CHAPTER 1

R[E]VOLVING HEALTHCARE INDUSTRIAL COMPLEX

[The Changing Health 2.0 Economics and Financial Ecosystem]

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Healthcare reform is no longer just a moral imperative, it's a fiscal imperative.

-President Barack Obama

In 1972, Nobel Laureate Kenneth J. Arrow, PhD shocked academe' by identifying health economics as a separate and distinct field. Yet, the seemingly disparate insurance, financial and business management principles that he studied are just now becoming transparent to some physician executives and healthcare administrators. Nevertheless, to informed cognoscenti, they served as predecessors to the modern healthcare advisory and practice management era. In 2004, Arrow was selected as one of eight recipients of the National Medal of Science for his innovative views.

Ultimately, savvy medical professionals are realizing that the healthcare industrial complex is in flux. Physicians are frantically searching for new ways to improve office efficiencies, revenues and grow personal assets because of the economic dislocation that is managed care, not to mention the 2007-09 meltdown of the domestic economy. Increasingly, the artificial boundaries between medical practice management, health economics, finance, banking and technology is blurring in 2010-11 and beyond.

Throw modern social media and new-wave health 2.0 collaborative business skills into mix, and a disruptive - even transformational - paradigm shift becomes evident. Patients are empowered by it and doctors are worried because of it. First noted by grassroots medical practitioners, then elucidated by electronic citizen journalists like Matthew Holt [www.TheHealthCareBlog] and finally codified by the Institute of Medical Business Advisors and others [www.MedicalBusinessAdvisors.com], this emerging philosophy is now engrained in the popular culture. And, the twenty billion dollar American Recovery and Reinvestment Act [ARRA] of President Barack H. Obama in 2009 provided further political support for health information technology and related management initiatives by physicians going forward. With the recent retirement of Dr. Robert Kolodner, the National Coordinator for Health Information Technology's [NCHIT] David Blumenthal MD leads the pan-collaboration of stakeholders today.

An Imprecise Science

A basic, but hardly promoted premise of this new wave, and all healthcare business, is imprecision. Nevertheless, we may define traditional healthcare economics as how the medical industrial complex allocates its limited resources (cerebral input, equipment, IT, infra-structure, time and financial assets, etc) to the insatiable appetites of the US consumer, through the natural competitive laws of supply and demand. This occurs because physicians are willing to sell, and patients are willing to buy, their services. At some point of equilibrium, supply equals demand; for a price known as *market equilibrium*.

For example, let's take a look at the medical practice of Dr. Jane Smith and her competitor Dr. Harry Jones. When the price of a non-covered Medicare service is lowered by Smith, her patient load increases and Dr. Jones' volume slows. Conversely, if she raised her fees, Dr. Jones's practice would flourish. This phenomenon, illustrated by market forces or the "invisible hand" of Adam Smith, can be reviewed from the traditional, contemporary and futuristic healthcare economic perspectives outlined below.

TRADITIONAL HEALTHCARE ECONOMICS

Demand Side Considerations in Medical Care

Medical care may be defined as the examination and treatment of patients. Implicit in this definition is the fact that the lower the direct out-of-pocket price offered to the patient, (all other factors held constant) the greater the number of units of medical commodity the patient will demand. In this relationship, *"demand"* is defined as the set of service quantities (outputs) demanded at various prices, while the *"quantity demanded*", are the amount of care requested at a specific price. Changes in demand occur as a result of personal income and tastes, physician shortages and surpluses, personality and perceptions, and a host of other factors A pictorial representation of this relationship is the classic downward sloping demand curve, and the rational behind the curve lies in the possibility of substitution since very few, if any, commodities [even medical care] are absolutely identical.

Supply Side Considerations in Medical Care

Historically, physician suppliers were motivated to maximize their profits by augmenting services and minimizing costs. Implicit in this definition is the fact that physician suppliers will endeavor to provide as many services as possible. In this relationship, *"supply"* is defined as the set of services quantities (outputs) provided at various prices, while *"quantity supplied"* is the amount of care rendered at a specific price. Changes in supply occur as a result of similar, but opposite, factors as found in the demand relationship. A pictorial representation of this relationship is the classic upward sloping supply curve, while equilibrium is reached when the supply and demand curves intersect at the historic usual, customary and reasonable price point.

Marginal Revenues and Marginal Cost

If a doctor has the opportunity to see even a single additional patient at a profit, he will rationally do so. The *"marginal revenue" (MR)* from the extra office visit exceeds the *"marginal cost" (MC)* of the visit. Once the cost of the visit equaled the revenue it produced, the incentive to see more patients is lost. In other words, no additional profits is left at the point where *MR = MC*. This standard business concept hold true absent situations such as monopolies or oligopolies. Once satisfied, healthcare gratification, or *utility,* diminishes and more care has a lower return on health and productivity.

Marginal Utility and Medical Price Elasticity

If utility is a word used to describe the value of medical service to a patient, then "*marginal utility" (MU)* is the value of treating one additional patient. At some point the treatment plan is completed, the patient is satisfied, and additional services are of no

value. Another example of this is the inadvisability of having two offices in the same neighborhood, rather than in different geographic locations. The marginal utility of the second neighborhood office is often negligible.

In our example of Dr. Jane Smith, some patients may not decide to leave her practice despite the fee increase. Patients may consider such intangibles as her pleasant demeanor, location, or quality of service and elect to continue their relationship with her. When this occurs, we say patient demand is *"inelastic"* to price change or price increases. On the contrary, if patients quickly go to Dr. Harry Jones, demand is said to be *"elastic"* to price pressure and some experiential studies show that a mere $25-35 monthly increase in out-of-pocket costs is enough to send patients elsewhere. Medical service elasticity is affected by insurance deductibles, co-payments, physician's reputation and communication skills, waiting room time, and the like. When an industry becomes more competitive, as in healthcare today, fees tend to become more elastic and patient volume becomes very sensitive to even small changes in price. In a managed care environment, every "non-covered" service will have its own level of pricing elasticity, and every doctor should estimate that level for all fees, in order to achieve optimum patient volume.

Traditionally, medical services and food were inelastic to price changes, while computer and technology sales are very elastic to price sensitivity. This relationship is rapidly changing and there is even a mathematic equation stating this phenomenon in ratio form:

$$\textbf{Elasticity of Medical Supply} = \frac{\textbf{\% Change in Total Revenue}}{\textbf{\% Change in Price}}$$

For instance, if a twenty percent increase in an office visit charge resulted in a thirty percent increase in quantity of services supplied, the price elasticity would be 32/22 = 1.45. Therefore, a high elasticity coefficient equates to higher price elasticity. Generally, a coefficient greater than one is considered elastic, while a coefficient less than 1 is inelastic. Interestingly, exact unity prevails when elasticity of supply is exactly equal to one.

In addition to price elasticity of demand, the competitive marketplace drives supply and prices. For example, there is usually more medical competition in large metropolitan areas than rural areas. Prices tend to rise and fall, respectively while the market is more sensitive to price fluctuation due to this structure. In the traditional medical community, this led to the development of four basic medical market place types.

The Four Traditional Models of Medical Competition

In a discussion of competitive medical models, assumptions must include normal demand quantities, many fully informed patients and the fact that physicians cannot directly influence demand for care. These assumptions, although fluid, also preclude that patient buyers are large enough have any influence over price and result in the following structures:

- In a *"pure monopoly"*, there is only one provider with a unique service. The doctor is a "price maker" and charges whatever he wishes.
- In an *"oligopoly"*, there are a few physicians who provide similar services. For example when it becomes clear to Dr. Smith and Dr., Jones that neither can win their price war, oligopolists return prices to prior, but still inflated levels.

- In *"monopolistic competition*", there are many providers with differentiated services. For example, should Dr. Jones decide to have evening hours, she may charge a premium for her fees if Dr. Jones doe not follow suit.
- Finally, when "*pure competition"* occurs, there are many physicians, providing similar and substitutable services. Marketing and advertising does not affect fees, and prices are determined by supply and demand. The doctors become "price takers" by accepting fees arrived at by practicing competitively.

Externalities that Defy Traditional Medical Supply-Demand Competitive Economics

The above marketplace structures, while efficient are not necessarily timely or applicable in healthcare. This is particularly true in medicine and is attributed to various "externalities" that seemingly deter competitive forces.

Formally, *externalities* are defined as the cost or benefits of market transactions that are not directly reflected on the price buyers (patients) or sellers (doctors) use to make their decisions. They represent errors, defects or inefficiencies in the pricing system and can be either positive or negative. Pertinent competitive externalities for the physician, and healthcare practitioner, include but are not limited, to the following

Barriers to Entry: Physicians and other "learned healthcare professionals" receive an extended formal education. This not only ensures competence and protects the public, but it also reduces competition. Certificate of Need [CON] regulations, and licensing laws for example, are an entry barrier to competing and substitute providers and services. However, critics like Shirley Svorny PhD, professor of economics and chair of the Department of Economics at California State University Northridge, argues that

licensure not only fails to protect consumers from incompetent physicians, but raising barriers to entry makes health care more expensive and less accessible. Institutional oversight and a sophisticated network of private accrediting and certification organizations, all motivated by the need to protect reputations and avoid legal liability, offer whatever consumer protections exist today. Source: Policy Analysis, No 621, September 2008.

Link: http://healthcarefinancials.files.wordpress.com/2008/11/medical-licensing.pdf

2. Competitive Advantage: Once medical school, internship, residency and/or fellowship training is over, a medical degree and license to practice is an effective strategic advantage over a non-degreed practitioner.

3. Monopsony and Oligopsony: Occur when discounts are extracted from healthcare providers because of supply and demand size inequalities, and may run afoul of anti-trust laws. Many providers have monopoly or near-monopoly power, yet antitrust laws prevent some potentially beneficial integration.

4. Moral Hazards: All know that cigarettes, dietary indiscretions, drinking, drug use and promiscuous behavior are unhealthy. Yet, many pursue this life-style that drive up healthcare costs for society as a whole.

5. Mortal turpitude: Since physicians take the "Hippocratic Oath", they are expected to place patient welfare above their own [fiduciary responsibility]. This is not necessarily true with business entities that must adhere to legalities only.

5. Little Transparency: Patients typically do not purchase services directly from medical providers; they don't compare prices directly between providers and they lack information to do so.

6. Barriers to Exit: The increased cost of "doing business", effectively precludes many physicians from terminating practice unit all fiscal investments are recouped. Observe that few doctors can practice "part time" today and still afford their overhead. This protects protect low quality providers.

7. Political Fiat: The government is the largest purchaser of healthcare so capital investments may be overly subsidized; just as private purchasers often lack market power.

Miscellaneous Competitive Externalities

Other externalities that drive up the cost of healthcare, are well known, but not easily changed.

First, most Americans have group insurance through their employment, and don't even buy it, it making them fairly indifferent to the cost or need of individual health care purchases. Second, acquiring health insurance is not like buying a commodity, and it is difficult for a layman to know what purchases make sense and at what price? Third, most health insurance purchasing decisions are made by the doctor (i.e., refer to a specialist or have surgery), not the patient consumer, and hence has a vested interest in increasing service demand. Lastly, what well informed person would be a tough bargainer when their health is at stake? Who is going to negotiate with a neuro-surgeon?

During the so called "*Golden Age of Medicine*", 1965-1990 *approx*, Medicare, Medicaid and all these factors worked to isolate American medicine from financial

reality. In the last decade, however, the private sector has demanded cost containment by negotiating prices for medical services.

Medical Profit Maximization

Now that competition and related inefficiencies have been reviewed, it is time to consider how these externalities are applied to the profit maximizing private medical practice marketplace. And, the imperfect fee-for-service marketplace, which became a bit more perfectly competitive in the managed care era; will become even more so as healthcare political reform is phased-in [2014-2018]. For example, consider the following economic scenarios.

1. A relative dearth of physicians but with a surplus of government subsidized patients in a quasi-nationalized healthcare system - as of the March 21, 2010 health insurance reform legislation - causes them to become "price takers"; selling a homogenous (commoditized) service. An appendectomy is an appendectomy! Or is it? Financially, many doctors are *"taking what they're given (by MCOs, Medicare, Medicaid, etc), because they're working for a living"*. Women and younger doctors under 40 are especially inclined to work for less, or others, since they have had little exposure to fee-for-service compensation. Mature providers are retiring as society loses their experience; and mid-lifers are frustrated and depressed. Perhaps providers need to "differentiate" themselves from the competition? Ponder the generalist *versus* hospitalist controversy, since one of the fastest growing areas of specialization is hospital medicine. Or, consider the potential economic impact of *any willing provider* laws, or recent legislative

proposals in the state of Massachusetts [April 2010] that may require physicians to accept Medicare and Medicaid patients in order to receive a medical license?

2. Physicians have an increasing smaller share of the medical marketplace because of extended care providers. Does this help or hinder them? Price information is freely available to all MCO's because of computerization, yet doctors can not collude. Recall the fee schedule surveys popular several years ago; or the internet transparency today? How does this knowledge impact contemporary medical care pricing?

3. Doctors have been defeated in their ability to influence the marketplace by selling a quality, but nevertheless standardized, service. Consider the economic effects of practice guidelines and standards, evidenced-based medicine [EBM] and comparative-medical effectiveness [CME] in this light?

4. As medical care becomes efficient, each doctor becomes a perfect substitute for the other. This may either be an accolade; or a curse since patient demand becomes perfectly elastic at the HMO's [payer's] set price. This being the case, there is no incentive to lower fees in an attempt to attract more patients, since doctors would not be able treat any more patients than they would otherwise. The price decrease just lowers income, but has no effect number of patients treated. It simply decreases profits.

5. Since marginal revenue is the fee obtained from seeing one extra patient, marginal revenue becomes equal to HMO price, and marginal profit is zero when marginal revenue just equals marginal cost. Will the MD still want to wait another hour just to see that last late HMO, Medicare, Medicaid or socialized-medicine patient?

6. A profit maximizing office will operate at a short-term loss as long as its minimum average cost is less than its minimum possible average variable cost. But, just how long is "short term", anyway?

7. Efficiency prevails when medical services are made available just up to the point that marginal benefits equal marginal costs. When efficiency is achieved, it is not possible to make more money without decreasing another doctor's income in a risk pool situation. Voila! Managed competition, anyone? Furthermore, consider those physicians now fleeing the states of Florida and California, as examples.

Regardless of the technical nature of the above arguments, practical attention must be directed toward the possibility of increasing increased governmental intervention relative to two other concepts that directly affect medical practices; price ceilings and price floors.

"Price ceilings" are maximum legal charges and always result in shortages when set below market equilibrium prices. How long is the wait at a local charitable hospital vs. a local for-profit medical center? Price ceilings often result in an underground black market economy that exceeds legal limits.

Non-price rationing (i.e., free medical care) on the other hand, distributes available services to patients on a basis other than ability to pay. The most common non-price rationing device is "first-come, first-served".

"Price floors" establish minimum prices, which often result in surpluses when they exceed equilibrium price levels. The minimum wage is a good example of a price floor.

Price ceilings and floors benefit certain groups but impair the distribution of goods and services by the price system in free competitive markets. Government intervention interferes in the functioning of competitive markets and is likely to result in "resource allocation" problems. Remember, Keynesian macro-economic philosophy. In evaluating managed care price controls, the gains to beneficiaries of price ceilings and floors must be weighed against the resulting allocation problems. Alternative methods that will make the gainers just as well off without impairing the rationing function of medical prices, can be considered as ways to increase efficiency in the medical economy.

Traditional Methods of Healthcare Delivery

Prior to 1970, the healthcare reimbursement system was not a monolithic complex and most Americans received their healthcare through one of five third-party organizations: (1) Blue Cross/Blue Shield (pre-paids), (2) Commercial insurance (private) companies, (3) Medicare (federal-elderly), (4) Medicaid (state-poor) and (5) CHAMPUS (Tri-Care military health system).

The four participants in this fragmented system were the patient (consumer), the physician (provider), the employer (buyer or payer) and one of these third-party intermediaries. Moreover, the doctor-patient relationship was often muddled by the third parties who became brokers between MD and patient; both seeking to understand: (a) who was responsible for payment (b) how the MD would assist the patient obtain reimbursement and, (c) how to establish the ultimately responsible party?

In the meantime, commercial insurance medical costs were accelerating at a rate greater than three times the Consumer Price Index [CPA], a measure of goods and services in a market basket intended to be representative of a typical patient's purchases.

There was no single reason for medical cost escalation, but many economists believed the following circumstances conjoined at one point over time to increase health care costs dramatically. Important factors include the following:

1. Law of Supply and Demand, as too many aging patients needed [wanted] medical care from a society with relatively too few physicians [upside-down primary care/specialist ratio].

2. The US Federal Budget will generate a deficit of almost $1.4 trillion for fiscal 2011 or >10.5 % GDP.

3. Increased administrative costs and advancements in technology. The primary use of new technology has been in the areas of diagnosis, medical imaging, interventional treatments, pharmaceuticals, electronic connectivity and inter-operable medical records. However, HMOs also use technology to increase operational efficiency and reduce costs. The price paid is in the loss of jobs or reduction in the skill level needed to perform certain tasks, formerly done by trained technicians, para-professionals, nurses or physicians.

4. Malpractice phobia, misinformed patients, hungry trial lawyers and class action lawsuits. Yet, this fear is not without some foundation. For example, in 2000, the Institute of Medicine [IOM] estimated that more than 1,000,000 hospital infections, accidents and adverse events occurred. By 2010, improvements were sparse as the IOM estimated that nationwide, preventable medical errors in hospitals unintentionally kill the equivalent of

one jumbo jet crashing each day. And, new reports by psychiatrists are emerging about fearful medical residents abrogating decision-making responsibility in favor of repeated diagnostic tests. This epidemic of diagnostic imaging and invasive cardiology are prime examples.

5. Cultural, social and political timing (i.e. medical care is a right; not a privilege) as some patients or employers may not be willing to pay the price for medical care; despite impending sanctions by the Obama administration's reform.

Productivity Crippled by Aging Demographics, Care Variations and Exploding Healthcare Costs

Traditional organizations, except for the military, provided a type of insurance known as *indemnity insurance,* which has the following features: (A) An insured individual has the ability to choose the physician and the hospital he or she wants to visit. (B) Medical providers are paid a separate fee, for every service provided, as long as it is covered by the patient's benefit plan. Under the system of indemnity (fee-for-service) reimbursement, the implication was that it was the MD's' fault if he was not paid, and it was the doctor's problem if the medical needs of the patient were not met.

Although confusing, the system gave patients great freedom and MD's great incentive to supply care, but insurers have little control over the care rendered and its associated costs. Healthcare cost estimates skyrocketed to more than one trillion dollars, or 18% of GNP, crippling US productivity by 2011.

Moreover, consider that since 1963 in the Medicare system alone, the following happened:

- Workers contributing to the system decreased from 6:1 to 2:1.
- Enrollees increased from 20 million to 50 million currently, and are still climbing.
- The elderly population increased from 10% to 16% of the US population.
- The average life Span increased from 70 to 78 years.
- The Medicare Trust Fund ballooned as an accounting fiction since technically the fund holds interest earning US government bonds, representing an accounting surplus of payroll taxes collected minus benefits paid. But, these are very special government bonds, as the trustees cannot sell them on Wall Street and can only hand them back to the US Treasury. This does not increase the size of Uncle Sam's wallet since every trust fund asset is a Treasury liability. For the government as a whole, the asset and liabilities net out to zero and, if the trust fund was abolished, there would be no effect on private bondholders or economic activity. The government would not be relieved of any existing obligations or commitments. The Medicare bonds are essentially IOUs the government has written to itself; a $38 trillion unfunded liability with insolvency variously projected in seven years. And, the federal portion of Medicaid is growing at 21 percent each year.
- From 2000 to 2009, Medicare Part B premiums went up by an average of 8 per cent a year. In 2010, Part B premiums were about $110.50 a month, up from $96.40, but for only about 27 percent of those in the program. Most people didn't have to pay that increase due to a "hold harmless" provision in the law: Since there was no Social Security cost-of-living adjustment in 2010, Medicare didn't have to pay the higher premiums. And, in 2011, about 8% of Part B beneficiaries

were subject to higher premiums, sums deducted from Social Security payments. Beneficiaries paid $120.20 in 2011.

- Furthermore, the rising cost of healthcare can be contributed to wide variability in treatment patterns that could be ascribed only to style and not to patient differences. For example, studies by John (Jack) Wennberg, MD, in the early 1970's at Dartmouth Medical School, shocked the healthcare community when he discovered that differences in hysterectomy, tonsillectomy and prostatectomy rates in one county were 30-50% higher than rates in adjacent counties. By the early 1980's Wennberg's studies concluded that new physician incentive were needed if doctors were to provide appropriate care at acceptable costs. For almost 30 years, the Dartmouth Atlas Project documented these glaring variations in how medical resources are distributed and used in the United States. The project uses Medicare data to provide comprehensive information and analysis about national, regional, and local markets, as well as individual hospitals and their affiliated physicians. These reports, used by policymakers, the media, health care analysts and others, have radically changed our understanding of the efficiency and effectiveness of our health care system. This valuable data forms the foundation for many of the ongoing efforts to improve health and health systems across America [www.dartmouthatlas.org].
- Other causes of spiraling healthcare costs include: voracious consumer appetite, lifestyle drugs, DME and elective medical interventions, inflation, cost shifting, and the relative insulation of consumers to the true cost of medical care due to the business deductibility of health insurance premiums. Not coincidentally, corporate

America, insurance companies, and even the Federal Government, looked for methods to contain costs and provide pro-active, rather than retroactive-active medical care.

Additionally, iatrogenic factors contributing to healthcare costs continuer to escalate this new decade. For example, it is now estimated that:

- More than half all surgeries may be unnecessary.
- One-third of all medical office visits may not needed.
- One-third of all hospital admissions may be iatrogenic.
- Medication still errors abound, according to the Institute of Medicine (IOM), resulting in more than 98,000 deaths during the last reporting period.
- There is a virtual epidemic of diagnostic radiology with resulting increase in associated iatrogenic malignancy rates.

Medicare Cost Containment Policies

In the past, Medicare controls to stymie the cost spiral included: (1) increasing Medi-gap premium taxes making co-payment and deductibles more expensive and discourage enrollees from obtaining first dollar insurance coverage on medical expenses, (2) increasing Supplemental Medical Insurance (SMI) premiums, co-payments and deductibles (cost sharing), (3) lowering physician assignment fees, (4) screening out unhealthy patients ("cherry picking" and "adverse selection"), (5) reducing beneficiary benefits (rationed care), (6) incorporating utilization review (prospective, concurrent and retrospective) programs, (7) pre-certifying hospital and ambulatory surgery center admissions with reduced DRG, MS-DRG and Ambulatory Payment Classification (APC) payments, (8) increasing the use of second opinions for surgical procedures, (9) implementing case management of expensive disease processes, (10) organizing corporate self insurance, (11) using direct employer contracting, (12) pushing back the age of Medicare eligibility to age 67 years, (13) increasing the use of pre-paid managed care organizations, (14) encouraging the use of high deductible Health and Medical Savings Accountants (HSAs/MSAs), (15) promoting Medicare HMOs or

Medicare+Choice or *Medicare Advantage Plans* [MAPs], (16) using "rescission" to drop insurance coverage for gravely sick patients, and now (17) the debatable healthcare reform legislation of 2010*.

Needless to say, the above cost reduction attempts were largely ineffective, and now the Medicare/HMO precursors are still projected to loose money and benefits. Moreover, as the US Congress tinkers with future budgets to augment the above measures, there is always the potential for the incorporation of onerous medical practitioner user fee(s), as proposed below:

- Fees for medical claim not submitted electronically or for un-process able "dirty" medical claims submissions.
- Provider registration fees and HIPAA electronic date interchange fees.
- National Provider Identifier [NPA] number fees.
- eMR implementation costs estimated at $35-$75,00 per medical practitioner, with proposed American Recovery and Reinvestment Act government subsidies for demonstrated "meaningful use" by 2011 of up to $44,000 in some cases.

Additionally, until about two decades ago, traditional fiscal output-maximizing models were used by most hospitals to maximize reimbursement, according to something like the following formula.

Hospital Cost = Costs Per Service (X) Services Per Patient / Per Day (X) Days Per Admission (X) Number Admissions.

That is to say, third parties reimbursed hospitals for expenses already incurred, on some retrospective formula based on a lower of cost or charges (i.e., *cost-plus)* basis.

Regardless of how costs were defined, this encouraged hospitals to expand, adding facilities, technology and expenditures.

*NOTE: Rescission is a maneuver in contract law to drop insurance coverage for a gravely sick patient, whose care is considered expensive, by reviewing the insured's application to discover discrepancies that suggest untruth and thus giving the insurer legal permission to drop the claim.

Diagnosis-Related Groups

In 1983-84, the federal government introduced a prospective payment system for hospital, known as *Diagnosis-Related Groups* (DRG's) for Medicare patients. According to this system, all charges were reimbursed on a per diem diagnosis case basis. The model suggested that hospital would minimize costs since they were at risk for any expenses incurred above the given reimbursement rate and would strive to reduce costs to an efficient level. This was unlike any hospital behavior reimbursable under the older retrospective system and, recognizing that the model predicted a tendency for hospitals to maximize the number of patients admitted, Medicare regulations made provisions for professional review to determine the necessity of care.

Under current reimbursement rules, the Health Care Finance Administration (Centers for Medicare and Medicaid Services) mandates that patients must stay the national average length of stay for the specific DRG, for hospitals to earn a full DRG payment. More recently, these have been replaced with Medicare Severity adjustments using MS [Medical Severity]-DRGs. Hospitals which normally discharge faster than average have two choices: 1) retain the patient until the national average is reached (most likely), or 2) discharge the patient earlier (least likely) to incur the full cost of treatment and get a serious reduction in revenue.

Unfortunately, not being an all-payer system, hospitals shifted services and costs to non-Medicare patients and DRGs had wide ramifications beyond their intended population. Therefore, prior to the 1973 HMO Act, it was apparent that the healthcare delivery system needed more dramatic changes. A new strategy, known as *managed care*, which is an approach that links the delivery and financing of healthcare in order to coordinate-ordinate care, was adopted.

This new approach caused insurers and providers to renounce the traditional incentives of indemnity insurance, to control costs and eliminate inefficiencies. The ideology produced what is known as the *medical reimbursement paradigm shift* because it was a dramatically different way of thinking about medical care payments. Weather this lofty goal of reducing federal Medicare and state Medicaid spending has indeed been achieved however, is still debatable [FIGURE 1.0].

[Insert Figure 1.1]

Nevertheless, the following types of formal, and informal, models exist in the managed care system and they must be understood in order to economically survive as a health 2.0 business unit, into the second and third decade of this millennium.

Ambulatory Payment Classifications

Most doctors are aware of the Medicare payment regulations known as Ambulatory Payment Classifications (APCs), originally termed Ambulatory Payment Groups (APGs), that replaced cost based, or cost plus reimbursement for outpatient services. Much like Diagnostic Related Groups (DRGs), they changed the hospital and

IPA landscape forever. The Federal Government planned this shift to prospective payments through its Outpatient Prospective Payment System (OPPS) as a result of the Omnibus Budget Reconciliation Act (OBRA) of 1986. The system was designed to explain the amount and type of resources utilized in outpatient ambulatory visits. Each APC consisted of patients with similar characteristics and resource usage and include only the facility portion of the visit, with no impact on providers who continue to be paid from the traditional CPT-4 fee schedule and modifier system. This effectively eliminated separate payments for operating, recovery, treatment and observation room charges. Anesthesia, medical and surgical supplies, drugs (except those used in chemotherapy), blood, casts, splints and donated tissue are also packaged into the APC. Unbundled, fragmented or otherwise separated codes were eliminated from claims prior to payment. Exempted facilities include clinical laboratories, ambulance services, End Stage Renal Disease (ESR) centers, occupational and speech therapy services, mammography centers and Durable Medical Equipment (DME) suppliers.

Rise of Hospitalists and Hospital Based Medical Groups

The usual role of inpatient care in this country saw hospitalized patients cared for by their primary care or admitting physician. Although this model has the advantage of continuity, and perhaps personalization, it often suffered because of the limited knowledge base of the physician, as well as familiarity with the available internal and external resources of the hospital. Furthermore, the limited time spent with each individual patient prevented the physician from becoming the quality leader in this

setting. These shortcomings have led hundreds of hospitals around the country to turn to the hospitalists as dedicated inpatient specialists.

The term *hospitalist* was coined by Dr. Robert M. Wachter [www.*the-hospitalist.org/blogs* and personal communication] who is widely regarded as a leading figure in the modern patient safety movement and Dr. Dr. Lee Goldman of the University of California at San Francisco. They first used the term in an influential 1996 essay in The New England Journal of Medicine. Wachter's most recent book, *Understanding Patient Safety,* (McGraw-Hill, 2008) examined the factors that have contributed to what is often described as "an epidemic" facing American hospitals.

A hospitalist denotes a specialist in inpatient medicine. More formally, the *New England Journal of Medicine* defines a hospitalist as a general internist who cares for over 100 Medicare patients per year and whose E&M codes are at least 90% hospital-based. According to Wachter, this is a reasonable methodology for highlighting trends, but it misses vast numbers of hospitalists. For this reason (the study excludes pediatricians, family physicians, subspecialty hospitalists, and those who work in organizations like Kaiser Permanente or the VA, who submit very few Medicare bills), the 2010 estimate of about 15,000 hospitalists is low. The actual number of U.S. hospitalists is closer to the American Hospital Association's estimate of 28,000, making the field larger than cardiology. But the news is in the growth curve. From 1997 to 2006, the hospitalist workforce increased by 29% a year. In keeping with this growth, the percentage of Medicare patients cared for by hospitalists increased from 9% to 37%, and now exceeds 80% in some high penetration markets such as Austin, Texas and Mesa, Arizona. Paralleling these trends is substantial growth in ambulatory internists (<10%

hospital codes), now up to 35% for all internists and rising fast [Wachter's World, March 2009].

At its center is the concept of low cost and comprehensive broad based care in the hospital, hospice or even extended care setting. If well designed, hospitalist programs can offer benefits beyond the often cited inpatient efficiencies they bring. John Nelson**,** MD is perhaps the nation's preeminent expert on hospital medicine practice management. A practicing hospitalist since 1988, Dr. Nelson co-founded the Society of Hospital Medicine and remains an active figure today in the evolution of hospitalist practice nationally.
Link: http://SHMPracticeManagementBlog.com

On the other hand, states like Texas and California prohibit hospitals from hiring doctors and some physicians want to keep it that way. The purpose is to address rural shortages, but some physicians fear lost autonomy. http://www.ama-assn.org/amednews/2009/08/03/prl20803.htm And, grass-roots medical practitioners like Brian J. Knabe MD, CFP®, CMP™ suggest that hospitalist care is more rightly delivered under the traditional auspices of admitting primary care physicians [personal communication].

Moreover, critics may ask where does an MD's "duty' rest in this model; to the patient or the hospital? So, is this the beginning of the end, for doctors as professionals working in the best interest of their patients?

MANAGED CARE FINANCING

The physician activist Dr. Paul Ellwood advocated coined the term, Health Maintenance Organization (HMO) decades ago. An HMO is a group responsible for both the financing and delivery of health services to an enrolled population.

Managed care is a prospective payment method (providers, hospitals, out-patient centers, vendors and ancillary care givers) whereby medical care is delivered regardless of the quantity or frequency of service, for a fixed payment, in the aggregate. It is not the individual care of the traditional indemnity insurance. It is essentially utilitarian in nature and collective in intent.

Pre-paid medicine is not new but rather was promoted extensively by the precursors of today's managed care revolutionaries, the so-called "Four Horseman of the Apocalypse", (Walter McClure, Clark Havighurst, Alain Enthoven and Paul Ellwood). Since passage of the HMO Act in 1973, the growth of HMOs and Managed Care Organizations (MCOs) have increased enrollment to more than 100 million. This represents an increase of 20 fold within the past decade, with a 10 percent commercial growth rate in prior years. Medicare enrollment is obviously expected to accelerate in the future.

According to Alain Enthoven, PhD, of Stanford University, the term *managed* care covers a wide range of options that differs dramatically in incentives offered to physicians and the methods used to control utilization and expenses.

Structurally, HMO's are often divided into two types, and six sub-types. The two basic HMO types include the *command control* and *empowerment* models. In the former, it is assumed that doctor's need strictly controlled, dominated and micro-managed because they will not take responsibility for managing the quality and cost of medical

care. The latter HMO type assumes the exact opposite of its physicians, giving them more latitude for independent thought and decision-making skills. According to Peter R. Kongstvedt [personal communication, PR Kongstvedt Company, LLC, McLean, VA], the six traditional HMO sub-types are listed below:

- A *Staff Model* HMO is the most restrictive plan, to both doctors and patients, and requires that physicians be employees, treat only it's own members who must be seen at centralized locations and with a closed panel of providers; it is in market decline because of its lack of flexibility.
- In a *Group Model*, the doctors are not employees but may treat non-HMO members and work out of a private office.
- In a *Network Model*, the HMO contracts with the MDs who may or may not have an exclusive relationship with it, and may be in a closed or open panel.
- An *Independent Practice Association (IPA Model*) is built around a group of independent physicians who retain the right to see other patients and exist in an open panel who have doctors retain their own separate self administered offices.
- In a Direct *Contract HMO*, the provider's practice is similar to the IPA model, but the HMO administrators have a direct contract with each participating MD, who may or may not retain the right to see non-HMO patients and practice in a variety of settings.
- Finally, the least restrictive *Mixed Model* HMO, represents a combinations of the above five HMO types.

Nevertheless, premiums and HMO deductibles continued to rise. This chart suggests an annual rate of 15% percent in the past decade for co-payments alone.

[Insert Table 1.1]

Employee Retirement Income Security Act

When dealing with the major medical programs, one must be cognizant of the Employee Retirement Income Security Act of 1972 [ERISA - IRC 404{c}], which determines whether the third party is an insurance company or an ERISA organization, since state laws through the Freedom of Choice Acts (FCA) preclude discrimination on the part of insurance companies. Since ERISA programs are covered under federal law, they are not subject to the Act. Generally, patients can sue health plans and employers in federal court, though not in state court, for the cost of a denied benefit, legal fees and court costs, but not for compensatory or punitive damages. They can also sue doctors for malpractice in state court. Federal employees may sue the Office of Personnel Management (OPM) in federal court only for the amount of denied coverage, plus attorney and court costs. If it loses, the OPM can obtain a court order to require the insurer to pay. Thus, ERISA has shielded non-governmental health plans from punitive and compensatory damages in state courts. This is known as the "ERISA exemption" and has allowed MCO's to flourish. Moreover, the anti-trust exemption for health insurers [McCarran-Ferguson Act] was not repealed by health reform in 2010 [http://www.whitehouse.gov/blog/2010/02/23/repealing-antitrust-exemption-health-insurance-companies-0].

Preferred Provider Organizations (PPO's)

A preferred Provider Organization (PPO) is a bridge between traditional indemnity insurance and an HMO, and consists of several different types. It attempts to feature the provider choices seen in indemnity insurance, with the non-risk cost reductions seen in HMOs.

Two similar entities, known as and Exclusive Provider Organization (EPO), or Point of Service or Swing Out (POS or SOP) plans, consist of an exclusive provider panel who have agreed to accept a deep discount in their medical fees in return for the volume of patients the plans can provide to them. A combination of the above type models has been very successful for many employers, and this model is not as restricted by the HMO Act. A payment time line for a typical PPO may look something like the following:

Healthcare Provider bills PPO ---> PPO bills company --> Company pays PPO ---> PPO pays Provider

Changes in Medical Payment Delivery Models

As payments have shifted from the older fee for service model, to the newer managed care capitation model, the following differences were also observed

Traditional (Fee for Service) Methodology

Characteristics include:

- Full fee for service rendered as medical payment.
- Illnesses and diseases were treated, retroactively.

- Individual patients were treated.
- Active and acute diagnoses were made.
- Medical care was rendered in the office or hospital setting.
- Referrals to specialist were made in difficult cases.

Contemporary (Managed Care-Partial Capitation 1.0) Methodology

PM/PM Capitation: The Per Member/Per Month medical capitation model requires the payment of a fixed sum of money to a medical provider to cover a defined set of health care services for an individual enrollee, over a defined period of time. Under PM/PM capitation, the doctor assumes the risk for the incidence (utilization rate) of medical conditions requiring procedures specified in the MCO contract. It seems best suited for chronic medical conditions with known disease management guidelines.

Characteristics are listed below:

- Discounted payment from HMO's and MCO's.
- Illnesses are prevented proactively.
- Population cohorts are treated collectively, not individually.
- Chronic diseases are intervened before acute disease exacerbates.
- Care rendered in networks, the home or other sub-acute care facility.
- Outcomes are evaluated based on results, not specialty care.

Under PM/PM capitation, the MD is at risk for: (a) utilization and acuity, (b) actuarial accuracy, (c) cost of delivering medical care, and (d) adverse patient selection.

Manipulating the Capitation Payment Numbers

Since MCO's pay a fixed amount of money, regardless of the quantity of care provided (i.e., capitation), we can begin to explore how reimbursement issues have been dramatically changed under this new payment paradigm.

Example: For simplification, suppose Dr. Kosmicky received a capitated MCO contract to evaluate and the following numbers were supplied to him by the MCO:

- Capitation Range = 5 per 125 cents ($1.25) Per member/ Per month (PM/PM)
- 10,000 Lives @ 30 cents. / Pt / Month / Year
- 5 % Patient Encounter Rate (range = 2.5 - 7.5%)

The following is the financial yield possible from this contract:

- $10,000 (5%) = 500 Visits / Yr. or 41 Visits / Mo. or 10 / Week
- $ 10,000 X .30 = #-3-K Month or 36-K/Year
- **$72 dollar average per New Patient**

NP = 3 Visits/Year average = **$ 24 per old patient visit.**

Now, a capitation analysis might evolve to look something like the following, if he is able to treat the numbers of patients given in the example below, by accepting additional similar contracts.

- $24/Patient X 3 Patients/Hour = $ 72 Hour.
- 72 Patients X 8 Hours = $576/ Day
- $ 576 X 5 Days / Week = $ 2,880/Week
- $ 2,880 / 4 Weeks / Month = $ 11,520/Month

- $ **11,520 X 12 Months = $ 138,240 / Year**

In other words, the provider becomes a quasi-employee of the HMOs, and is reduced to an hourly worker; even though he may yield increased compensation, at the indicated volume demonstrated below:

- 6 Patient / Hours / 48 Day = $ 276, 480 per Year
- 9 Patient / Hours / 72 Day = $ 414, 720 per Year

Also realize that many times, the doctor does not even derive the full $72 economic benefit from new patient visits, since most patients have already been in the existing practice. The result is simply an across the board wholesale fee reduction for the practice.

Dr. Kosmicky also recognizes that this rate is based on averages and he will receive no additional payment if all members of a single contract visit him more than three times a year; nor is his payment reduced if they don't visit him at all. The rate is reasonably close to his normal office fee of $30, so he accepts the financial risk of the contract.

Adoption of Full-Risk Capitation 1.0 *plus*

For some physician's the recent past, and future, might include some "full risk" medical care contacts. This is because of market pressure and the expansion of partial risk PPO contracts.

In the full risk payment system [capitation 1.0 *plus*], the participant agrees to provide "all" of the care for a given patient population or contract. In other words, the MD would have to include services such as diabetic management, trauma, radiology, emergency care, pediatric immunizations, geriatrics, home IV antibiotics, DME and all specialty care in the consideration of this "full risk" contract. Of course, increased benefits accompany the increased risk.

The risks: all medical and surgical care necessary for the contracted population. Since there is the potential for more reward but with much more risk, the physician business executive must carefully consider these contract types and maintain the following relative and negotiated contingencies:

- Stop-loss re-insurance.
- 25-75 mile coverage radius.
- Sub-capitated medical specialists with deep discounts.
- 25-100 providers in the network.
- 100-250,000 patient population, or more (more patients mean less risk)
- Sub-capitated hospitals, surgical centers, pharmacy and DME vendors with discounts.
- Encompass a small (<20-25%) portion of the practice.

Certainty, this system does not bode well for the solo practitioner or even for small medical group practices.

Specific Episode of Care Capitation 2.0 [Condition Specific Reimbursement]

Under the Specific Episode of Care (SEC) capitation 2.0 model, doctors deliver care for specific medical condition on a fixed basis per episode, in order to increase immediate value added benefits. But, some believe this new concept is flawed and is diminishing in favor of a variant called micro-capitation payments; or Condition Specific Reimbursement [Personal communication, Scott Shreeve MD; Aliso Viejo, CA; http://ww.blog.crossoverhealth.com/2009/03/06/return-of-microcapitation-condition-specific-capitation-payments].

Micro-capitation, or other forms of pre-paid care, can create alignment between the patient, the physician, and the payers. But, it only works within an integrated system where everyone is motivated to help keep the patient healthy and can enjoy the gain sharing achieved through higher performance; hence the promise of integrated records and health 2.0**.** "Capitation 1.0″ failed previously because it was just a per-head model, without any consideration for the disease condition, the health status, or the perverse incentives of a fragmented system. Capitation 1.0 *plus*, and Cap 2.0 is still evolving.

MCO Carrier Benefits

Some of the benefits of capitation, and other fixed rate reimbursement derivatives for corporate America (payers), who supply the majority of health insurance to its employees (insureds), are listed below:

- Known medical expenses (fixed; not variable costs) to companies.
- MD/providers bear the risk and benefits of patient compliance, not corporations.
- Less administrative staff needs since medical claims are no longer reviewed.
- Costs are reduced through economies of scale.

- Patients are controlled and medical providers carefully managed.

Medical Provider Benefits

The following is a brief list of the benefits physicians supposedly may derive by participating in managed care plans.

- Stable patient load and predictable cash flows.
- Potential referrals and community visibility.
- Reduced office expenses, liability and utilization review.
- Reputation equivalency (i.e., all doctors in the plan are good).

Point of Service (POS) Plans

Capitation offers the same advantages to Point of Service (POS) plans as it does to HMOs, but is more risky for the provider. The main reason for the discrepancy is medical risk acceptance without considering POS peculiarities. For example, these plans, unlike HMOs, allow out-of-network services and POS managers and providers must then pay the unmanaged outside contractors in addition to the discounted in-service physicians. Re-insurance is useful, but these plans tend to be chronically short of capital and, as a result, should expect higher operating costs than traditional HMOs.

HEALTH CARE ORGANIZATONAL DELIVERY MODELS

The following healthcare delivery models have developed over the last two decade with mixed results.

Physician Hospital Organizations (PHO's)

A Physician Hospital Organization, or PHO, is a blend of private doctors and hospitals, maintaining its concentration and control of surgical, rather than medical care. Ownership may be divided by a governing board, according to a pro-rata basis with the larger partner having most organizational strength and bargaining power in the corporate structure. Typically, this favors the hospital. From a strategic standpoint, most MD's are still not currently aligned with many PHO's, since surgical care is increasing being delivered in private offices or Ambulatory Care Centers (ACs). Additionally, PHOs may become potential MD competitors often lack managed care contracting experience, have inflexible provider networks and may require MD exclusivity in their organization.

Nevertheless, the function of a PHO is to:

- Negotiate managed care contracts
- Negotiate on all health insurance contracts.
- Establish insurance product(s).
- Employ doctors and support staff.
- Consolidate and acquire physician practices.
- Acquire alternative medical practices.

Medical Networks and IPA's

In an attempt to increase market share, and augment profits, some doctors contemplate forming Independent Physician Associations. The IPA Association of America (TIPAAA) is the leading trade association serving IPAs [www.TIPAAA.com].

Some of the benefits of these organizations include: 1. Marketing and advertising benefits with reduced equipment costs through economies of large scale for equipment. 2. The network pays the MD/DO directly. 3. There is no need for individual negotiations. 4. A patient and cash flow stream is available. 5. Collective group autonomy exists [http://www.tipaaa.com].

On the other hand, potential risks include: 1. The MD/DO is not capitated but the physician pool likely will be. This merely means that the per unit price of each medical intervention will likely decrease as individual doctors in the pool competed for its limited resources (managed competition). 2. Variable income due to the managed competition described above. 3. 10-20% administrative fee, payable in cash, to the IPA managers. 4. Reduced and discounted fee schedules. 5. Lost personal autonomy.

Obviously, signs of insolvent networks include: 1. Delayed data entry. 2. Telephone or facsimile delays. 3. Slow payment schedules 4. Poor expense tracking. 5. Insufficient MIS and software. 6. Sparse interest statements or financial information.

Management Service Organizations (MSOs)

Most MSOs for doctors are organized as IPAs. Under such plans, the MD's make the rules, regulations and medical care guidelines, while MSO executives administer those policies. Centralized data is collected and the organization is responsible for utilization review, quality control, and eligibility verification and payment. The MSO is more of a broker, who works for the physicians in the plan, marketing, selling and running it on a daily basis. This leaves the MD's unfettered to provide patient care; for a price that is typically 10-18% of net patient revenues, per month.

A practitioner may be a candidate for an PHO, IPA, MSO or similar organization if s/he possess most of the following characteristics: excellent medical education, management and leadership skills; practices in a large multi-doctor group with rising net income; possess current management information and technology systems with gross margins exceeding sixty percent; provide ancillary services such as a wound care center or ambulatory surgery center; is under 50 years of age and desirous of practicing medicine in the future. Finally, the provider should have some business savvy and practice in an area with relatively weak MCO market penetration. A provider should also consider joining a MSO if his future professional outlook is optimistic and positive.

[START BOX]

HEALTH 2.0 EXAMPLE

An Innovative Primary Care Working-Lab

www.RenHealth.net

For several years, Rushika Fernandopulle MD, MPP and Pranav Kothari MD worked to perfect an innovative primary care practice known as Renaissance Health. Serving as a working lab for innovation, the practice now provides an unprecedented level of service and access to patients, and has been critically acclaimed both locally and nationally as a medical practice model for the future. Based on several years of research at Harvard University, this new-wave practice embodies several innovative features, including:

* Time and focus on preventive care and wellness, including comprehensive annual strategic health assessments with proactive planning to provide resources such as

nutrition, exercise, stress reduction and other counseling to achieve these goals. There is an added ability to directly contact doctors anytime by phone or email, without having to go through receptionists, nurses or other gatekeepers. Often, these interactions substitute for face to face [F2F] visits. Appointments were guaranteed same day, or next day, appointments with no waiting room patients.

* A full spectrum of resources to help patients play an active role in self-care, including 24/7 access to medical record (either online, on a secure key chain, or on paper), educational material and group visits.

* Proactive management of medical conditions - rather than simply being reactive

* Full performance transparency regarding satisfaction, costs and outcome variables

* Optional patient involvement in new services and operations improvement

[END BOX]

DIS-ENFRANCHISED MEDICAL PRACTITIONERS

Despite the above historical review, reimbursement schemes and purported healthcare delivery models benefits, more than anecdotal evidence suggests that MD's are less happy about managed care and the political impact of practice, compensation and their profession, than ever before. There are other reasons, as well:

- Fewer fee-for-service patients and more discounted or private-pay patients.
- More paperwork and electronic scrutiny of medical decisions and claims.
- Lost independence and medical morale.
- Healthcare providers are making less money, as Medicare reimbursements have been annually cut since 2002.

- The profession of medicine feels no longer satisfying.

And in the past few years, the following occurred:

- The Health Care Financing Administration (HCFA) became known as the Centers for Medicare and Medicaid Services (CMS). It is re-organized into three parts. The Center for Medical Management runs the traditional fee-for-service program. The Center for Beneficiary Choices expands the number of Medicare beneficiaries belonging to private plans. The Center for Medicaid and State Operations shares responsibility with state governments.
- For many doctors and hospitals, their biggest liability may be a single unfortunate event that could result in a lawsuit, an HHS investigation, and/or bad publicity from eMR and HIPAA breaches, the Sarbanes Oxley Act or the PATRIOT ACT.
- The executive committee of the Pharmaceutical Research and Manufacturers of America (PhRMA) adopted a new marketing code to govern big pharma's relationships with physicians. Although now voluntary, DHH is urging compliance as critics charge that Direct to Consumer (DTC) advertising results in appropriate prescription patterns, frustrated patients and increased costs.
- Almost one-quarter of US medical students graduate from medical school with $200,000 or more in debt. The median cost of attending a year of medical school is $62,243 at private schools and $44,390 for public schools. Most of the $2.5 billion in financial assistance comes in the form of non-subsidized loans, while few top schools have the resources to discount tuition for students from lower-income families. The steep costs may discourage low-income students from going to medical school, and

sway graduates toward higher-earning specialties like radiology, surgery, invasive cardiology and gastroenterology; and away from lower-paying ones like primary care; well-know for sparse compensation and long hours. [Source: New York Times, December 19, 2008].

RECENT HEALTHCARE POLICY ISSUES

In 2010, and for the last decade, Uwe Reinhardt PhD, the James Madison Professor of Political Economics at Princeton University in New Jersey, and an opponent of MCO liability, opined that in the near future there will be a three tiered financial system of medical care in the US. The bottom tier will consist of the uninsured and uninsurable (approximately 15-45 million until health reform related insurance commences in 2014-2018), the middle tier will be served by managed care organizations, and the top tier will continue to demand traditional (indemnity) fee-for-service medicine.

Regardless of future model(s) of care, the policy goals of any optimal healthcare economic policy should include the following characteristics: (1) low demand barriers of price, travel, wait time, referral ease and electronic connectivity, (2) adequacy of supply regarding medical personnel, clinics, drugs and equipment, (3) technical efficiencies such as service mix, (4) public expenditure control with tax reductions, and (5) quality of care for the common social good.

And so, a review of several prominent but flagging healthcare policies might provide some useful ideas for the future.

Special Waivers

Some state governments applied for, and received, special waivers from the federal government (Kathleen Sebelius – Secretary, Department of Health and Human Services) forcing more than 22 million Medicaid enrollees to various managed care risk plans. The resulting fixed payment methodology is usually varied, with states using a "take-it-or-leave-it" or "bid" payment methodology to further reduce costs. Under the former method, states offer the same payment structure to all HMO plans. Under the latter method, HMO plans submit a proposed payment schedule within the states pre-defined range, preventing lowball underbidding (promoting under utilization) or over-bidding (promoting excessive profits). Unfortunately, pricing floors and ceiling may be effectively created in this manner as bad debt expenses slowly increase.

Development of Social HMOs

This type of HMO offers extended coverage for some of the unconventional expenses associated with senior healthcare, such as transportation and in-home day care not covered by traditional MCOs. Many are now extinct.

Proliferation of Fraudulent Faux ("Mirror") MCO Schemes

A silent, non-directed, ghost, blind, *faux*, or "mirror" PPO, HMO, or other provider model is not really a formalized managed care organization [MCO] at all. Rather, it was simply an intermediary attempt, and Ponzi-like scheme, to negotiate practitioner fees downward, by promising a higher volume of patients in exchange for the discount. Of course, the intermediary [discount-broker] then resells the packaged contract product to any willing insurance company, HMO, PPO or other payer, thereby pocketing

the difference as a nice profit. Sometime, these virtual organizations are just indemnity companies in disguise. As part of a silent PPO scheme, insurers try to pass off the discount as legitimate on Explanation of Benefit [EOB] forms. Physicians should not fall for this ploy, since pricing pressure will be forced even lower in the next round of "real" PPO negotiations! Medical providers should also be on guard for silent HMOs, MCOs and any other silent insurance variation, since these virtual organizations do not exist, except as exploitable arbitrage situations for the middleman.

Collapse of Medical Labor Unions

Healthcare journalist William F. Shea opined a decade ago that there were numerous psychological barriers against the formation of physicians union [personal communication]. These included (1) public perception of doctor's as a "cut above" ordinary workers; (2) doctor's attempts to wrap collective bargaining in a mantle of patient's rights that lacked credibility; and (3) the highly educated physician's ability to re-engineer and seek alternate employment opportunities rather than accept the salary scale or lack of autonomy present in restrictive managed care entities. Time has proven him correct as MD resignation, through individual re-deployment and/or innovation, has been more effective than "strike", if called by one practitioner at a time.

ASSESSMENT

Unfortunately, among professional people like accountants, attorneys and especially physicians, there is a misconception that whatever they do is so uniquely creative and important that it can't possibly be reproduced in a computer system, or

placed in the internet "cloud" where it can be easily and cheaply accessed by mere mortals. Yet increasingly, some healthcare services can indeed be delivered thru this channel. Obviously, this is bad news for doctors and medical students who spent a lot of money, time and energy to acquire medical degrees with the expectation of high salaries.

For some physicians, the fall from intellectual and economic grace is hard to swallow after so many decades, and from such a seemingly arrogant and self-important breed of worker. Nevertheless; according to Harvard's Henry Lee Professor of Economics, Claudia Goldin, PhD; "the lesson of the past is that we have to remain sanguine about income inequality" [personal communication]. The current economic and competitive crisis is not intrinsic to medicine and will surely pass, ingratiating those courageous and risk tolerant enough to change, while steam rolling over those who are too weak or risk adverse accommodate to new ideas. Of course, just how sanguine and optimistic you should be depends on how you practice medicine today, or how you hope to practice in the Health 2.0 era. History does seem to suggest however, that it is clearly possible for the declining wage premiums enjoyed by today's cognitive "physician elite" will continue to shrink, and that medical related labor unions to the contrary, will have no impact one way or the other, on physician economic survival in the future.

CONCLUSION

In the short term, the most practical way for physicians to regain their place as "conductors of the nation's emerging new health 2.0 symphony" is to master the concepts of health economics and finance, third party reimbursement, insurance coding and compliance, accounting, health information technology; marketing, advertising, patient

relations management, and especially new-wave social media, participatory medicine, e-collaboration and the related business management and competitive analysis skills contained herein. The remaining chapters of this book will assist in this endeavor.

COLLABORATE NOW: Continue discussing this chapter online with the author(s), editor(s) and other readers at: www.BusinessofMedicalPractice.com

Readings and References:

Chretien, K, Greysen, R, et al: Online Posting of Unprofessional Content by Medical Students. JAMA: 2009; 302 (12):1309-1315.

Dranove, D and Ludwick, R: Competition and Pricing by Nonprofit Hospitals: A Re-assessment of Lynk's Analysis; Journal of Health Economics 18 (November: 87-98, 1999)

Ginn, G, and Hetico, R: Improving Operations Management to Achieve Strategic Objectives. In, Healthcare Organizations [Financial Management Strategies]; Specialty Technical Publications, Blaine, WA 2009

Graham, J: The Federal Trade Commission and Physician Practice. Medical Practice Management: (March/April 259-262, 2005).

Kongstvedt, Peter: Managed Care: What It Is and How It Works (Managed Health Care Handbook, Jones and Bartlett Publishing, Sudbury, MA, 2008.

Marcinko, David E: Status of Doctor Medical Unions: In, Financial Planning for Physicians and Healthcare Professionals. Aspen Publishers; New York, 2003

Marcinko, David E, and Hetico, Hope R: Dictionary of Health Insurance and Managed Care. Springer Publishing Company, New York, NY, 2005

Marcinko, David E, and Hetico, Hope R: Dictionary of Health Economics and Finance. Springer Publishing Company, New York, NY, 2006

Marcinko, David E, and Hetico, Hope R: Dictionary of Health Information Technology and Security. Springer Publishing Company, New York, NY, 2007

Marcinko, David E, and Hetico, Hope R: Analyzing and Negotiating Cost-Volume Profit Medical Contracts. In, Marcinko, DE [Editor]: Healthcare Organizations [Financial Management Strategies]. Specialty Technical Publishers, Blaine WA, 2010

Reinhardt, Uwe: Hidden Costs of Health Care. NPR, Fresh Air, WHYY Washington, DC Marcy 11, 2009

Robert Wood Johnson Foundation: IOM Suggests 20 Indicators to Track U.S. Health, RWJF, Princeton, NY, 2009

Senterfitt, B, and Farrer, J: Silent PPO regulation under increased scrutiny. Managed Healthcare Executive, page 9, October 2009

Additional Readings

Birkenshaw, C: Handbook for Hospital Billing. AHA Press, Washington DC, 2010

Brown, F: ICD-9 CM Coding Handbook for 2010. AHA Press, Washington DC, 2010

Chaff, LF: Total Health and Safety for Healthcare Facilities. AHA Press, Washington DC, 2009

Gerber, K: Fundamentals of the US Healthcare Delivery System. AHA Press, Washington DC, 2009

Hilbert, J: Strengthening Ethical/Wisdom Tools for Transforming your Healthcare Organization. AHA Press, Washington DC, 2008

Hilbert, J: Total Health and Safety for Healthcare Facilities. AHA Press, Washington DC, 2009

Maulik, S and Horack, B: Healthcare Transformations. AHA Press, Washington DC, 2009

Manioin, J: The Engaged Workforce: Proven Strategies to Build a Positive Healthcare Workplace. AHA Press, Washington DC, 2008

Table 1.1
HMO Co-Payments Rise [1999–2010]

Copayment	2009	1999
$5	6%	23%
$10	16%	60%
$15	29%	12%
$20	30%	1%
Other	19%	3%

Source: Kaiser/HRETHRET Survey of Employer-Sponsored Health Benefits
www.kff.org

THE END