

2011

Health Care Reform's Effect on Private Medical Practices

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Recommended Citation

Clark, Spencer R., "Health Care Reform's Effect on Private Medical Practices" (2011). *CMC Senior Theses*. Paper 209.
http://scholarship.claremont.edu/cmc_theses/209

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Introduction

In March of 2010, the 44th President of the United States, Barack Obama, signed into law a health care reform bill that will change the medical and business approach to healthcare that has been witnessed for quite some time. The Patient Protection and Affordable Care Act, aims to eliminate several inefficiencies encountered in our current health care system, as well as extend coverage by providing affordable care for the roughly forty six million Americans currently uninsured. Many of the changes will be implemented over the next several years, but hospitals, businesses, physicians, and insurance companies are no doubt planning ahead for the effects these changes will have on their particular industry. Although there will be many facets of change affecting all of the previously mentioned occupancies, the goal of this paper is to investigate the effect healthcare reform will have on private medical practices in the United States. The following sections will cover ways in which medicine has been practiced in the pre-reform era, historical attempts made to pass health reform legislation, several of the issues our current system faces along with the reform changes implemented to fix them. Then I will investigate the effect these changes will have, if any, and conclude by relating everything back to independent medical practices.

Pre-Reform Era

With the exception of some previously established government programs like Medicare, Medicaid, and CHIP, in the pre Obama health reform years, medicine was practiced largely without government intervention. The private sector, i.e. insurance companies, held the majority of responsibility for the coverage of individuals, families and groups. It was up to them to set the terms of agreement, with a specific set of rules and regulations for different policies, indicating

which health benefits are covered and which ones are not. These insurance industries had the ability to drop coverage whenever it was found necessary to do so, usually when they are losing money on a particular policy due to any number of reasons. In an effort to maximize profit margins and minimize risk, insurance companies will often cherry-pick desirable clients to insure, sometimes leaving options unavailable for those with pre-existing medical conditions, or long medical histories. This causes problems for those who may need coverage the most, and raises questions as to how insurance industries can deal with problems like adverse selection.

Adverse selection occurs when consumers of health insurance pursue policies because they know they will likely need coverage more often than the average individual. This results in skewed reflections of real market prices for health insurance because individuals with worse health make up most of the market, and insurance companies have to account for that risk by increasing costs of coverage. Such issues provide the basis for many of the reform based changes and will be brought up again in this paper. As a result of the changes taking place, insurance industries will no longer enjoy the same freedom in decision making they have encountered in the past. Government is stepping in with multiple rules, regulations and requirements in an attempt to extend the supply of coverage to Americans at an affordable rate.

When one gets sick or is injured, there are a few situations they might find themselves in. Their need could be an emergency, in which they will be rushed to the nearest hospital by friends and family, or in an ambulance to receive immediate care in the emergency room. In the ER, employees will check patients in and assess the severity of their problem in order to place them on a waiting list in order of urgency. A patient could be in for a long wait in the waiting room, or if the situation requires immediate attention, they will be seen right away. An ER doc will treat the problem themselves if they can, or they will page an on call doc who specializes in

the particular type of injury or illness. This doctor will come in and assess the patient's need for either immediate action, or they will schedule operations for a preceding day.

The hospital then bills the patient's insurance provider in a fee-for-service structure meaning a separate fee is charged for: the ambulance, any medicine and equipment used, the emergency room doctor's time, and if you stay overnight they charge you for the room you stayed in much like a hotel would. These are all considered overhead costs for a hospital, and these fees are covered, to a different degree, by individual insurance plans. Any fees not covered by your plan are paid out of pocket. If a patient is not insured and cannot afford the care, then the hospital eats a share of the cost since emergency rooms are not allowed to turn anyone away or deny care. A portion of uncovered costs are paid for by the federal and state governments through tax revenues which are then used as Disproportionate Share Hospital payments, grants to Community Health Centers, and by other mechanisms; in the year 2008, government spent \$42.9 billion in uncompensated care costs alone.¹

Another option for consumers in need of medical attention involves seeing a primary care doctor. He or she may be self-employed with their own practice, or they may be employed by a larger hospital system on salary, usually with benefits. This doctor will assess the situation and recommend treatment options. If it is something they themselves cannot treat, they will need to refer the patient to a specialist. This referral can be made to another doctor employed by the same hospital, to a doctor with a good reputation in another hospital system, or it may be a physician who owns their own private practice outside of a larger hospital system. Although it is

¹ The Economic Case for Health Care Reform." The White House. June 2009. Accessed April 1, 2011. doi:http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf

not prohibited, referrals made by physicians to doctors outside their own hospital system are typically frowned upon by administrators for sending business away.

Hospitals prefer patients to receive all care within their own system, so they can collect all the payments for care, rather than having someone else receive the business. Private care physicians bill your insurance through their practice, just like the hospitals as mentioned before, however, in this case their practice receives all of the payments since the care took place in their facilities and under the watch of their employees. Many doctors, after a number of years, prefer to do business this way and branch out on their own for this very reason. With their own private practice, payments are not shared with a hospital because their practice owns all of its own equipment, physicians, buildings, and medicine. Historically the returns these physicians incur, with an investment in their own capital, are significantly higher when compared to being on salary with benefits in a large administrative system. Many private care doctors fear these returns will not be sustainable under the new legislation.

Mandated Coverage

The changes incurred in the current reform bill will not necessarily change how approaches to seeking medical attention function on a basic operational level, but there will be many systematic changes. For example, health care insurance is not currently required by law, but it will be in the year 2014. Government mandated insurance has been included in this bill to deal with problems like adverse selection. By requiring all individuals to own health insurance, the pool of those seeking insurance is no longer comprised mainly of those who tend to exhibit worse health conditions. This should act as a cost controlling mechanism for the health insurance

market, by eliminating excess amounts charged by insurance companies, and allowing market prices to accurately reflect the cost of insuring individuals.

In order to provide insurance coverage for low and some middle income individuals, the federal government has required each state to set up health insurance exchanges, in which private insurance options will be pooled together by state and federal governments to form a new competitive health insurance marketplace; this new market will consist of private insurance plans that will have to compete for business based on cost and quality, and that will eliminate complications by acting as a one-stop-shop for consumers.² States will administer the coverage options in order to make sure each plan meets the essential health benefits requirement. Any state that refuses to set one up is subject to having the federal government step in and implement one for them.

The start-up of exchanges will be funded by the government or non-profit organizations, and they will contain four different levels of coverage to choose from: Bronze (60%), Silver (70%), Gold (80%), and Platinum (90%) plans. The different levels of coverage will all have the same “essential health benefits” covered, but they will vary in the amount of cost-sharing. Actuarial values will be used to specify different levels of coverage. For example, the silver plan has an AV value of 70% meaning that for a standard population the plan will pay 70% of their health care expenses while 30% will be paid by them through some combination of deductibles, copayments, and coinsurance; the percentage will likely vary from the actuarial value for any given enrollee, depending on the health services used and total cost of those services.³ The act also places a cap on out-of-pocket expenses in high-deductible plans eligible to be paired with a

² Health Reform.gov, Jay Angoff, Director of the office of consumer information and insurance oversight <http://www.healthcare.gov/news/blog/settingthestage.html>

³ Kaiser Family, What the av values in the affordable care act mean

Health Saving Account at \$5,950 for an individual and \$11,900 for a family; the plan pays for all covered expenses beyond that point.⁴ People will be required to at least have a bronze level of insurance coverage or pay a federal tax penalty.

The hope here is that by introducing more competition into the market, individual non-group market prices will fall, following simple rules of price and quantity accurately reflecting supply and demand. The demand for health insurance will increase since law will require coverage, and this mandated increase in participation on the consumer side, with an estimated 24 million more people purchasing coverage through the exchanges by 2019, will be met by an increase on the supply side as insurers develop their own packages to meet specified actuarial values. Both will result in a larger quantity of individuals being insured, but unless supply increases at a greater rate than demand, prices will not fall. This may not be a potential problem since new options will be pooled together rather quickly, and consumers will integrate into the exchanges at a much slower rate.

Overall, the president's vision for reform is to put us on a path toward a patient-centered health care system that preserves an individual's choice of doctor and plan, and assures high quality, affordable care for every American through substantial cost containment and coverage expansion.⁵ These issues are not new to health reform or the American public. In fact, many of the reform issues addressed in Obama's Patient Protection and Affordable Care Act have been around for quite some time. The following section will be devoted to looking at some of these historical issues on health care reform in the United States, investigating policies and programs previously pursued, as well as discussing holes and inefficiencies in health care provision.

⁴ Kaiser Family, What the AV values in the affordable care act mean

⁵ Executive Office of the president of the United States Council of economic advisers

History

Several key changes occurred during the industrialization of medicine which led to increases in both costs and demand. As urban areas became more populated, and medicine became widely recognized as a science, hospitals developed into treatment centers and people were encouraged to make frequent visits to physicians.⁶ The AMA formed the Council on Medical Education to standardize requirements for medical licensure, and adopted a structure recommended by Abraham Flexner of the Carnegie Foundation which called for stricter entrance requirements, better facilities, higher fees, and tougher standards.⁷ As a result the number of medical schools fell, and with the increased requirements on physician's licensure, the supply of physicians fell as well. These decreases put upward pressure on the cost of physician's services. Advances in medical technology, increased standards of quality for doctors and hospitals, and rising demand of medical services caused prices to rise significantly.

Dating back to the presidency of Theodore Roosevelt, the United States encountered one of the first major attempts at national health reform. "In 1912, Roosevelt's Bull Moose Party campaigned on a platform calling for health insurance for industry; as early as 1915, progressive reformers ineffectively campaigned in eight states for a state-based system of compulsory health insurance."⁸ The factors behind this reform involved protecting workers against both wage loss and medical costs during sickness.⁹ Many doctors and physicians did not jump on board with this idea as they feared it would lower the amount of money they could make, and they saw it as a

⁶ Health Insurance in the United States

⁷ Health Insurance in the United States

⁸ The Henry J. Kaiser Family foundation, march 2009

⁹ Health care reform and social movements in the U.S.

threat to their independence.¹⁰ Ironic we still hear the same concerns from doctors today when the issue of a nationalized health insurance program emerges.

In the 1920's, the Committee on the Costs of Medical Care was the main advocate for reform, proposing ideas like group medicine and voluntary insurance; these ideas were rejected by the American Medical Association and deemed "socialized medicine."¹¹ Around this same time, the composition of medical technology was not particularly advanced and therefore was not particularly expensive. People did not see a need to have health insurance; instead families would purchase sickness insurance, which is similar to today's disability insurance.¹² Also, insurance companies did not think health was a "commodity worth insuring"¹³ due to issues of moral hazard and adverse selection, issues we still face today. Moral hazard in this context would involve a change in an individual's behavior due to a change in their insurance status. For example someone who newly acquires health insurance may be inclined to exhibit more behaviors that put their health at risk, because they know potential injuries and sicknesses are covered. Insurance companies were also worried about sick people pretending to be well in order to obtain health insurance. Today many believe the problem lies on the industry side, with insurance companies cherry picking desirable clients to insure. Regardless, this first attempt at compulsory, national health insurance failed due to low demand and physician opposition.

By the 1930's, Franklin Roosevelt's administration, and the American people, were in the middle of the great depression. Groups of citizens organized seeking relief from the government, including government-sponsored health protection.¹⁴ During this time however, unemployment

¹⁰ Health Insurance in the United states

¹¹ The Henry J. Kaiser Family foundation, march 2009

¹² Health insurance in the united states

¹³ Health insurance in the united states

¹⁴ Kaiser Family

was the focal point of problems to be addressed since the nation saw unemployment rates reach up to 25 percent in 1933 and 1934; national health insurance was in a preliminary report but was eventually left out of the Social Security Act.¹⁵ Around this same time however, a revolutionary payment system was established by a precursor to today's Blue Cross, and the idea of pre-paid services was born. Community hospitals organized to reduce inter-hospital competition, and they enjoyed tax exemption at the state level for treating a large number of low income individuals; physicians eventually created a similar organized effort to compete with community centers, and eventually private insurers entered the market as well.¹⁶

In 1937 the Technical Committee on Medical Care was convened as a second group to readdress NHI (national health insurance) under the new deal; reform committees called for state-run systems with compulsory health insurance for state residents, in which states could choose whether or not to participate. The federal government would provide subsidies and set state minimum standards; the committee also pushed for reform in the areas of expanding hospitals, public health, maternal and child services.¹⁷ Once again these reform ideas saw a great deal of opposition from the AMA, believing physicians would lose their autonomy and have to practice group medicine with a salary or by "capitated methods."¹⁸ Private insurance companies also opposed the idea and this second attempt at mandatory national health insurance failed as well.

The next attempt at reform came under the Truman administration and included national health insurance as a part of his Fair Deal proposal. Reformers moved away from the idea of

¹⁵ Kaiser family

¹⁶ Health Insurance in the united states

¹⁷ Kaiser family

¹⁸ Kaiser family

state run systems and proposed that health insurance become national, universal, comprehensive and run as part of social security; “his own plan involved a single insurance system that would cover all Americans with public subsidies to pay for the poor.”¹⁹ Truman, like others before and after him, also put a large emphasis on the importance of construction and expansion of hospitals and hospital systems; a bill which actually did pass in 1946 under the Hill-Burton Act.²⁰ Due to situational factors such as the rise of communism, the president lost a lot of public support for NHI due to lobbying efforts by the AMA, which opposed the bill for their same historical reasons. The AMA was able to successfully run a fear campaign against “socialized medicine” at a time when anticommunist sentiment was extremely high. Congress also played a part in blocking the passage of this bill as southern democrats blocked Truman’s initiative due to fears that federal involvement could lead to action against segregation at a time when blacks and whites were still separated in hospitals.²¹ During this time business and labor unions were able to grow the private employer based health insurance plans we have today, because the War and Labor Board ruled during WWII that “certain work benefits, including health insurance coverage, should be excluded from the period’s wage and price controls;”²² this allowed employers to use large group health insurance plans to recruit employees, and individuals did not need a national health insurance plan under these private coverage accommodations.

In the 1960’s, Americans witnessed the greatest passage of health care legislation in history, apart from the recent passage of Obama’s health care reform bill. Medicare and Medicaid were introduced at a time when private insurance companies were using an

¹⁹ Kaiser family

²⁰ Kaiser family

²¹ Kaiser family

²² Kaiser family

“experience rating”²³ to determine individual’s premium rates. By default, this made coverage plans much more expensive for the elderly, who are at a greater risk of getting sick or injured. In this same time period, and largely as a result of the previously mentioned practices, the elderly and the poor became the government’s focus in health concerns. Insurance companies did not find it profitable to insure the elderly, so they were on board with a government based program that would cover them. Businesses were also on board, because they also found it would be expensive to cover retirees, so the labor unions supported coverage for the elderly as well. The AMA of course did not support them, as they see any government involvement in medicine and socialist. Despite AMA opposition, this time legislation passed in 1965 under the Social Security Act; unfortunately for future generations, there were no federal agencies like the ones now too estimate the economic costs of legislation.²⁴ Today Medicare and Medicaid remain two of the largest and most expensive government programs that drive deficit concerns and raise questions as to how future generations will pay for them. Recent budget cut proposals include plans to reduce Medicare spending by up to 25%; this cut has been temporarily blocked by congress by GOP opposition, and special thanks went out to them by the California Medical Association.²⁵

Medicare uses a physician pricing rule called, the resource based relative value scale (RBRVS), which basically assigns values to doctor’s time and operations for certain procedures. Doctors who operate on Medicare patients will only receive the amount dictated by this scale for the procedure, regardless of what they bill. I spoke with an orthopedic doctor in Seattle Washington who told me he has to operate on two Medicare patients (the specific procedure in question was a total knee) in order to receive the same amount he would on one procedure done

²³ Kaiser family

²⁴ Kaiser family

²⁵ California Physician.org

to a patient with a private insurance plan.²⁶ For a doctor working in a large hospital system this is not a problem, because the hospital is volume driven and their staff are on salary meaning they do not make any more or less based on the number of procedures done or the type of insurance covering them. To a doctor with his own private practice, programs such as these present a major set-back in profit margins. In a recent YouTube video produced by the CMA, doctors with their own practice who see a large amount of Medicare patients voiced their concerns about further Medicare cuts. These physicians claim the amount of reimbursement for a care, which can often be life saving, hardly covers their overhead costs and sometimes not at all.²⁷ Cuts to Medicare would mean many practices could shut down and at a minimum not be able to take on new Medicare patients.²⁸

The 1970's were not left out of reform attempts, as several parties, including President Nixon, submitted reform proposals. The increases in health care costs were of major concern, and at this same time wage and price freezes were being implemented to control inflation; these put specific limits on annual increases in physician and hospital charges that were later dropped in 1974.²⁹ Amongst the proposals was Kennedy's Health Security Act which advocated a single-payer plan with a national health budget, no consumer cost sharing, and was to be financed through payroll taxes; there was also Nixon's Comprehensive Health Insurance Plan (CHIP) which advocated universal coverage, voluntary employer participation, and a separate program for the working poor and unemployed replacing Medicaid.³⁰ Despite support from the Washington Business Bureau and the Chamber of Commerce the bill failed to pass largely

²⁶ Interview, Herb Clark M.D.

²⁷ <http://www.youtube.com/watch?v=YrCiwCF19EQ>

²⁸ <http://www.youtube.com/watch?v=YrCiwCF19EQ>

²⁹ Kaiser family

³⁰ Kaiser family

because information became clouded by the sheer number of proposals, as well as the overshadowing effect of the Watergate scandal which occurred in this same time period.

Also during the 70's, as part of the Nixon administration's cost containment initiative, the HMO Act was passed in 1973. Health Maintenance Organizations were designed to implement a tight utilization review and authorization process along with restricted choice of providers and a means of managing utilization and quality.³¹ The hope was that HMO's would reduce health care costs by eliminating other regulatory restrictions. HMO's are a type of managed care organization that contracts with hospitals, physicians, and others to provide care for HMO enrollees. Their original structure began in the early 1930's as pre-paid health benefits and cooperative health plans; and they were implemented by industrialists such as Henry Kaiser.³² Private insurers contracted with physicians and hospitals to organize cooperative plans, but it took some time before HMO's became a valued option for coverage. The Act passed in 73' now allows for federal endorsement to such organizations meeting qualification standards; many, like Kaiser, remain independent of federal funding however. During this time, many HMO's were sponsored by for profit businesses and well established insurers, which contributed greatly to their expansion in the marketplace.

In the 1980's, enrollment exploded from around 9 million to over 76 million participants by 2001.³³ The large increase in enrollees was largely due to a lifting of qualification restrictions, and continued increases in health care costs. This system was thought to be very cost efficient, but studies have used information provided by HMO members via surveys, and "decomposed

³¹ HMO article

³² http://www.rand.org/content/dam/rand/pubs/rgs_dissertations/RGSD172/RGSD172.ch1.pdf

³³ HMO article

expenditure data”³⁴ to show that enrollment alone in an HMO program does not provide any significant overall cost savings. Skeptics of the program argue this is because they impose no regulatory burden on the health care system, they contain many industry compliance costs equivalent to an excise tax raising prices and lowering demand, and that they act as a form of industry protection from competition; this reduction in competition has adverse effects on health expenditures by allowing facilities to charge higher prices.³⁵ They are still widely used today but failed to lower care costs as intended.

During the Carter administration the economy experienced a period of stagflation, and there was a shift in focus from a NHI plan to a cost containment approach in health care. This didn’t stop Senator Kennedy from submitting yet another proposal which focused on private insurance competition, hospital and physician care cards priced by income, employer covered costs for the employed, and government covered costs for the poor; Carter also submitted a plan one month later that proposed businesses provide a minimum package of benefits, public coverage for the aged and poor be expanded, and that a new public corporation created to sell coverage to everyone else be created.³⁶ Neither of them stood a chance due to changes made amongst congress in wake of the Watergate scandal. Jurisdiction on health reform now needed to pass through four committees instead of two. Needless to say these attempts also failed to establish NHI.

After a period of relatively little focus on health reform, due to a dominating focus on the economy and international affairs, it isn’t until the 90’s that another large mix of proposals again began to surface ranging from market oriented reforms expanding the private system, public

³⁴ HMO article

³⁵ Duke article

³⁶ Kaiser family

single-payer plans, employer mandates, health care tax credits, and purchasing pools.³⁷ With the election of President Clinton in 1992, the Health Security Act was born. In his plan to reform the health care system, President Clinton advocated universal coverage, employer and individual mandates, competition between private insurers, and government regulation as far as cost containment was concerned.³⁸ The defeat of his plan was multi-factorial. The complexity of the proposal no doubt dragged the process out longer than preferred with its many 1400 pages. Successful opposition campaigns were also run by the Health Insurance Association of America, and the National Federation of Independent Businesses that hurt the bill's chances of passing. However, in 1997, the Children's Health Insurance Program was enacted; it built off Medicaid and extended coverage to many low-income children.³⁹

History has shown us several attempts at achieving a national health insurance coverage program. It has contributed several aspects, in the form of many proposals, to the reform issues of our health care system. As one can see, the issues encountered in health care reform repeat themselves throughout history in several unsuccessful attempts of legislation passage. The fact President Obama was able to pass his legislation is astounding given historical outcomes of similar attempts! His plan builds off of, and contains many similar elements of reform attempts witnessed in the past. Proposals stem from many key concerns about internal, systemic and operational disparities witnessed in our health care system still today.

Systemic Inefficiencies & Reform Actions

One of the leading economic indicators showing there are indeed several inefficiencies in our health care system is the percentage of health care expenditures as a share of GDP. In a study

³⁷ Kaiser family

³⁸ Kaiser family

³⁹ Kaiser family

done by Gerard Anderson (PhD Johns Hopkins University) and Bianca Frogner (doctoral student Johns Hopkins) investigated the health spending in OECD countries. After obtaining value per dollar amounts, they found that the United States spends significantly more on healthcare than other OECD countries; currently we spend 18% of GDP on health care expenditures.⁴⁰ When compared internationally, we find countries like Italy, the U.K, Spain and Japan spending closer to 8 or 9% of GDP and achieving similar health outcomes. Statistics such as these indicate we could free up to 5% of GDP for other resources with efficiency improvements, and approach a spending level closer to that of countries like Canada (10% in 2006) , Germany (10.5% in 2006), and Britain (8.3% in 2006).⁴¹ Comparisons can also be made between States levels of spending within the U.S. Inconsistencies again engender inefficiency concerns. In one study investigating geography and Medicare spending, researchers John Wennberg, Elliot Fisher, and Jonathan Skinner recorded a large variance in the level of specific procedures used, and per capita spending amongst different geographical regions.⁴² Again, there were no significant differences in health outcomes found. Analysis run by Katherine Baicker and Amitabh Chandra published in 2004, investigated the differences between care quality and spending across geographical regions, and found that areas with high rates of per capita spending have higher intensity of services in an inpatient setting, higher rates of minor procedures, and greater use of specialists and hospitals (supply-sensitive services).⁴³ These differences also imply there are a large amount of expenditure reductions that could be made simply with efficiency improvements.

⁴⁰ Gerard Anderson and Bianca Frogner. Health Spending in OECD Countries: Obtaining Value Per Dollar

⁴¹ Organization for Economic Cooperation and Development, OECD Health Data, 2008

⁴² John E. Wennberg, Elliot S Fisher, and Jonathan S Skinner; Geography and the Debate over Medicare Reform

⁴³ Katherine Baicker and Amitabh Chandra; Medicare Spending, The Physician Workforce, And Beneficiaries Quality Of Care

There are many sources of inefficiency in our system covering a large range of issues. The United States has a complex system, and health care is not a conventional good or service. Markets for medical care and health insurance contain a large amount of asymmetric information. This means one party is likely to have different information than the other, and therefore may have a comparative advantage in making informed decisions, and conducting informed policies. In some cases, asymmetric information can lead to adverse selection, with people who know they will likely have a lot of health care needs seeking more insurance. On the industry side, asymmetric information can often lead to issues of moral hazard when health care insurers insulate patients from cost consciousness and promote unnecessary care.⁴⁴ According to the Executive Office of the President of the United States Council of Economic Advisors, there are several main drivers of inefficiency in the current U.S health care system which I will explain in the following paragraphs.

The first are provider incentives. Payment systems follow a standard business model of fee-for-service, which isolates individual services performed as separate fees. This provides financial incentives for doctors and hospitals to focus on the volume of care given, rather than on issues of quality, cost, or efficiency because the more individual services they provide, the more fees they get to charge the recipients and their insurers, resulting in higher revenue streams.⁴⁵ This problem brings to question whether or not services and procedures being recommended by doctors are really necessary, or if they are performing them for profit driven reasons. Research run by David Studdert (LLB, ScD, MPH) surveyed physicians in six specialties through the mail, and showed that many doctors in fact practice “defensive medicine” in which they supply additional services of little marginal value including additional diagnostic testing, and

⁴⁴ Executive Office of the president of the United States Council of economic advisers

⁴⁵ Executive office of the president of the united states council of economic advisors

unnecessary referrals to specialists.⁴⁶ In a situation where a doctor may be conflicted as to whether or not a service is necessary, the hospital system or a private employer will often recommend it since they see no monetary downside in doing so, as long as the patient has insurance to cover that service, and there is a liability upside to making sure they use all available resources to avoid mal-practice lawsuits. The patients, in most circumstances, don't know any better due to a lack of knowledge and information. This is one example of wasteful practices incurred in our system, a theme that will continue to be relevant in this thesis.

A second major source of inefficiency is limited financial incentives for consumers. The way health insurance benefits are currently designed often hinder consumers attention to prices, care quality, and setting since they are enrolled in a cost-sharing mechanism.⁴⁷ Consumers fail to shop around or look at such aspects when they are not responsible for covering all of the expenses upon utilization. Research done during the RAND Health Insurance Experiment from 1974-1982 randomly assigned participants to different health plans and tracked their behaviors; one of their findings showed that mechanisms such as cost-sharing, in many instances, actually lead consumers to choose more expensive doctors, care and facilities.⁴⁸ This more expensive care leads to higher premium payments required by insurance plans, and contributes to the overall increase in health care costs. In the current reform Act, certain preventative services must be provided without cost-sharing. This will not eliminate the inefficiencies caused by cost-sharing however, and may in fact decrease the amount of attention consumers pay to prices even further since their insurance plan will be covering all of the cost. It will however promote better overall

⁴⁶ Studdert, David, M.Mello, W.Sage, C. DesRoches, J Peugh, K. Zapert, and T. Brennan. "Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment." *Journal of the AMA*, 2005, 293(21):2609-2617

⁴⁷ Executive Office of the president of the United States council of economic advisors

⁴⁸ Willard G Manning Health insurance and the demand for medical care: evidence from a randomized experiment

health and make sure individuals are not avoiding essential preventative services because of the remaining costs they still have to pay.

Fragmentation is a term used to describe the multiple-payer health care system practiced in the United States which contains an abundant number of organizations, processes, care and coverage providers that cloud the system with different forms of billing, care guidelines, formalities and have patients with different covered benefits.⁴⁹ Different providers use forms, billing systems, and benefit designs that are unique to their individual organization. This results in high administrative costs for hospitals, as they must hire additional personnel to sort through and make sense of all the different administrative functions for individual payers. Some, like Dr. Stephen C. Schoenbaum (MD, Executive VP for programs at The Commonwealth Fund) believe that a standardized billing form, and standardizing such procedural processes in general, would result in a great reduction of administrative waste; that is, excess administrative overhead costs stemming primarily from the complexities of insurance and provider payment systems.⁵⁰

In 1997 the Health Insurance Portability and Accountability Act (HIPAA) actually made an attempt at simplifying the fragmented processes mentioned above by introducing a single standardized form for claims submission, determination of claim status, and verification of eligibility and benefits.⁵¹ Although the intention was to simplify the process, the act ended up having the opposite effect. Larger than expected investment requirements in information sharing technology presented financial hindrances and Insurance companies all required different data needs, so they each came out with their own guides for filling out the single form, which further

⁴⁹ Waste in the U.S health care system

⁵⁰ Schoenbaum, S.C. 2006. Keys to a high-performance Health System for the United States. Healthcare financial management

⁵¹ Waste in the US healthcare system

complicated the process.⁵² Current reform provisions readdress this issue and require the development of uniform explanation of coverage documents for exchange enrollees, and to further increase transparency it requires health insurers to provide a summary of coverage to applicants so they know what benefits are taken care of and which are not.⁵³ Whether or not these actions will reduce fragmentation is still unknown.

The market for health insurance is not a well-functioning one, and as a result contains many market failures. These failures in the market misalign the costs of benefits for individuals and household from their true values. Adverse selection happens to be one of the biggest market failures. Insurance providers do not price out coverage for individuals based on an average cost of covering the uninsured, because this would lead only individuals who knew they would be getting sick to seek coverage. To compensate for adverse selection, medical underwriting and insurance premiums are added into the price of coverage, leaving individuals with a much higher average cost than it actually takes to cover him or her.⁵⁴ In order to deal with issues like adverse selection, there are programs being implemented to lure young healthy Americans into the insurance market; one of these plans, the “young invincible plan,” is available to Americans under the age of 25 that would have high deductibles and low premiums.⁵⁵ These plans should be able to balance some of the risks caused by adverse selection, and encourage healthy Americans to purchase such options instead of simply paying the penalty for not having health insurance.

Another market failure result from restrictions, such as coverage exclusions for pre-existing conditions for children, insurance companies are allowed to place on individuals seeking

⁵² Waste in the US healthcare system

⁵³ AMA article

⁵⁴ Executive Office of the president of the United States Council of economic advisers

⁵⁵ Time Article

coverage. The positive externalities that could result from an additional individual being able to receive care are unaccounted for. For example this individual would be healthier and less likely to spread infectious diseases or illness to those around them; however they do not have access to such care either because they cannot find someone who will cover them with their current health status, or their current health status causes insurers to price their policy at an unaffordable rate. Insurance industries in this market are not doing enough to contain costs of coverage, guarantee coverage for individuals, offer coverage for more individuals, or share information with their consumers and the public. Government provisions are forcing this action by eliminating many of the restrictive abilities of insurance companies, such as banning coverage exclusions of pre-existing health conditions or rating and coverage restrictions based on health status of adults.⁵⁶

More ACA Provisions

As mentioned briefly before, in order to expand coverage, the federal government is providing funding for states to set up exchanges to facilitate purchasing of private health insurance plans for individuals and small employers; the legislation outlines the creation of both American health benefits (AHB) to serve the individual market, and small business health options (SHOP) to insure the group market.⁵⁷ In order to qualify for coverage under an exchange program, individuals must meet the following criteria: are unemployed, self-employed, or work for a business of fewer than 100 employees (50 in some states), or that does not offer its employees health insurance even after the tax incentives to do so; the cutoff income for eligibility is four times the federal poverty level for individuals.⁵⁸ For individuals with incomes between 138% and 400% of the federal poverty level, federal sliding-scale subsidies will be

⁵⁶ AMA packet

⁵⁷ A profile of health insurance exchange enrollees (Kaiser)

⁵⁸ “

available, in the form of tax credits, and will result in enrollee's spending between 4% and 9.5% of their income on health insurance premiums; the congressional budget office estimates that 24 million people will use the exchanges by 2019.⁵⁹ Individuals with incomes less than 138% of the FPL are expected to join the expanding Medicaid program. A profile of these exchange enrollees will be provided in another section to come.

Several other changes made involve direct regulations on insurance companies in the individual and group markets that will eliminate practices hindering cost control and coverage expansion. Before health reform, insurance companies were able to drop a client's coverage when they became sick, even if they had been paying their premiums for years. Known as a rescission, insurance companies became banned from doing this, six months after the bill was signed into law. Other banned practices include denying coverage for children who have pre-existing medical conditions, and imposing life time coverage limits.⁶⁰ For patients previously denied coverage due to pre-existing conditions, there will be immediate access to health insurance, through a temporary high risk pool.⁶¹ In an even further attempt to empower the consumer, insurance companies serving individuals and small groups will be required to provide public disclosure of overhead/benefit spending showing that they are spending eighty percent of their customers' premium payments on medical services; insurers in the large group market will have to spend eighty five percent on medical services.⁶² These restrictions will effectively ensure the safety of consumers' coverage plans, and along with requirements to guarantee renewability of coverage, will allow for an expanded coverage by insuring clients of all health status.

⁵⁹ A profile of health insurance exchange enrollee's

⁶⁰ About.com us government info

⁶¹ "

⁶² About.com us government info

Further reform based changes include things such as providing small businesses (25 or fewer employees) with tax credits for providing their employees with health insurance. If a small business decides to offer their employees health insurance, they will become eligible for tax credits of up to thirty five percent of their total employee premium payments, and starting in 2014, the small business tax credits will cover fifty percent of premiums. This will relieve some of the pressure on individuals to purchase their own plan, and expand coverage to many individuals working for small businesses which previously could not provide them coverage. The Act also requires employers with more than 50 full-time employees to offer health care coverage or pay a penalty⁶³, again effectively expanding coverage to these individuals. Since group plans can often be purchased at lower rates from private insurers for buying in bulk, these requirements and incentives will allow for the banding together of purchasing power in the exchanges and result in lower premium payments there by assisting in making care more affordable. Some of the other changes that will take effect help answer the specific question I am investigating in this paper to a lesser degree, but are worth mentioning nonetheless.

There will be extended coverage for kids, by allowing them to remain on their parents' health insurance plan until age twenty six; there will be free preventative care under Medicare which will eliminate co-payments for Medicare covered preventative services and exempt them from deductibles; there is a temporary reinsurance program to help businesses offset the costs related to health benefits for retirees ages 55-64 which will end once state health insurance exchanges are in place; and lastly there will be a closing of the Medicare part D "donut hole" which involves payments made for prescription drugs, and their coverage gap; beneficiaries will no longer be required to pay 100% of the cost for prescriptions once they reach the coverage

⁶³ AMA packet article thing

gap.⁶⁴ The plan hopes to see that percentage drop to only twenty five percent by the year 2020. In the mean time, to close the gap, subsidies and discounts will be provided to those who have already reached their coverage limit.

Finally, the bill also focuses a large amount of attention on creating more doctors and nurses by funding programs intended to increase the number of health professionals, as well as increased funding for community health centers which they hope will be able to double the amount of occupancies it can hold in five years.⁶⁵ These sorts of programs may have an effect on the question at hand, because with a 100% increase in capacity in community hospitals and health programs in order to make sure health care organizations have the capacity to treat the increased supply of insured individuals, there will be twice as many people using these public services and not going to see a private physician. However, it may turn out that this increase mainly includes lower income individuals who would not have been able to afford private care in the first place. Regardless, several of the changes taking place have been reviewed, along with many of the problems encountered. This next section will investigate exactly what these reform changes mean for insurance companies and for the future of private medical practices.

Effect on Insurance Industry

For insurance companies, the key changes I would like to focus on are not being able to deny or drop coverage, requiring proof that 80-85 percent of premium payments are used for medical services in people's health care plans, eliminating lifetime limits on benefits, and providing preventative health services without cost sharing. The private and group insurance industries, like any other for profit business in our capitalistic system, seek not only to provide a

⁶⁴ About.com Us gov't info

⁶⁵ "

valuable service for people but also generate revenue that exceeds their expenses. In the realm of health insurance, it would be considered a bad investment to insure customers who have higher than average health needs or concerns. On a purely profit maximization basis, returns to these companies would be much higher if the people they covered were predominately healthier. Since the industry is dealing with the health of individuals however, the issue becomes one involving morality and ethics. It is easy to see why insurance companies in the early 1900's did not view health as a commodity worth insuring from a profitability stand point, because insurance companies are not social enterprises.

The regulations focused upon here mean that insurance companies really have no way of knowing exactly how expensive insuring a new individual might turn out to be. With no caps on potential claims, and with no ability to deny coverage to undesirable clients insurance firms could see decreasing returns with additional spending on sicker and more expensive individuals to insure, however, maybe these will be offset by the increased number of individuals purchasing their coverage who do not end up needing a lot of medical attention. The overall effect of these changes results in a great deal of the unknown and potentially increased perceived risk for private insurers who would prefer to hedge risks taken by imposing payment limitations.

Across the board, the potential result is that premium payments will have to increase for everyone, in order to compensate for any perceived risks. Since there is still a lot of developments to be made as to how exactly the health reform laws will pan out, there are a lot of uncertainties in the insurance world as to exactly what the outcomes will mean for them. In fact, three actuarial and benefit consulting firms, Actuarial Research Corporation, Aon Hewitt, and Towers Watson, expect premiums to grow 7% annually until 2014, at which point premiums will

be revaluated once the details of exchanges are worked out.⁶⁶ If they do indeed result in higher premium payments for those who want to be insured, then the adverse effect will be even higher medical costs. One central argument for many insurers is that there may not be enough new Americans purchasing insurance to make up for the new rules forbidding insurers from setting premium rates based on health status, and that any additional increased fees will simply be passed onto consumers.⁶⁷ They worry many Americans will opt to pay the penalty instead of purchasing insurance.

In an August of 2009 publication for the Wall Street Journal, the question of whether a public option actually hurts insurance companies was investigated. The results indicated fears of a public option wiping out profits for the private insurance industries may be more symbolic than substantive,⁶⁸ because insurance companies are not actually as profitable as one may think. In the realm of health coverage, WellPoint, the biggest private health insurer on Wall Street, only makes a few cents on the dollar for premium payments; the net after-tax income as a percent of total revenue came out to 4.1%.⁶⁹ This indicates that a public option would really only be able to undercut private ones by about 4% and that substantial reductions in costs of health care rely upon savings found at the doctor and hospital level and not the insurance profit margin level.⁷⁰ Regardless, cutting into the 4% profit margin of private insurance industries is something any for profit industry would rather avoid; to compensate for these losses premium rates would have to increase, but since the government is implementing a premium rate increase review process, these industries may be forced to accept these losses.

⁶⁶ Kaiser Family, What the actuarial values in the affordable care act mean

⁶⁷ How Valid is the Insurers' Attack on Health Reform? Time Magazine article

⁶⁸ Wall street journal

⁶⁹ Wall Street Journal

⁷⁰ Wallstreet Journal article

How Hospitals Can Control Costs

There are a few mechanisms by which hospitals, doctors and physicians are able to reduce the cost of an output. To illustrate, I will use an example demonstrated by OraLabs Inc in their quest to eradicate blindness. Lenses for a complicated procedure done on patients eyes to remove and replace corneas affected by cataracts originally cost \$300 per lens. In order to make this procedure affordable for patients experiencing blindness, the company invested a large amount of money in the technology of producing the lenses, and also made the manufacturing sector a part of the hospital organization. Combining these two strategies, which had equivalent cost reduction effects, the lenses now cost \$3 dollars each. The effect this had on the original manufacturer of these lenses follow a basic pattern of competitive markets, and their profits in this area declined.⁷¹ The main point of this case study I would like to focus on is the amount of incurred savings a hospital organization experiences when they are able to keep as many steps of a process within the hospital organization. Since reform efforts are calling on and funding the expansion of hospitals and community health centers capacity to treat individuals, these hospital organizations are going to do so in the most cost effective way possible which, as this case study indicates, will involve many mergers and acquisitions of private and public entities alike.

Virginia Mason is a medical center in Seattle Washington that adopted an idea called “lean thinking” in which they applied efficiency measures to all goods and services involved in patient care.⁷² They were able to reduce the duplication of services by improving its use of information technology, reorganizing physicians’ stations, and implementing multidisciplinary bedside rounds; VM reduced its inefficient production of care by cutting waiting and transport

⁷¹ Lecture given by Professor _____ in lead10

⁷² Waste in the U.S health care system

time for patients and maintaining only frequently used instruments in operating rooms.⁷³

Swedish hospital, also in Seattle Washington, was able to save millions of dollars adopting this same technique of one standardized instrument package for all doctors who typically have their own preferences. By replacing brand name drugs with generics whenever possible and appropriate, and implementing computerized clinician order entry and patient safety alerts

Virginia Mason exemplified ways in which hospital systems can greatly reduce the amount of waste, errors, and defects, however, a reduction in operational waste and a shifting to cheaper treatments is likely to hurt their profit margins.⁷⁴

Analysis

The Henry J Kaiser Family Foundation used the 2007 Medical Expenditure Panel Survey to simulate demographic, health status, and health utilization profile of the individuals across the nation expected to obtain health insurance coverage through the Exchanges in 2019.⁷⁵ Of the 24 million expected enrollees by 2019, 16 million will be individuals who would not otherwise be insured, 3.5 million individuals who lose their employer-based insurance, 1.5 million individuals who previously had employment-based coverage in which its payments exceeded 9.5% of their income, 1 million individuals who would otherwise purchase insurance in the Nongroup market, and about 2 million adults above 138% of the federal poverty level who lose their Medicaid coverage.⁷⁶ (Medicaid is expanding its program to include individuals with incomes below 138% of the FPL). The median income of these exchange enrollees is 235% of the FPL (\$23,994 for an individual and \$48,528 for a family of four in 2007); 1 out of five are unemployed and 81% will

⁷³ Waste in the US health care system

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⁷⁵ Kaiser Family Foundation, a profile of exchange enrollees

⁷⁶ Kaiser family foundation, a profile of exchange enrollees

qualify for federal subsidies.⁷⁷ Overall, the projected 2019 exchange enrollees are relatively older, less educated, have a lower income, are more racially diverse, and report that they are in worse health than current privately insured individuals.⁷⁸

This profile of typical 2019 exchange enrollees raises several concerns for independent medical practitioners, especially with regard to how coverage options will be structured based on actuarial values and caps on out-of-pocket expenses. The profile on exchange enrollees indicates a majority of these individuals will probably purchase cheaper levels of insurance with lower AV values. Even when this is not the case however, there is an underlying concern that while their new insurance plan may cover anywhere from 60 to 90 percent of specified services; will the individual be able to account for the rest of these costs? These individuals are in general less healthy, and if enrollees reach the cap on out-of-pocket expenses but continue to need medical treatment, there will be anywhere from 10% to 40% of costs that are uncovered. For a large hospital system this problem is less severe, due to focuses on volume, but for physicians with private practices this is detrimental to their revenue streams. With overheads reaching payment amounts of tens of thousands of dollars per month, and mal-practice insurance requiring up to fifty thousand dollars a year, many practices will simply not be able to cover their costs, and either be forced to shut down, or required to cut staff and cherry pick clients with insurance plans that reimburse them enough to cover their overhead and investments. “These plans for healthcare reform will greatly impact specialty practices.”⁷⁹ The implication here is that to meet the increased demand for healthcare caused by the huge increase in supply of insured individuals,

⁷⁷ Kaiser Family a profile of exchange enrollees

⁷⁸ Kaiser family a profile of exchange enrollees

⁷⁹ Healthcare “reform” – a potential crisis for practitioners!

large hospital organizations have the structural and systemic capacity to take on these patients while many small independent practices will not.

The government, through healthcare reform, is creating a system full of incentives for doctors, hospitals, and insurance providers to direct care and coverage in a desired fashion, and a predetermined direction. There are a large number of payment incentives that focus on treating Medicare patients, treating areas experiencing shortages of health professionals, treating low income areas, and forming ACO's (accountable care organizations).⁸⁰ These organizations would comprise of doctors, hospitals and care providers in a combined effort to treat patients with ACO options.⁸¹ By combining their efforts and implementing ACO's the government hopes the amount of waste due to fragmentation can be reduced. Such organizations will focus largely on patient care, sharing the decision making process with them, and making sure all the right information and options are put on the table.⁸² While organizations such as these have large potential benefits for consumers, it leads to one major concern for private practitioners who would largely consider their smaller practices to be specialty centers. As patients shift from private plans to exchange purchased options, there may be costs which health care organizations have to eat, when the exchange enrollees need care but cannot afford their percentage of payment requirements that larger organizations will be able to take but small private ones will not. Creating incentives for the formation of ACO's further encourages the formation of large integrated practices or organizations, and make it harder for smaller private specialty practices to compete.⁸³

⁸⁰ Washington state medical association economic resource center

⁸¹ The new England journal of medicine

⁸² “

⁸³ Healthcare “reform” – a potential crisis for practitioners!

“With health care reform taking hold, hospitals are buying up medical practices to boost their profits and get an edge.”⁸⁴ In 2010 Seattle, Washington saw two major hospitals, Northwest and Stevens, merge into affiliation with medical giants, the University of Washington Medicine Health System, and Swedish Medical Services.⁸⁵ These large organizations are not just acquiring new affiliations with other large hospitals, but they have also been going around and buying up doctors, facilities, and practices in order to expand the amount of coverage they will be able to provide.⁸⁶ In Illinois, St, Johns Hospital’s executives have been “trying to put together a dream team of their own” and have bought up several of the independent medical practices left in the Midwest.⁸⁷ All across the nation the solo family doctors are now likely collecting paycheck from a larger hospital system, and practicing by their “strict playbook,” as they unload their practices during tough economic times; at least one in six doctors now work as an employee of a hospital system, and what started as a “trickle of change has turned into a torrent.”⁸⁸

Many private practice physicians are being offered positions within these larger organizations, and many are accepting as they see the social enterprise medicine is becoming, and find the assurance of salary and benefits to be more appealing than fighting for their share of the market especially during these tough economic times. Others still refuse to be part of a large administrative system and prefer to practice on their own. The future of such practices indicates that the number of them will continue to fall, and only those who can cover their costs under new legislation will survive but with lower profit margins. As health care reform takes its full effect, the private practices that remain may come to resemble concierge medicine, with a very specific

⁸⁴ Farewell to the family doctor

⁸⁵ Washington Hospital Closures

⁸⁶ Interview Raphael Pascually

⁸⁷ Farewell to the family doctor

⁸⁸ “

set of customers who prefer to have a recurring personal relationship with their doctor, can afford special attention and care, and do not want the hassle of navigating a large administrative hospital system. Private care and in home care may easily become luxury goods, only available to people wealthy enough to afford them. In one article found in SmartMoney, Jim Pizzo, a Chicago-area hospital consultant jokes, “there are two types of physicians today: those employed by hospitals and those about to be.”⁸⁹

Conclusion

The American government has decided it is their responsibility to make sure every American has health insurance. The result will be a health care system dominated by large hospitals, community health centers, Accountable Care Organizations, and other socially beneficial mechanisms. Although the communist movement gave the term socialism or social movements a negative connotation, government mandates and intervention in medicine are suggesting medical care may indeed be a social enterprise. The ACA will provide care for millions of previously uninsured Americans, but there will be adverse effects for independent private practitioners as many will have to close or sell their practices. For their patients, this means the amount of interpersonal relationship and care will fall along with the number of independent private medical practices in general, because many of these patients will have to seek care from larger hospital organizations, and administrative system.

⁸⁹ Farewell to the family doctor