

Dallas Business Journal

Q&A: Views from the trenches

North Texas doctors offer perspectives on health care reform's pros, cons

January 15, 2010



As health care reform moves closer toward becoming law, with both the Senate and House approving different bills now headed to conference committee, questions and concerns still remain about what impact a federal law may have on North Texas businesses. In late December, the Dallas Business Journal asked four area doctors their thoughts on how proposed health care system overhaul plans would affect their business and the practice of medicine. Their responses are edited for length and style.

Q. At this point in the game, do you think that legislators will be able to pass federal health care reform legislation and how effective do you think the end product of that legislation will be in helping to cure what ails the current health care system? Why?

Dr. Christopher Crow: Yes, I believe they are likely to pass health care reform legislation. However, their overriding goal seems to be to lower the uninsured number. It will not bend the cost curve, and there isn't much evidence that patients' quality of care will improve. Health insurance coverage does not equal access to medical care. Medicaid patients often experience this when they are forced to get most of their care in the emergency room because too few physicians accept it.

Dr. Guy Culpepper: It is clear that the effort to pass health care reform has become more about politics than policy. The agenda now is focused on being able to say "we did something" instead of being able to produce positive change. As a result, the end product of this legislation is going to cause more harm than cure. Bad policy is always worse than no policy. That is why a physician's core principle is to "above all else do no harm." It would be good for America if our legislators would adhere to that same core principle to guide health care reform.

Dr. Bruce W. Landes: I think that some form of legislation will be passed. I am sure that it will be effective in increasing taxes and having a greater portion of gross domestic product flowing through federal government hands. There are so many different parts to these bills that it is hard to say which will cause effective change, much less say that the changes will be beneficial. When there are so many changes to a very complex system and the effective dates of some of those changes are three to four years hence, the final result will not be known for a decade. I doubt that Congress will wait a decade before making more changes again, so the net effect of this action may never be known. Many of the changes in these bills are not directed toward curing the ailing system of today but result from ideological attitudes about paying for health care (government vs. private) that go back decades. I think that many of the ideological changes are as likely to create new problems as they are to cure the current problems.

Dr. Ron Skufca: Legislators will pass some type of government health care plan — and it looks like they do not care what the American people want. They seem determined to change the way we get our care in very radical ways. The end product, by their own admission, will be years away from implementation, with the higher taxes beginning immediately. This in itself will hurt the country, taking away income from people who would otherwise spend some of their money on health care. I believe history is the greatest indicator of how well this is going to work. Where is the government program to date that runs within budget, continuously improving the scope of what it does for the American people?

Q. Many health care reform proposals have been bandied about — a public option plan, payment reform, tort reform and insurance reform. In your opinion, what absolutely are the most crucial elements to include in any type of legislation? Why?

Crow: One important element to improving our health care system is to provide incentives for individuals and businesses to purchase health insurance. Mandates should not be included. Transparency in pricing is important for both providers and insurance companies. Measuring providers' quality and outcomes so best practices can be formulated is also critical. With quality and price information available, we can create a much more meaningful market for purchasers of health care. Insurance reform including pre-existing conditions, standardization and simplification of administration and the use of exchanges is clearly needed. Finally, tort reform is necessary to reduce the large amount of defensive medicine. The health care industry also needs to do a better job of leveraging technology with electronic medical records and health information exchanges to better share medical information the way banks and every other industry does. At Village Health Partners, we use our EMR system to track patient progress, provide statistics and monitor trends we are seeing in our patients. This allows us to improve efficiency, offer a higher level of patient care and ultimately save our patients time and money.

Culpepper: The most crucial element to include in any health care reform is the ability to support and reward primary care physicians. Every analysis of a better health care model shows that quality, value and efficiency improve with access to empowered and involved PCPs. The road to better outcomes and lower costs always leads to enhancing the role of the PCP. Yet our existing system of reimbursement has led to the threatened extinction of the most critical member of the health care

team, the family doctor. There is nothing substantial in the health care reform legislation that will stop the death of primary care. And without primary care, all of the other changes will be moot.

Landes: One of the trends that has reduced the quality of care and increased the costs is the decline in the numbers of medical students who will train to practice in primary care and general surgery. America has a ratio of about 40-to-60 of primary care to specialists; ideally this should be closer to 60-to-40. This is a lifestyle issue almost as much as it is a financial issue, but the impact of annual earnings should not be underestimated, particularly when the average educational indebtedness of a medical school graduate today is about \$140,000. A procedural specialist may earn two to three times what a primary care physician makes. Our Independent Physician Association added 187 new physician members in the past year; only 22% were practicing primary care. Both bills address the relative underpayment of these specialties to some extent, but not enough to make an impact, and I consider this critical for the long-term future. The Centers for Medicare & Medicaid Services Regulation 1413 partly addressed this in 2009, but it boosted primary care payment at the expense of specialty care, which is not a desirable approach. Payment reform is critical to the mix of the future physician work force.

Texas passed effective tort reform in 2003 capping non-economic damages. The number of medical licenses issued per year immediately increased and has doubled since then, demonstrating that tort reform has a real impact when so many doctors have made a geographical move to escape the states that do not have tort reform. Federal tort reform capping non-economic damages is crucial for other states. We all know that a broken hip from a fall in a hospital will be "worth" two to three times as much as a broken hip from an auto accident. The reason is non-economic damages. The tort system is supposed to make the injured party whole, not reward them for having been injured by an entity perceived as having deep pockets. Both bills speak of tort reform, but do little, and the House bill specifically forbids capping any damages.

Skufca: Our Constitution does not allow for a government takeover of health care. This should not happen in any shape or form. The current system, however, needs many smaller reforms to help those who are changing jobs or no longer have jobs. We are constantly hearing about those poor people that are going bankrupt because of health problems and are not able to pay their medical bills. Reform could take the shape of some type of catastrophic insurance plan for only the big problems that life throws at us, not every injection or pill. This would be at a much reduced cost to the policyholder. But what is developing is a transfer of cost from the young to the older. Young adults do not need a lot of care, but still must buy the plan that covers what an older person needs. The result is the young are going to supplement the care of older people under a government plan.

Q. From a physician's perspective, what do you think gets left out of the health care reform debate that is needed to improve the current system?

Crow: We should be focusing much more on end-of-life care. The last six months of a person's life is when most of the costs occur. Unfortunately, the majority of the time the additional care and resulting costs do not equate to the same value in terms of quality or the patient's longevity.

Culpepper: The area of concern that deserves more attention when discussing health care reform is the lack of accountability by health insurance companies. Most of the health insurance companies are keeping 20% to 40% of the insurance premium dollars for their overhead costs and profits. Compare this to their using only 10% of that premium to pay for all of the primary care services of internists, pediatricians and family physicians.

If the health insurance companies were held accountable to more efficiently lower their costs, including their excessive executive compensation programs, our country could double the number of primary care physicians available. The overall reimbursement to family doctors has actually decreased during this past decade while employers and employees have suffered dramatic increases in health insurance premiums. This is a crisis of health insurance rate increases, not of health care.

Landes: In the past 50 years a significant amount of medical care has evolved from treating patients when they are sick to managing the health of patients. This has increased the need for physicians who are adept at management and are able to use multiple resources to help patients stay well instead of merely helping them get well. Health insurance executives, Centers for Medicare & Medicaid Services and company human resource directors have seen this need and have done everything they can to fulfill this need except for one thing — paying for it.

Payment for cognitive services is still based on having a face-to-face encounter with the patient. Can you imagine a lawyer or accountant only being able to bill for face-to-face time with their clients? It's tantamount to paying for a salad and expecting the price of the steak to be included. There is no reimbursement for coordinating the care of a patient when the patient is not physically present. Good management is particularly needed after a hospitalization to prevent a costly return to the hospital. Coordination of care is also important for treating diabetes, asthma, heart failure and other chronic conditions. This is a relatively cheap thing to fix, but Medicare has not done it, and the commercial insurers won't do it until Medicare does. Neither bill addresses this directly, but they do speak of pilot projects of the patient-centered medical home, which is a step in the right direction because it will reimburse the cost of the more complex, non face-to-face medical management.

Since 2003, physicians have had to beg Congress annually to reverse cuts in their fees as required by the Sustainable Growth Rate. The SGR was implemented in 1997 and ties the overall growth of all physicians' Medicare payments to the growth in American per-capita gross domestic product. No other Medicare health providers, such as hospitals, Medicare Advantage organizations and skilled nursing facilities, have such a cap. The Medicare conversion factor that sets physician fees is mainly influenced by the SGR. The SGR has called for a cut in physician fees every year since 2003 and every year Congress has reversed the cuts, but the cuts are only deferred and are cumulative. As of Jan. 1, 2010, physician Medicare fees were cut by more than 21%. For many physicians, this would represent a cut in their personal pay of more than 50% because overhead costs (averaging 60%) do not go down when reimbursement is cut. Neither reform bill really addresses this issue; to address it, the House passed HR 3961, which is a separate bill from the main health reform bill, HR 3962. The Senate failed closure on its bill, S 1776 prior to that, which would have been a semi-permanent

fix. The Senate HR 3590 reform bill only provides another temporary fix. Without a permanent SGR fix, physicians live in fear every year that these cuts will not be reversed. Small businesses cannot make long-term plans when their revenues are under annual threat of draconian revenue cuts.

Medicare essentially fixes the prices for all medical services. Private insurers may pay more than Medicare, but tend to pay as a percentage of the Medicare fee. This causes our entire health care payment system to count on Medicare "getting it right" in terms of the relative value of different services. What that means is that with the ability to fix prices comes the responsibility to set prices so that some things are not overvalued while others are undervalued. If something is overvalued, you have too much supply, and if undervalued, too little. Many hospitals have built towers or new units for certain specialty procedures that generate significant high-margin revenue; few have built new facilities for non-procedural low-margin revenue. We have many (maybe too many) outpatient CT and MRI scanners, the number of which has partially been driven by the price paid for scans. Medicare price fixing has and continues to have a major influence on medical capital investment and malinvestment. Neither bill addresses the economic hazards of governmental price-fixing; instead they try to perfect the price-fixing mechanism.

Skufca: The Big Picture is missing. Many, many health problems relate directly to the personal choices people make about lifestyle, nutrition, family planning and risky behaviors of all sorts. Air pollution, urban planning and other environmental factors also affect personal health. Poverty, substance abuse, ignorance, social breakdown and violent crime certainly contribute enormously to rising health care costs, directly and indirectly. It's a very complex picture, and it's terribly misleading to put so much emphasis on the health care system, which must absorb the impact of all these other factors. We need to be much more aggressive as a society in requiring individuals to take more responsibility for maintaining their health.

Q. Some fear any health care overhaul will lead to the rationing of care. In your opinion, is that a legitimate concern and how likely is that to happen? How can be avoided?

Crow: If a public option becomes available, it will no doubt attract many of the uninsured, especially those who are the sickest. Over time, this safety net will become more and more costly, which forces the system to lead to rationing of care. Nothing is being done to control costs, so the only choice is to limit services. Europe and Canada are evidence of this.

Culpepper: The fear of health care rationing is realistic. It already exists. Smart rationing is necessary. The challenge is to identify and provide the core health care needs while rationing the "feel good" medicine that creates unnecessary cost. It is crucial to quality care that properly trained physicians make those decisions instead of legislators and committees. Physicians are trained to make prudent health care decisions in the individual patient's best interest. Much of the excessive costs are driven by the threat of frivolous lawsuits. Many expensive tests are ordered for the legal medical record instead of for the patient.

Landes: Rationing is a legitimate concern with any third-party payment system, but it is not likely to be the form with which people have been frightened. No "death committees" will judge who gets

care and who doesn't. It will be done by pressure on physicians to follow evidence-based medicine, which is the idea that there is a best treatment or diagnostic evaluation for a given condition or symptom. If the EBM suggests that X should be done and the doctor does X, then there are no questions asked. But if the doctor thinks that Y is best in this case, they will be required to give a full justification for using Y instead of X. Given the pressure of time, eventually fewer doctors will offer Y, even if it might be the better choice for some patients. EBM is clearly supported in both the House and the Senate bills.

Skufca: History is the key. In the past, Medicare has reduced the payments to physicians. Both times the reduction was less than 6%. This resulted in a reduction in the number of physicians accepting Medicare by one-third each time. On Jan. 1, 2010 Medicare is reducing payments by 21%. Should I wonder how physicians will respond? This can only lead to shortages on every level in the delivery of care. Many supporters of the reform proposals respond by pointing to the Canadian system, even though there are waits of two or more years to get on a family doctor's patient panel. Why is it this way in Canada? Simple: The Canadian system limits the amount of money a doctor can make to equal the income of a tenured high school teacher. This effectively eliminates the incentive to work harder, be available by working more hours and more days to see more patients and have a better income for their family. In every country that has socialized medicine it is more difficult each year to find physicians.

Q. Some believe that the key to health care reform will be controlling rising medical costs. What do you believe is the best way to achieve that?

Crow: Doctors, hospitals, drug companies, patients, lawyers and insurance companies are all part of a complex web of costs. All can do better, but legislating that will be hard. I believe the single best way to control rising costs is to address the most expensive time in patients' lives — their last six months. This is where more than half the health care costs are spent. Getting patients to create a living will that provides health care workers their wishes would significantly improve the cost curve. There is so much care provided that we don't know if patients even want, but their families insist. Getting patients to make choices in advance for their end of life would make a significant difference to our health care system. Everyone should have a living will and let their families know of their wishes.

Culpepper: The best way to control rising medical costs is to empower the consumer. Put the first \$1,000 of annual expenses in the patient's control. Cover one annual preventive visit and then preserve insurance for catastrophic expenses. Allow patients and employers to see the actual cost of primary care, emergency room care, imaging, etc. Let market competition drive the best use of those dollars. Encourage primary care physicians to remain independent patient advocates. Reward PCPs for helping their patients find the best quality and value from multiple health care resources. Remember that when a physician is employed by a large health care system, he has a financial motive to use that system's resources and refer to that group's specialist, regardless of value or quality. Rewarding and protecting independence will ultimately preserve the flexibility necessary to pursue savings.

Landes: The way to control costs is to increase the probability that every patient will get the right care at the right time in the right location. Too often, the control of costs turns into an attempt to control prices. The reason is that the people interested in cost control often have little insight into the soft complexity of medical care, while prices are tangible. I call this “spreadsheet cost control” where, on a spreadsheet it seems that if you get the lowest price for everything, your overall cost will go down. Unfortunately, this rarely translates to reality in any business — but particularly does not work in medical care.

What rational business, facing rising costs, would try to fix it by cutting the salaries and quality of its managers? I think that the solution lies in a concept like the patient-centered medical home, which is primary care that not only treats 90% of what walks in the door but also has time to communicate and coordinate the other 10% of care that accounts for the majority of costs. The “gatekeeper” was tried and despised by patients and physicians alike. But a patient who has a primary care physician that they know and trust as an advocate and adviser will be less likely to self-refer to a higher-cost level of care or demand expensive tests that are not needed. That is true “managed medical care” and it increases quality and reduces costs by encouraging better management.

Skufca: Tort reform would be the quickest route to at least some reduction in the cost of medicine. We have seen this happen in Texas. Physicians have lower costs for malpractice, but much more could be done to lower the expectation that if someone dies, it’s the doctor’s fault because he did not do every exotic test in the book each time a person sneezed. This environment encourages defensive medicine and excessive utilization, which increase the cost for everyone. The government is addicted to decreasing payments for physicians and hospitals, and eliminating what is covered and patient choice. We’re essentially penalizing health care providers for being there for us when we need them and for doing their jobs.

Q. Some say that the way to reform the current health care system is to change the national insurance market. Again, many proposals have been discussed as ways to do this — individual mandate, employer-mandate, public option plan, health co-ops, and health exchanges. What do you think the answer is?

Crow: Mandates are not popular and rightfully so. Mandating more costs to business will only continue our jobless rate and stifle economic development. The insurance market needs to be much more transparent in pricing and practices. The insurance market is basically an oligopoly and it is protected from antitrust, which is ironic since doctors are not. This makes negotiations one-sided. Not-for-profit co-ops that are not run by the government are a great idea. Many are already in place around the country. They don’t have shareholders to drive their behavior, and it could allow many small businesses and individuals to be a part of a larger pool, thereby decreasing risks and lowering costs.

Culpepper: The best answer to reform the health care market is based on the uniquely American principle of freedom. First, protect and support the ability of primary care physicians to maintain independent practices dedicated to the ministry of patient care. One way to do this is to allow groups of independent physicians to work together when negotiating rates with giant insurance

companies. Don't force them to become employees of a single system for that right. Next, empower patients to know the costs of basic health care and to be responsible for their purchases and rewarded for their savings. Then allow small businesses to work together as purchasing cooperatives to get better rates for health insurance. The majority of the uninsured work for small businesses that would be able to provide insurance if they could get insurance rates comparable to large companies. Make it possible to purchase health insurance across state lines. This could eliminate many of the insurance monopolies that drive up costs. Finally, make health insurance portable so that a person can change jobs and still keep the same insurance. Eliminate pre-existing exclusion clauses. Give insurance rate reductions for lifestyle choices that lower disease and cost.

Landes: Removing the antitrust exemption of the insurers would be a good start. Many markets are highly concentrated in the hands of one or two insurers, enabling them to dictate high customer premiums and low provider reimbursement so that they increase their profits from the widened spread between the two.

The individual mandate with low-income subsidies has worked well in Switzerland, but probably would not do so well here with a more heterogeneous culture. After all, we have an individual mandate for auto liability insurance in Texas, yet 26% of the cars on the road have no insurance. Having said that, I think that the individual mandate is an essential condition for guaranteed policy issue with coverage of pre-existing conditions which, for the consumer, is a very important piece of health payment reform.

The creation of public or mutual groups to compete with current commercial insurers runs into a harsh reality — the actuarial risk formula. Without permanent subsidies by the taxpayers, these entities would have a hard time competing with established insurers. These are what I would call “vertical competitors” as they would have to market themselves, charge premiums, adjudicate claims and pay claims.

I think the public option should be a “horizontal” risk acceptor that reinsures the insurers. The established insurer would pay medical expenses per individual up to, say \$25,000 per year, and 20% of expenses over that with the public option picking up the other 80%. A similar proposal is already in HR 3962 to help struggling retirement health benefit plans. This would allow smaller insurers to enter into concentrated markets without the risk that a few catastrophic cases will bankrupt them before they reach an adequate number of members. More competition means less spread between premium revenues and payment for medical services.

Private insurers have demonstrated better ability to control fraud, waste and abuse than Medicare carriers, and this would keep private insurers in the game to control that. Plus, it would not require the creation of another large federal bureaucracy to administer a vertically competitive public option. We already enroll everyone with end-stage kidney failure into Medicare; kidney failure is not the only life-threatening catastrophically expensive chronic condition out there. Catastrophic medical conditions are relatively rare, and the risk for their cost should be spread widely among the population at risk. This is where the horizontal public option reinsurance would excel and, by reinsuring private insurers, promote competition and lower premiums.

I think that the other proposals, all of which have been put forward and some of which have made it into these bills will be costly, controversial and, in the end, ineffective.

Skufca: We need to uncouple health insurance from employment because it has become too much of a financial and administrative burden on businesses of all sizes. The employment-based system also encourages people to stay in jobs they don't like simply to keep the insurance. Mandatory health insurance, like auto insurance and homeowners insurance, is probably necessary in order for the insurance companies to accept all comers, regardless of age or pre-existing conditions. Individuals should be able to meet the requirement, however, by choosing a kind of plan that best fits their particular situation. The federal government should create incentives for health insurance companies to become nonprofit enterprises, which require lower profit margins than for-profit companies. We ought to encourage the formation of buying cooperatives or other kinds of group purchasing organizations to reduce marketing and administrative costs for the insurance companies, while giving consumers genuine choices. We should have national insurance rules and standards, rather than state-by-state, to reduce marketing and administrative expenses as well. A tax-supported insurance program, or public option, should be avoided because it inevitably will become another huge financial burden on taxpayers. Another option would be to improve the medical savings plans that exist today. This would motivate the individual patient to be more involved in their own care and make more economical decisions for their own care. This would be in contrast to expecting insurance — someone else — to pay for our care and a mentality of pay-for-every-exotic-test-in-the-book-or-I-will-sue-someone.