be filled with foreign graduates. That would require a much-needed increase in immigration quotas.

Another way to increase supply is to loosen licensing and supervision laws for non-physician providers such as Nurse Practitioners. Allowing the NPs to operate their own clinics, a practice banned in many states, would greatly relieve the pressure.

The Medicaid 'best price' policy: Putting a floor on discounts

Working Americans are often paying too much for pharmaceuticals because of still another wrongheaded regulation. It's called the Medicaid "Best Price" policy.

It dates from the early 1990s, when HMOs and hospitals were putting tremendous pressure on drugmakers for steep discounts. These big purchasers would shift almost all of their patients to a Merck or Pfizer drug in exchange for a big price reduction, often exceeding 30%. The buyers were effectively trading big volumes to whoever provided the lowest prices.

The new power of managed care and pharmacy benefit providers terrified the drug industry. So Merck and other

manufacturers pushed Congress to pass the "best price" rule. It sounded like a great deal. Medicaid, the program for the poor, would receive a guaranteed discount of around 16%.

But here's the catch: If an HMO or another private buyer got a bigger break, the manufacturer had to extend the same discount to all the Medicaid programs in the fifty states. Suddenly, it became extremely expensive to give deep discounts to pharmacy benefits managers or drugstore chains. The additional business didn't come close to paying for the lost revenue from Medicaid. In a short time, the rule put a floor under discounts of -- you guessed it -- 16%.

The rule is still in effect. The CBO has determined that since manufacturers regularly raise the prices the discount is based on, that Medicaid banks puny savings, and that the rule is a major barrier to getting the best prices for consumers.

Another simple solution: Strike down the "best price" rule.

--In one of our coming columns, we'll look at the how specific cases of how much more middle class Americans will pay for health care under Obamacare.

Read Shawn Tully's other installments in this series:

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