

# ST. LOUIS METROPOLITAN MEDICINE

VOLUME 31, NUMBER 2

MARCH / APRIL 2009



## Solving the Health-Care Reform Puzzle

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is fiscal sustainability  
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Disappearing primary care  
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Managing a practice in uncertain times  
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**St. Louis Metropolitan  
Medicine**

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## Health-Care Reform: The name of the ballgame is ... Fiscal sustainability!



Medical Society President  
Elie C. Azrak, MD

In other words, cutting the growth of spending on health care.

Such was the message delivered by Mr. Peter Orszag, director of the White House Office of Management and Budget (OMB), to address the central problem of the increasing gap in the budget deficit, i.e., the gap between the rate of growth in the economy – the Gross Domestic Product – and

the rate of growth in spending. To emphasize the importance of health care in addressing the budget, Mr. Orszag often states that tackling all other issues of budgetary relevance in our economy without changing how health care is financed, would not amount to a substantial effect: Health care is simply – and clearly – the 800-pound gorilla in the room!

This indeed is a very revealing statement to those of us who have naively believed that improving quality, or even achieving universal health coverage, is the main driving force in the national debate on health care. In this context how do we then interpret the multitude of “quality” programs rolled out nationwide, by the federal government – CMS’s *Pay for Performance* – or the private sector in the form of provider ratings and star programs? The answer to this question becomes conspicuously clear: the primary focus is not higher performance/better quality, but less pay/cheaper care! And where does this place the issue of access to health care in the equation?!

The above notwithstanding, many stakeholders in health care realize that cutting costs cannot be done at the expense of reducing quality or neglecting access. The question then becomes more complex and contentious: How to reduce the costs of health-care delivery while maintaining or improving quality of care, as well as achieving universal health coverage as an individual right in our society?

### The Obama Plan

During the 2008 presidential election campaign, then-candidate

Barack Obama laid out his plan for health-care reform, emphasizing the need for universal health coverage, by supplementing employer-based insurance with a *national health plan*, creating a health-insurance exchange and a reinsurance subsidy to protect against the high cost of catastrophic illness. His plan also proposed a *play-or-pay* mandate on employers: those who do not contribute to the cost of coverage for their employees would pay a percentage of payroll toward the costs of the national health plan.

When President Obama nominated former U.S. Sen. Tom Daschle to the position of secretary of Health and Human Services and White House health czar, all eyes turned to a book recently co-authored by the secretary-designate: *Critical: What We Can Do about the Health-Care Crisis*, calling for a *Federal Health Board*, which would have authority over federally funded programs, set standards and systems and create guidelines on the cost-effectiveness of treatments and procedures.

Sen. Daschle has since withdrawn his nomination over allegations he failed to pay \$140,000 in back taxes and interest. But his lieutenant and the co-author of his book, Dr. Jeanne Lambrew, a fellow of the Center for American Progress, a Clinton-era veteran of the 1993 Medicare overhaul and managed care initiative and now the deputy director of the White House Office on Health Reform, has outlined the health provisions in the economic stimulus package, signed into law in the *American Recovery and Reinvestment Act* (ARRA) of 2009: allowing temporary COBRA premium subsidies to laid off workers, providing additional federal matching funds for state Medicaid programs, incentives for adoption of health-information technology, increased funding for comparative-effectiveness research (CER) and establishing a *Federal Coordinating Council* (FCC-CER). Other important provisions include additional appropriations to address shortages by training primary-care providers, and helping pay medical-school tuition for students who agree to practice in underserved communities.

In the first week of March, the President selected Kansas Gov. Kathleen Sebelius, a former Kansas insurance commissioner, as his alternative nominee to head Health and Human Services. It is yet unclear how she will carry the president’s plan for health-care reform, and implement so-called value-based health financing.

## Many Solutions Advocated

Amid this cacophony of ideas on how to fix health care, some argue that the “market” should determine the value of health-care services, that the “consumers” should pay directly for the health care they “consume.” This movement of *consumer-driven health care*, championing health-savings accounts and high-deductible health plans, was intended to replace the employment-based model of private health insurance. Since its inception nearly a decade ago it has met a fate similar to that of the managed care initiative of the early nineties: it has mutated into forms far removed from its original design and purpose, according to health-policy experts.

It is certainly evident that everybody has some idea of how to fix health care, but I would wager that the medical profession, not the health-care economists, not the employers, not the consumers or payers for health care, has a pivotal responsibility to help shape this intensifying discussion, and define the direction in which health policy and financing will move. The medical profession in my opinion can and should be the nucleus holding together this

“Cutting costs cannot be done at the expense of reducing quality or neglecting access.”

highly polarized molecule that forms the components of our health-care sector. The medical profession knows what works and what does not work in health care, it knows what the consumers – the patients – need

and want, and it knows how much that providing (or withholding) health care can cost. So what is organized medicine’s plan for fixing health care?

In this issue of *St. Louis Metropolitan Medicine*, we invite as many perspectives as there are stakeholders in the health-care debate. You will find the American Medical Association’s position paper on health-care reform, as well as input from employer organizations, representative health plans and the Missouri Hospital Association. You will also find a review of Sen. Daschle’s book.

In turn, I invite every reader of this issue to share with us their thoughts and opinions. If you know a physician who is not an SLMMS member, offer them a copy of this issue. Let us open a dialogue and let *Medicine* be the forum for this discussion.

Tell us what you think, at [president@slmms.org](mailto:president@slmms.org).



## Upcoming 2009 Issues

Article submissions welcome

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### May-June

Copy and advertising deadline: May 1

Publication date: June 1

**Feature: Twenty-First Century Epidemics – Obesity, Diabetes and Cardiovascular Disease**

- Resources for Physicians
- What Physicians Can Do

### July-August

Copy and advertising deadline:

July 1

Publication date: August 1

**Feature: Legal Issues and Malpractice-Strategies for Minimizing Risk**

- Risk-Management Strategies
- Corporate Structures

### September-October

Copy and advertising deadline:

September 1

Publication date: October 1

**Feature: End of Life Care**

- Difficult Conversations
  - Resources for Physicians
- Bonus Feature: AMA Women in Medicine Month

## Solving the Health-Care Reform Puzzle

What should be the key features of health-care reform? How should we pay for it? Leaders from key sectors share their comments.

**P**resident Barack Obama is making health-care reform a top priority on his policy agenda and an essential ingredient of his economy recovery plan. In his address to Congress in February, the President said, "Health care reform cannot wait, it must not wait, and it will not wait another year." On March 5, Mr. Obama summoned key leaders to the White House for a Health Care Summit to lay out the issues.

The pressures for reform are building. More and more Americans are becoming uninsured, and more families struggle to pay high health-care bills or go without needed care. Businesses, after being hit with double-digit increases in health-insurance premiums year after year, now are cutting back on benefits or passing on increases to employees. Physicians, hospitals and other providers face cost challenges while trying to maintain quality care.

In this special section, *St. Louis Metropolitan Medicine* assembles key perspectives in the health-reform discussion. Starting with the American Medical Association health-policy agenda a review of former U.S. Sen. Tom Daschle's book on health reform, we then invite commentary from four key sectors: insurers, hospitals, business and physicians.

Next: your perspective. See the comment form on page 19 and send us your thoughts, by e-mail to [editor@slmms.org](mailto:editor@slmms.org), or by fax to (314) 989-0560.

***Whatever legislative reform is passed will determine to a large degree how medicine is practiced in the future. So make your voice heard!***



## Facts About the Crisis in Health Care

*Source: National Coalition on Health Care*

### The Uninsured

- Nearly 18 percent of non-elderly Americans – 46 million people – were without health-insurance coverage in 2007.
- The number of uninsured in the United States increased by nearly eight million people between 2000 and 2007.
- The percentage of people with employment-based health insurance has dropped from 70 percent in 1987 to 60 percent in 2007.
- The number of uninsured children in 2007 was 8.1 million or 10.7 percent of all children.

### Costs

- It is estimated that \$2.4 trillion was spent on health-care services in 2008, about 4.3 times the amount spent on national defense.
- Health-care spending is estimated to reach \$4.3 trillion a year by 2017, just eight years from now.
- Health-insurance premiums for employers have increased 100 percent since 2000.
- The annual premium for an employer health plan covering a family of four averaged nearly \$13,000 in 2008.

## 2009 AMA National Health-Care Policy Agenda

*Editor's note: Following is the text of the official AMA health-care policy agenda.*

**T**he American Medical Association (AMA) believes that all Americans are worthy of a fair and affordable health system.

Today, Americans are faced with a fragmented health system. Millions don't visit a doctor until their illness reaches a serious stage. As a nation, we can and should do better.

At the center of the AMA's vision is the concept that every American, regardless of means, has health insurance. And every patient maintains the freedom to choose his or her own doctors and health plans, and maintains control over his or her own care. For a senior, this includes having ready access to doctors in the Medicare program. For a pregnant woman, it means finding a physician who hasn't been forced out of business by high liability insurance rates. And for everyone, it means receiving the best care possible. Specifically:

- The AMA urges lawmakers to implement a system of tax credits to enable individuals to buy health insurance. We have a detailed proposal for this system.

- Under current law, Medicare will make deep cuts in payments to doctors every year until 2015. This policy erodes patient access to care and is a barrier to practice innovations. Congress and the next Administration need to permanently replace the flawed payment formula.

- Medical lawsuits are driving up health costs for everyone and making it hard for many to find a doctor. The AMA seeks reasonable limits on the noneconomic damages juries can award so that doctors aren't forced to move, cut services or go out of business.

Physicians and other health providers must work with government and private payers on strategies to restrain rising health care costs while maintaining quality of care. Medical science and technology have moved forward at a lightning pace. Patients are ready for the American health system to follow suit. The AMA is committed to:

- Finding new ways to enable doctors to use promising new technology
- Pioneering new methods to measure and improve the quality of care
- Preventing errors by studying ones that have happened, without the threat of lawsuits

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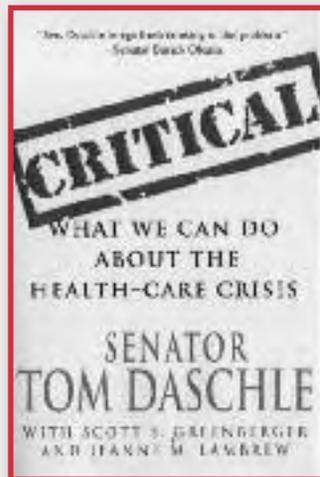
## The Daschle Blueprint for Health-Care Reform

*By Arthur H. Gale, MD, SLMMS Past President*

**I**n 2008 former U.S. Sen. Tom Daschle published a book on health care titled *Critical: What We Can Do About the Health-Care Crisis*.

Shortly after its publication President Barack Obama nominated Daschle to the dual positions of secretary of the Department of Health and Human Services and director of the White House Office on Health Reform. Daschle withdrew his nomination because of tax problems and because of conflict of interest issues involving large speaking fees he received from the health-insurance industry – an industry that he would regulate when he assumed his new positions. Nevertheless, many believe the book still provides a blueprint for Obama's health-reform plan.

The first part of the book describes why health reform is necessary and why previous efforts at reform have failed. In the second part Daschle lays out his reform proposal, especially the new and controversial Federal Health Board.



Daschle states the exorbitant costs of our present health-care delivery system cannot continue. There are 47 million uninsured Americans, four fifths of whom are employed or are members of a family of an employed adult. An additional 16 million are underinsured. Sixteen percent of the economy, or more than \$2 trillion, is spent on health care, which is more than twice the industrial world's average and 50 percent more than Switzerland, the next most expensive country. Medical bills are the leading cause of bankruptcy in the United States.

### All in Health Care Share Blame for High Costs

Daschle blames all of the major players in health care for these skyrocketing costs. Americans pay more for drugs than citizens in any other country. Half of the profits of drug

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## 2009 AMA National Health-Care Policy Agenda *(continued from 11)*

- Directing more resources and effort toward disease prevention
- Helping Americans lead more healthful lifestyles
- Eliminating gaps in care, particularly for racial and ethnic minority patients, the elderly, and low-income families
- Preparing better for large-scale health care emergencies

Today, patients are forced to endure miles of insurance company red tape and piecemeal policy attempts to solve one problem or another. America's patients will be best served when our country eliminates the disproportionate influence of insurers and government into medical decision-making. These important decisions must be placed in the hands of the patient and the physician.

Our nation needs a well-trained medical work force, and more doctors in primary care. We must make sure our medical education

**At the center of the AMA's vision is that every American has health insurance. And every patient maintains the freedom to choose his or her own doctors and health plans.**

business practices

- Antitrust rules that restrict doctors from negotiating with health insurance companies

As physicians and medical students, we see firsthand every day how urgently our patients need a better health system. Together, we can shape one America truly deserves.

stays the best in the world, and make paying for it less burdensome. So too must we address the barriers that threaten the viability of many physician practices, such as:

- Payments that fail to reflect the true cost of providing care
- Health insurers' deceptive



## The Daschle Blueprint for Health-Care Reform *(continued from 11)*

companies worldwide are derived in the U.S. He cites the role of physicians in contributing to high drug costs. Drug (and device) companies pay for conferences and shower doctors with gifts. He discusses how the independence and integrity of some of the most respected medical journals have been compromised. As a result, physicians often use the most expensive drugs, treatments and procedures on patients with questionable benefit over existing therapies.

The insurance industry comes in for a major share of the blame. Daschle notes the high administrative costs of private insurers and how they contribute significantly to health-care inflation. Administrative costs in the U.S. are more than three times higher than the most efficient nations – France, Finland and Japan. They are between 20 and 30 percent higher than Switzerland and Germany, two other countries where private insurers play a substantial role. Daschle harshly criticizes hospitals also. He cites the outrageous costs and billing practices of nonprofit hospitals especially as they affect the uninsured.

Whether or not one accepts all of the statistics and data cited by Daschle, the fact that costs are out of control is irrefutable. Doctors, hospitals, insurers and large employers all of whom opposed

previous health-system reform efforts, recently formed a coalition calling for change. This coalition is composed of strange bedfellows. They include the American Medical Association, the American Hospital Association, the U.S. Chamber of Commerce, AARP, America's Health Insurance Plans and some large unions. The coalition has already agreed to call for more money for State Children's Insurance Plans (SCHIP) and tax credits for the uninsured. All members of the coalition signed a "principles statement" stating "America's health system is broken. ... Soaring health-care costs threaten workers' livelihoods and companies' competitiveness undermining the security that individuals of a prosperous nations should enjoy."

As a former Senate majority leader for many years, Daschle was heavily involved in health-care legislation. He blames the insurance industry primarily for the failure to pass significant health reform in the past. His major conclusions are:

- Managed care, after some initial success in controlling costs, eventually failed because the American people rejected its heavy-handed methods and its denial of care.
- HIPAA, the Health Insurance Portability and Accountability Act (Kennedy- Kassabaum) did not prevent insurers from denying

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## Five Essential Elements for Reform

By Marc D. Smith, President and Chief Executive Officer  
Missouri Hospital Association



Marc D. Smith

**M**any argue that the nation's system of financing health care is unsustainable. Costs have long grown faster than inflation, reflecting spiraling demand for the benefits of more effective, but costly, medical and pharmaceutical innovations.

Increasing costs are one component of rising health-insurance premiums that threaten the viability of our employer-based system of health coverage. To control their costs, businesses have opted to forego employee coverage or shift more of the cost to employees. Those seeking coverage in the individual insurance market often find themselves excluded because of high prices or underwriting restrictions. As a result, increasing numbers of citizens are uninsured.

When individuals are uninsured, their health suffers. Because they

lack access to primary care, individuals wait to seek care for their episodic or chronic conditions. When care is sought, it tends to be in the hospital emergency department – an expensive and inefficient alternative. When care is delivered in this manner, patients don't receive appropriate follow up care, compounding their medical conditions.

Because of the current economic and political climate, there appears to be strong momentum for fundamental change. There may never be a more opportune time to reshape and improve the health-care system.

Hospitals are certainly ready and willing to engage in this broad debate. Missouri's hospitals have been working to raise awareness about the importance of reforming the health-care system, using the principles outlined in a framework – "Health for Life: Better Health, Better Health Care" – developed by the American Hospital Association, state hospital associations like MHA, community leaders, elected officials, policymakers, employers, insurers, consumer and labor groups.

Health for Life is intended as a roadmap for improving Amer-

## Building a Sustainable Health-Care System

By Wayne Meyer, MD, Medical Director  
Anthem Blue Cross and Blue Shield in Missouri



Wayne Meyer, MD

**T**he urgency of the health-care crisis in today's economy calls for thoughtful solutions that work. As spending on health care is expected to continue to increase from 16 percent of Gross Domestic Product in 2004 to 20 percent in 2015, the current situation is economically unsustainable. Employers and individuals will continue to have difficulty affording the purchase of health-care benefits.

As one of the state's leading health benefits companies, Anthem Blue Cross and Blue Shield has real-world, proven solutions to share. We not only know how to get health-care reform done, but how to get it done right. We are putting that experience to work by actively engaging in policy discussions to reform our health-care system.

Anthem Blue Cross and Blue Shield is currently advancing strategies to help improve quality, which can help better manage costs and improve access to insurance coverage. By working together with the government, employers and providers, we can

build a health-care system that is accessible and provides quality care for all.

Our policy platform is built on three fundamental goals:

- Improving quality and safety in our health-care system, which can reduce health-care costs
- Reforming insurance markets to better meet the needs of consumers
- Enacting financing strategies to place America on a path to universal coverage

### Improving Quality, Helping Manage Costs

We believe that an essential ingredient for practical and sustainable health-care reform is improving quality, which can help manage costs. There are many opportunities to improve health care as we are far from having a system that provides the right care at the right place at the right time. Building on six principles, Anthem Blue Cross and Blue Shield has identified solutions that will help deliver better health care while helping to reduce costs:

- Promote evidence-based medicine; determine real-world outcomes
- Advance health-care quality by disseminating information throughout the system

“ There may never be a more opportune time to reshape and improve the health-care system.”

ica's health-care system with the goal of achieving consensus about the principles of health-care reform. Health for Life identifies five essential elements of reform upon which we must build if our nation wants to achieve better health and better health care.

**A Focus on Wellness** – Some but not all illness is preventable. Good primary care, health education and a healthy lifestyle are essential to improving individual and community health status. As health improves, costs of health insurance and health care can be better controlled.

**The Most Efficient, Affordable Care** – Americans will not be satisfied until the cost of insurance and the cost of health care becomes more affordable. Health-care providers must collaborate to find ways to deliver care that are not only effective, but efficient. Americans want better value for their health-care dollar.

**The Highest Quality Care** – The new health-care financing and delivery model needs to get doctors, nurses, hospitals, nursing homes and others to work together and team up with patients and families to make sure the right care is given at the right time and in the right setting.

**The Best Information** – Good information is the gateway to good care. Efforts to establish and implement a common platform for electronic medical records will improve care and the ability to evaluate outcomes.

**Health Coverage for All, Paid for by All** – Health coverage for all is a shared responsibility. Everyone – individuals, business, insurers and governments – must play a role in both expanding coverage and paying for it.

The opportunity to reshape America's health-care system is upon us. It will require the vision, trust and compromise of all stakeholders to create an accessible, affordable, high-quality and accountable health-care system.

**For more information on the Missouri Hospital Association:**  
[www.mhanet.com](http://www.mhanet.com)



- Focus on prevention and manage chronic illness
- Improve effective use of drug therapies to prevent and manage illness
- Promote strategies to reduce medical errors and adverse drug events
- Reduce costs through eliminating fraud, reducing costs related to litigation and improving administration

### Covering the Uninsured and Improving Coverage

Enacting strategies to improve quality and control costs is essential to building a health-care system that works both now and in the future. While Anthem Blue Cross and Blue Shield believes improving quality and reducing costs is the key to a better system, we also believe we must strive toward building a sustainable path to covering everyone.

Health plans must make the health-insurance market work more efficiently and effectively. Additionally, Anthem Blue Cross and Blue Shield has identified ways to improve health-insurance markets to better meet the needs of consumers:

- Ensure access to affordable coverage
- Create a vibrant health-insurance marketplace that facilitates competition and consumer choice and encourages insurers to create innovative products that meet the needs of consumers
- Enact strategies to expand and finance sustainable coverage for all Americans

With 82 percent of the uninsured having family incomes less than 300 percent of the Federal Poverty Level (FPL)<sup>1</sup>, even with strategies to improve quality and control costs, Anthem Blue

“ A sustainable health-care system will improve quality, control costs, promote innovation and wellness and provide coverage that is affordable and attainable for all Americans.”

Cross and Blue Shield believes that financing must be part of any strategy to significantly expand coverage:

- Improve and expand programs for the most needy
- Provide a bridge to self-sufficiency through premium assistance
- Expand the employer-based system
- Equalize tax treatment for individuals purchasing coverage on their own
- Increase funding for public-private partnerships

A sustainable health-care system will improve quality, control costs, promote innovation and wellness and provide coverage that is affordable and attainable for all Americans.

Reforming health care will take the collective efforts of our industry, government, employers, providers, brokers and every American family that accesses the system.

**For more information on Anthem Blue Cross and Blue Shield in Missouri:** [www.anthem.com](http://www.anthem.com)

1. Five Basic Facts on the Uninsured. Kaiser Family Foundation. September 2008. (<http://www.kff.org/uninsured/upload/7806.pdf>)

## Optimizing Availability and Quality Requires a Free-Enterprise System

By Jane M. Orient, MD, Executive Director, Association of American Physicians & Surgeons, Inc.



Jane M. Orient, MD

*Editor's note: Following are responses to questions submitted by St. Louis Metropolitan Medicine.*

### How serious is the need for health-care reform?

There is a desperately serious need for reform in medical financing. The government system is insolvent; indeed it has such massive unfunded liabilities that they cannot possibly be paid for. The so-called private sector, much of which is part of a public-private partnership, is barely compensated. Like a patient with heart failure, it could decompensate massively and catastrophically.

Financing reform must not be conflated with altering the practice of medicine – despite politicians' insistence on doing so. There is not a crisis in diagnosis or treatment of patients – although misguided “health-care reform” might cause one in the form of serious shortages.

### What should be our underlying goal in health-care reform?

What most Americans desire from reform is decreased costs, improved access, and at least preservation of quality. These goals are incompatible with the unstated (possibly unintended) conse-

“The most economical way to pay for medical services is to pay out of pocket at the time of service.”

quences of reformers' utopian goals of universal coverage and reduced “disparities.” Optimizing availability and quality of any goods and services requires a free-enterprise system with contestable markets and freedom of choice, in which the normal regulatory mechanisms of supply and demand can operate. The reformers' methods impose coercive central planning – with price controls, rationing, and bureaucratic micromanagement, which are already crippling our physicians and institutions.

### What are the key features you want to see in health-care reform?

The most important feature is freedom. That must include the freedom to refuse to purchase overpriced, undesirable products (as by an insurance mandate) or to work under conditions that one finds unacceptable.

### How should we pay for health-care reform?

Reform is not something that carries a price tag; it simply means to change the way we do things. Asking the question assumes that

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## Improve Quality and Affordability

By Louise Y. Probst, Executive Director, St. Louis Area Business Health Coalition



Louise Y. Probst

*Editor's note: Following are responses to questions submitted by St. Louis Metropolitan Medicine.*

### How serious is the need for health-care reform?

The need for health-care reform is critical and immediate. Reform efforts must look beyond how we pay for health care and examine what we pay for in health care. The Congressional Budget Office estimates about one-third of health-care

dollars do nothing to improve health. In these difficult economic times, health care must improve or sustain health without risking the financial future of our nation. Eliminating waste could lower health-care premiums, expand access to medical care, help sustain jobs, give workers raises and lower the cost of American goods. General Motors adds \$1,525 to every car to buy health care for its workers.

### What should be our underlying goal in health-care reform?

The creation of a financially sustainable system able to provide all Americans with high-quality, evidence-based medical care. This cannot occur without improvements in the quality and affordability of health care. Those improvements will gain little traction unless health-care consumers and their physicians gain the information they need to make medical decisions based on value. Then, we must align incentives to reward providers, patients and payers for choices that support these goals.

### What are the key features you want to see in health-care reform?

The Institute of Medicine, in *Crossing the Quality Chasm* and elsewhere, defines how a health system should behave and assigns stakeholders roles in the transformation. The IOM calls for a health-care system that is safe, effective, patient-centered, timely, efficient and equitable. These aims should serve as a roadmap to

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## Optimizing Availability and Quality Requires a Free-Enterprise System *(continued from 16)*

“we” (meaning taxpayers) are going to be forced to pay for something we wouldn’t freely choose to buy.

And why would we ask this question if we really expected “reform” to save money?

### How can we achieve cost savings in health care?

To achieve true cost savings, as opposed to the expenditure reductions that politicians frequently confuse with them, one must eliminate inefficiencies, and things that contribute nothing to patient care. The fattest target is the overhead required to channel 85 percent of medical payments through a third party—in addition to the lucrative opportunity for fraud that this presents. It costs about as much to process a claim for \$50 as for \$5,000. Physicians who stop “taking insurance” can slash their office overhead by 50 percent. Insurance is a mechanism for sharing catastrophic financial losses—most health plans are not insurance but rather outrageously expensive checkwriting services for routine, budgetable expenses.

In addition to the waste involved in claims processing, there are the perverse financial incentives. Everyone believes that the service is “free” or nearly so, and hence tends to demand more of it. Additionally, those who realize that they have paid a big premium naturally want to get something of value in exchange for it.

The most economical way to pay for medical services is to pay out of pocket at the time of service. It is also the best, perhaps only way to ensure that the doctor is working for the patient, not the third-party paymaster. Patients should pay the doctor, and they should then receive their reimbursement from their insurance company, if appropriate. Most patients should rarely have occasion to

file a claim. In a free market that did not permit monopolistic practices by big insurers, premium savings would more than pay the cost of increased deductibles.

Unencumbered by bloated claims management bureaucracies, medical care would be much more reasonably priced, making it much easier to aid the truly poor, and greatly decreasing the number of patients dependent on assistance to pay for their care.

### What are the most difficult issues to resolve in the health-care reform debate?

The most difficult obstacles to reform are: (1) the entitlement mentality that most patients have acquired; (2) the desire of politicians and bureaucrats to expand their power through controlling the medical care available to citizens; (3) vested financial interests who skim profits from the huge amount of money flowing through the system; and (4) lack of understanding of basic economics, and extensive misinformation about public systems in the U.S. and abroad.

### What are some points around which we can build consensus?

Consensus is impossible if there are two incompatible ideas at war: Freedom for patients and physicians vs. central control by government. We should be trying to find the right answer instead of pretending that we can square the circle or trying to come to an accommodation with forces determined to destroy our profession.

**For more information on the Association of American Physicians & Surgeons:** [www.aapsonline.org](http://www.aapsonline.org)



## Improve Quality and Affordability *(continued from 16)*

reform. The BHC’s policy objectives – to improve health, align incentives, achieve transparency and reduce waste – parallel the IOM’s role for purchasers.

### How should we pay for health-care reform?

The financing of the health-care system should be built on the current public-private partnership of employers, patients and the government. While we oppose requiring employers to provide a health benefit, making medical care more affordable will make expanded coverage achievable. The current system of shared financial responsibility encourages a shared responsibility for finding value. It also preserves patient choice and promotes ingenuity.

### How can we achieve cost savings in health care?

Our current system incentivizes physicians for providing more care, not better care. It offers little reward to physicians who work hard to help patients stay healthy or spend their benefit dollars wisely. Physician leadership is needed to realign these incentives and others. Ideally, strong physician leaders will transform the payment system to reward value and embrace the transparency nec-

essary to find high-value health-care treatments and providers.

### What are the most difficult issues to resolve in the health-care reform debate?

Health care is an industry, one of the largest in our nation. Every dollar of waste represents a dollar of revenue.

### What are some points around which we can build consensus?

Improving quality and reducing errors should be a priority for all. Nationally, patients receive recommended care only 55 percent of the time, according to a 2003 study by Rand. In 2007, The Commonwealth Fund found less than 43 percent of diabetics in Missouri receive recommended preventive care. It also found less than 39 percent of Missourians over age 50 received recommended screenings and preventive care. These statistics should demand our immediate attention. Lives depend on our action.

**For more information on St. Louis Area Business Health Coalition:** [www.stlbhc.org](http://www.stlbhc.org)



# Disappearing Primary Care; Evolving Solutions

A look at the crisis in primary care and what might be on the horizon

By Lawrence W. O'Neal, MD



Lawrence W. O'Neal, MD.

Interest in careers in primary care by U.S. medical graduates has declined markedly in recent years. The shortfall will be felt especially in rural areas, which will find difficulty in replacing retiring physicians.

Multiple factors enter into career choices. The nearly universal altruism of entering medical students undergoes a metamorphosis during the progression to graduation. While accumulated debt, available positions in training programs and lifestyle choices influence selection of specialty, increasingly

the choices are for business reasons.

Lifestyle choices are not related to intensity of work, but to control over scheduled hours of work and guaranteed off hours. Traditional lifestyle choice (dermatology, psychiatry, etc.) rates have fallen off. Definition of lifestyle has changed as more single specialty groups have formed. General surgery, orthopedics and cardiology can be lifestyle practices in large groups.

Family practice and internal medicine are clearly not lifestyle choices at present. In 1996, 16.1 percent of graduates chose family practice, falling to 9.5 percent in 2003 and 8.3 percent in 2007. Internal medicine was chosen by only 23.1 percent in 2007 about half of what it was in 1996. Many who complete the internal medicine certification requirements go on to get subspecialty qualification. Probably fewer than 13 percent of current graduates will practice primary internal medicine. Average starting income (first one to two years) for internists is \$154,000, compared with \$268,000 for gastroenterologists and \$258,000 for invasive cardiologists.

Evolving payment systems leave primary-care physicians at a huge disadvantage. Payment is limited for advice; procedures are favored. A primary-care physician, with 60 to 65 percent overhead, must take on more patients and spend less time with each in order to thrive. The capitated system of practice which would have favored reimbursement for primary care was once touted, but has not caught on.

## Nurse Practitioners Expand Role

Who is going to pick up the slack? Most specialists will have some proportion of primary care in their practices. Nurse practitioners will fill some of the void. A nurse practitioner must be registered, have a

“Evolving payment systems leave primary-care physicians at a huge disadvantage.”

Bachelor of Science degree in nursing, and then take a two year course leading to a Master of Science in Nursing degree. The core curriculum includes anatomy, diagnosis and treatment of common ailments, medical ethics and law and pharmacology. Considerable time is spent in hospitals and clinics in association with physicians.

About half of the states allow nurse practitioners to practice independently. Missouri currently has about 3,000 licensed nurse practitioners. The Board of Nursing does not have exclusive authority over

them, but jointly BoN/BoM regulates their scope of practice. Physician involvement is required in Missouri for any aspect of their practice. There must be a Written Collaboration Practice Arrangement (WCPA) which contains jointly agreed upon protocols and standing orders. The physician must review the charts.

When employed in hospitals, they are usually specialized in a clinical area and have been infringing on the role of physician assistants. WCPA is not required for

hospital-based practitioners. Retail practices are offered in some megastores such as Wal-Mart, Walgreens and CVS Caremark where common ailments are evaluated and immunizations offered. Clinical nurse practitioners earn about \$85,000 per year.

Insurers need to reassess payments for primary-care physicians, and perhaps the Accreditation Council for Graduate Medical Education needs to examine numbers of slots in the various certifying agencies. The market forces are out of kilter at present but the market tends to correct itself. Correction of the problem is already on the horizon. Recruiting for internists has intensified, but has fallen off for cardiologists and other medical subspecialties. In the Oct. 22, 2008 Journal of the American Medical Association, there were 39 recruiting advertisements for primary-care physicians and only three for medical subspecialists.

Dr. O'Neal is past SLMMS president and a retired surgeon



## The Daschle Blueprint for Health-Care Reform *(continued from 12)*

coverage to people because of their pre-existing medical conditions, as intended by the bill's authors. The insurance industry killed this part of the bill.

- Insurance interests killed the Patient Bill of Rights – a bill that was especially dear to Daschle's heart and was supported by the AMA.
- The passage of the Medicare Modernization Act of 2003 which, although adding a prescription drug benefit, actually constituted a massive handout to drug and insurance companies. It was much more costly to taxpayers than it should have been and it contained a "doughnut hole" where seniors had to pay huge out-of-pocket drug expenses. This legislation also resulted in Medicare overpayments to private insurers (Medicare Advantage). Once again insurance interests along with the drug industry rammed this bill through Congress. Daschle states the passage of this bill and the failure to pass a Patient Bill of Rights were his two most disappointing legislative defeats. One of Obama's main priorities in health care may be to initiate major modifications of the 2003 Medicare Modernization Act.

### Structuring a New System

Daschle then discusses how his proposed health system will be structured. Right off the bat he acknowledges that a single payer system is not politically feasible at this time. He opposes "high deductible" health insurance, which more and more employers have adopted to control costs. He does not specifically discuss health-savings accounts.

He states, "We should build on the model that we have. Nearly 80 percent of Americans are covered through an employer-based system, Medicaid, SCHIP and Medicare." For the remainder he proposes expanding the Federal Employee Health Benefit Plan, which is offered to members of Congress and covers more than eight million workers and their dependents. Underlying Daschle's plan is the requirement that all Americans have health insurance through an individual mandate. Daschle cites wide support for an individual mandate across the political spectrum that includes such conservative luminaries as Newt Gringrich and Mitt Romney as well as liberal icon Ted Kennedy.

Daschle proposes eliminating waste through implementing the twin mantras of evidence-based medicine and information technology. As usual, the devil is in the details. How does one go about achieving evidence-based medicine? Daschle supports pay for per-

“ **Daschle proposes eliminating waste through implementing the twin mantras of evidence-based medicine and information technology. As usual, the devil is in the details.** ”

formance (P4P). The AMA House of Delegates has debated this strategy many times. Its potential for abuse and denial of necessary patient care is well documented. As for information technology, there is little doubt that it expands access to data and may decrease errors but, despite all

the hype, it never has been proven to reduce costs. Furthermore there are many technical problems that have to be resolved before a national HIT program can be implemented.

The most original and controversial part of Daschle's proposal is the creation of a "quasi governmental organization," the Federal Health Board. The Federal Health Board would oversee the health system just like the Federal Reserve oversees the financial system (hopefully with better results than the recent financial meltdown would suggest).

Daschle acknowledges that under a Federal Health Board, "Doctors and patients might resent any encroachment on their ability to choose certain treatments, even if they are expensive or ineffective compared to the alternatives." He continues, "We will have to assuage the doubts of people who are simply scared of allowing an unelected board of strangers to make such critical decisions." It remains to be seen whether a Federal Health Board can be effective and be accepted by the American people or whether it just adds another layer of bureaucracy to a health-care system already overburdened with bureaucracy.

Most Americans agree that our health-care system is in crisis. The fact that diverse groups with disparate interests as noted above can come together and agree with this statement is unprecedented. Can these same groups put aside their historical differences and agree on a proposed solution to the crisis? Will Daschle's book serve as the template for Obama's health reform program? And if it does, will it work? Stay tuned.



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# Managing a Physician Practice in Uncertain Times

Examine your operations to enhance financial performance

By Steve Moro, CPA



Steve Moro, CPA

In July 2008, Congress passed the Medicare Improvement for Patients and Provider Act (MIPPA) of 2008. On July 1, 2008, the Medicare physician fee schedule was set to be reduced by 10.6 percent and another 5.4 percent cut on January 1, 2009. However, MIPPA extended the June 2008 rates and provided for 1.1 percent increase for 2009.

While this is positive for physician practices, with a new Congress and President, the talk of “health-care reform” may roll back reimbursement for physicians, thus, adding to the already uncertainty in the health-care industry. While other businesses are trying to figure out ways to maximize revenue in these uncertain times, physician practices have been struggling with the issue of uncertainty for years, as physicians have seen their reimbursement for certain services from Medicare and managed-care plans on a decline while operating costs have been increasing.

Unlike other industries, raising the price for services does not increase the net income for a physician practice because of the fixed reimbursement from the payers. So, what can a physician practice do to enhance the bottom line? Physician practices need to: 1) ensure that the proper amount of reimbursement is received from Medicare and other payers, 2) assess the profitability of procedures, and 3) establish metrics to monitor the operational performance of the practice.

## Ensuring Proper Reimbursement

Generally speaking, most physicians are participants in multiple managed-care plans, accept some commercial plans and may even participate in the Medicare program, which provides the reimbursement for the multiple services performed by a practice. As a result, a complex billing matrix is created that is difficult for a billing staff to memorize and ensure that the practice is receiving the correct payment from the payer.

For example, if a practice is in 20 managed-care plans and the 20 procedures provided by the practice are covered by the contracts, the billing staff would need to know the reimbursement rate by procedure by contract. Since this is not practical, many billing offices simply post the payments received and assume the payer paid the correct amount.

A better solution would be to leverage the billing system by loading the contract reimbursement rates into the system. The ad-

vantage of having payment terms loaded in the billing system is that the payment posted to the system from the remittance advice received from the payer is compared to the contract rate loaded in the billing system. Any variances from the contracted rates are identified immediately. In addition, the billing system is now able to calculate expected net revenue, which will provide a better estimate in predicting the cash flow for the practice. The one caveat to the aforementioned process would be if the billing system did not have the functionality to load payment terms.

For physician practices that use an outside billing service, the physician practice would want to ask the billing service if the contracts for the practice are loaded in the billing system to ensure that proper payment is received. If the billing service can not accommodate loading specific managed-care contract rates or other reimbursement terms, the practice would want to inquire as to what controls are in place to ensure that proper payments are received from payers.

## Profitability Analysis

A physician practice should perform a profitability analysis by procedure as well as by payer. The results of an analysis will identify those procedures that are most profitable for the practice or even identify those losing money. Based on the results, the physician practice would have to weigh the financial and clinical implications of discontinuing procedures that are losing money. The results of the analysis by payer may result in the physician practice discontinuing participation in a managed-care plan or not accepting patients that participate in certain health plans.

To perform a profitability analysis by procedure, the net revenue per procedure and the associated direct unit cost would need to be calculated. In addition, the indirect cost per procedure would need to be calculated as well. The indirect cost per procedure represents the allocation of the general expenses (such as: rent, utilities and administrative salaries) associated with operating a physician practice divided by the number of procedures performed by the practice.

Once the net revenue, the direct cost and the indirect cost per procedure have been calculated, the direct and indirect costs are subtracted from net revenue to determine the net profit (loss) per procedure. Because reimbursement for the same procedure may vary among the different payers, the net profit (loss) per procedure may not always be the same. Calculating net revenue per procedure by payer will provide the physician practice information needed to maximize net profit.

The following is an example of a unit profitability analysis by

## Net Profit Analysis on Selected Procedures

<b>2007</b>				
	<b>Laboratory</b>	<b>IVIG</b>	<b>Xolair</b>	<b>Vivaglobin</b>
<b>Net Revenue/Unit</b>	<b>\$28.41</b>	<b>\$31.55</b>	<b>\$19.57</b>	<b>\$6.17</b>
<b>Direct Cost/Unit</b>	<b>(8.99)</b>	<b>(26.48)</b>	<b>(10.97)</b>	<b>(4.90)</b>
<b>Indirect Cost/Unit</b>	<b>(9.33)</b>	<b>(9.33)</b>	<b>( 9.33)</b>	<b>(9.33)</b>
<b>Net Profit/Unit</b>	<b>\$10.09</b>	<b>(\$4.26)</b>	<b>( \$0.73)</b>	<b>(\$8.06)</b>

<b>2008</b>				
	<b>Laboratory</b>	<b>IVIG</b>	<b>Xolair</b>	<b>Vivaglobin</b>
<b>Net Revenue/Unit</b>	<b>\$42.49</b>	<b>\$42.70</b>	<b>\$19.65</b>	<b>\$8.77</b>
<b>Direct Cost/Unit</b>	<b>(19.77)</b>	<b>(41.35)</b>	<b>(17.04)</b>	<b>(7.53)</b>
<b>Indirect Cost/Unit</b>	<b>(10.09)</b>	<b>(10.09)</b>	<b>(10.09)</b>	<b>(10.09)</b>
<b>Net Profit/Unit</b>	<b>\$12.63</b>	<b>(\$8.74)</b>	<b>(\$7.48)</b>	<b>(\$8.85)</b>

selected procedure. By performing a unit profitability analysis periodically, it allows a physician practice to trend data.

In addition to analyzing net profit per unit, it is important that a physician practice perform an expense analysis on a unit basis. In some cases, the overall expense may appear to be going down when, in fact, the unit cost went up. For example, from the table below, the overall expense for the IVIG drug went from \$372,896 in 2007 to \$309,707 in 2008 or a decrease of \$63,189 (or 16.9 percent). However, on a unit cost basis, the unit cost increased \$14.87 per unit or 56.2 percent.

- Cash collection metrics will track payments, both at the time of services and payment received by payers.
- Accounts receivable will track the age of outstanding accounts by payer. Because payers settle claims according to different time schedules, accounts billed to payers need to be reviewed frequently to ensure timely payment. For example, Medicare will pay claims every 14 days, so it would be unusual to have claims older than 30 days. Generally, a Medicare claim over than 30 days would indicate that a claim was denied and would need to be investigated and appropriately re-billed.
- Claims that are denied need to be tracked routinely to determine the cause. Generally, denied claims must be appealed within a certain time limit as prescribed by Medicare or a managed-care contract.
- Payer mix will determine the composition of patient population the practice serves. To maximize revenue, practices need to focus on the mix that provides the highest level of reimbursement.

In these uncertain times, physician practices can enhance their financial performance by examining and enhancing operational procedures through ensuring proper reimbursement, performing profitability analysis and monitoring operational metrics.

<b>Operating Expense Analysis on a Unit Cost Basis</b>				
	<b>\$</b>	<b>Unit Cost</b>	<b>\$</b>	<b>Unit Cost</b>
	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>
<b>Salaries – Staff</b>	<b>323,917</b>	<b>\$3.52</b>	<b>305,392</b>	<b>\$3.85</b>
<b>Laboratory Expense</b>	<b>18,382</b>	<b>\$8.99</b>	<b>36,522</b>	<b>\$19.77</b>
<b>Medical Supplies</b>	<b>96,341</b>	<b>\$1.05</b>	<b>55,493</b>	<b>\$0.70</b>
<b>IVIG</b>	<b>372,896</b>	<b>\$26.48</b>	<b>309,707</b>	<b>\$41.35</b>

### Development of Operational Metrics

Developing a set of metrics will assist in monitoring the operational performance of the practice. The metrics should focus on scheduling activities, cash collection, accounts receivable, denial of claims and payer mix.

- Patient scheduling metrics will track the number of patients scheduled and the patient appointment no-show rate.

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