Downside UP

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Systemic Change in Health Care: Failed Opportunity or Impossible Dream?

I have just moved to Oregon. My toe has become infected. I need to fill a prescription for an antibiotic under my health insurance plan with supposedly national coverage. I go to one of the listed pharmacies but they have no concept of how to enter me into the system. "It may take an hour." I try another pharmacy which suggests I get it filled under their generic drug program which actually charges less out-of-pocket than my health plan co-pay. Huh?

I am having hip replacement surgery. The surgeon prescribes five pre-operative blood tests. The hospital warns me that Medicare will pay for three but will declare the other two "medically unnecessary" and not pay for them. The hospital, however, requires all the tests the doctor prescribes or the it won't let me have the surgery. I have to sign a statement saying I will pay for the tests out-of-pocket.

My insurer has a contract with a national laboratory chain to which I have to go to get coverage but without ever having to pay more than the co-pay. The lab regularly bills $100, the insurer discounts it to $25, I pay $18, and the insurer pays $7. This time, however, I receive a bill for over $600 because the insurer and the lab don't agree on the coding of the tests. Within a month, the lab has referred the bill to its subsidiary collection agency. Every month for six months I am on the phone to both the insurer and the lab before it is finally settled correctly -- that is, the way I knew it should be.

I belong to a PPP – a participating provider program -- where I pay only a co-pay if I use a participating provider but a deductible plus 20% of the "usual and customary" charge if I don't. During 2007, I was in the hospital for 51 days. To this day I am bitter about one doctor who showed up almost every day of what was my longest stay, almost 40 days. I was almost all the time drugged out in la-la land, too weak to check on his participating status. My wife was far too stressed to check. He would be there for five minutes tops. We never asked him to come. We don't know who did. Then the bills came. About $40 a minute: $130 to $345. He was not a participating provider and totally exploiting the system and the patients. By contrast, another specialist but a participating provider – who actually stayed and consulted, and was very helpful to us – charged $120 to $180 – and was paid $49.68 to $70.67 (too low: also a problem).

The worst exploiters of the pricing system in St. Augustine were the radiologists, pathologists, and anesthesiologists. As exclusive providers of the hospital's services in their specialties, they functioned as monopolists, shunning participating provider programs to charge whatever they wanted to patients who had no choice. Anesthesiologists sometimes end up being paid more than the surgeons on the same operation, which would be heart-rending if the surgeons were not, in turn, way

overpaid relative to primary care physicians – in family practice, pediatrics, gynecology, and internal medicine.

Three days out of the hospital from my cancer surgery, I was back in the hospital and in the emergency room with 48 hours to live or die. It would be nice to say that I lived because of the heroic accomplishments of American medical care. In fact, I lived because I was lucky enough to have a daughter who was a doctor. Emergency care was contracted out to a company in California which contracted in turn with local people working up to 36 hours straight. Only because my daughter was a doctor was she able to convince the staff that the problem was not that my kidney had failed but that my catheter was not inserted properly. It took her 24 hours to convince them, but with her help, they finally reinserted it.

Multiple Payers & Multiple Rules: Creating an Administrative Nightmare

The point of my stories is not that I had lousy health insurance. I had great coverage and only paid a tiny portion of the bills. In American terms, I am one of the health care rich. The point of the stories is that the system stinks. Health care is overwhelmed by a vast bureaucratic quagmire, dispiriting and exhausting, consuming hundreds of hours of untangling by consumers, providers, and insurers. The driving force at every point is profit, fighting over money, which gives a back seat to patient care and leaves all parties frustrated and dissatisfied. (My wife bore the brunt of my mis-billings. Mostly 10's of phone calls going on for over a year.)

Conservative estimates around for years indicate that a good 40% of US health care costs are administrative, mostly battling over pieces of the pie. It is not unusual for providers – hospitals, laboratories, physicians – to have to work with 10, 15, or more payers, each with its own set of billing rules.

I have no idea how many actual pages my hospital bill was. I assume it was hundreds, if not thousands, of pages long as the hospital charged for every individual thing from toothpaste to use of the operating room. The total bill for my longest stay was $188,206.12. Blue Cross, contracted with New York State, paid $64,150.14. What the heck does that mean? Which one was the real cost? Does anyone pay the original charge? Did what Blue Cross paid actually cover the cost and if so, how does the hospital justify charging others more than twice as much?

The same kind of thing happens with physicians and laboratories. Rarely is a participating provider paid what she, he, or it charges. It's the people in no plan with no private insurance and no Medicaid who really get screwed. "Usual and customary" has no meaning except that even participating providers like it to be high because the more non-participating providers charge, the more participating providers can claim and, presumably, get.

Providers hate them all. They hate the government the most because the government is harder to manipulate. But everyone, like the hospital and including the government and other insurers, is playing a balancing game taking into consideration taxes and premiums, high payers and low payers, no payers and low-income payers. In the end, the cost in time, money, equity, psychic energy, and quality medical care is enormous.

The average payment could be a lot higher or the real cost a lot lower if the system itself were not so cumbersome and chaotic.

For-Profit Medicine: Ensuring Poor Health Care

My hip surgeon charged Medicare $3,428, $1,371 of which was approved. He does eight operations a day, two to three days a week, running two operating rooms simultaneously. Even at the lower rate, 20 operations a week for 50 weeks a year would yield over $1.3 million a year. A lot of expenses come out of that, including the staff to process bills, but on top of that he is paid more by other payers and has office hours. In fact, net annual incomes in the high hundreds of thousands are not uncommon for surgeons and $1.3 million a year not terribly unusual.

It should be no news to anyone that primary care physicians don't get anywhere near as much – in the $150,000 to $300,000 range. Yet primary care physicians are on the front lines in the battle to educate about, diagnose, and prevent disease. Notoriously, we have too many specialists and not enough whole-human care people. We get what we pay for.

The current system is not only inefficient in its operation, it is counterproductive of quality health care. Every study I know shows that, in a given city or region, the more back surgeons there are, the more back surgeries there are and the more back surgeons charge. From hysterectomies to caesarian sections to arterial stents, the United State does more procedures than any other country per capita, huge numbers are unnecessary, and many do more harm than good.

When it comes to health care, the market economics which works very well in, say, home improvement products, absolutely does not work in health care. To the contrary, where the supply of specialists is large, some kind of culture develops to spur more medical demand in the face of rising prices. Apparently, if Wáng Yù had back surgery and she loved her surgeon and thinks he did a great job, then Ricardo wants that surgery too. Contrary to the rhetoric of "patient choice," this system proceeds in ignorance of scientific evidence and without regard to either necessity or benefit relative to risk.

In the American system, doctors are paid according to the number of procedures they perform, again whether they are medically necessary and beneficial or not. Medicare was likely right about my "medically unnecessary" blood tests but the hospital profited from the doctor's prescription of them. In a group practice, it is not unusual for the group to put pressure on a colleague who is less "productive," that is, orders fewer procedures than the rest of the doctors. As for spending more time with individual patients, counter incentives reign supreme. The trend of group practices to have their own labs rather than "lose" patients/revenue to regional labs is inefficient and costly – though I admit also convenient for both patient and doctor.

The list could go on. Suffice it to say that prevention is absolutely <u>not</u> rewarded in the American system and for all the rhetoric about preventive care, it is not going to happen when individual providers in fee-for-profit medicine lose money doing it. Many, if not most, doctors still get into medicine to serve society but the world does not encourage them to act that way.

Finally, none of this touches the enormous rewards and incentives for private capital invested in pharmaceuticals, equipment, prostheses, insurance, and even hospitals. There is a reason why a lot of folks, from surgeons to drug companies, like the system the way it is. Insurance companies moan about how hard it is for them to make a profit in the present system but lobby like heck not to change it. My

observation is that high tech procedures, drugs, and devices are the most likely to be reimbursed at little or no insurer discount, even by the government.

It is astounding to realize that under the Bush regime, privatization ideologues, in the name of "efficiency," pushed private sector alternatives to Medicare -- so-called Medicare Advantage (MA) plans. But, to entice the private sector to participate, traditional Medicare recipients ended up spending billions of dollars a year subsidizing the 14-20% higher costs of MA programs! This is the kind of change the big players in health care want: more government money for more people in the same stupid system. That means more profit.

Obama: Misdirected Efforts

There seems to be growing evidence that Obama wants not only to provide health care for all Americans but sees savings in health care costs as a means of paying for the enormous expenditures he is making in infrastructure and the environment. Unfortunately, the things he is talking about doing are not likely to produce anything like the savings needed just to pay for health care for all Americans. Obama is going for high-hanging fruit on the fringes of the American health care disaster because he has backed out of a struggle to change the fundamental problems of chaotic multi-payer administration and for-profit medicine.

I would love to be able to walk into any pharmacy in the country and walk out with my prescription but computerizing health records needs to follow from, not precede, creation of a single payer health care system. Without that, computerization will more likely just computerize chaos – and cost a whole ton of money. Wellness programs, preventive medicine, comparative effectiveness programs (surgical outcomes, hospital death rates, actually doing science-based medicine) will not work if all the incentives are left the same.

When it comes down to it, what I see moving through Congress is not a new system so much as more money thrown at the same failed system. This would be a remake of Medicare which did indeed provide health care for millions of Americans over 65 but it also kick-started an on-going and accelerated increase in health care costs. It wrote a semi-blank check for all providers and created a booming health care industry.

Single-Payer: the Alternative No One Dares Touch

With health care, doing less is doing more – and better. Like conservation in the energy field, switching to a single-payer plan should be the low-hanging fruit, least expensive and most effective. That might actually save the kind of money Obama wants to restructure the country.

In France, a French friend reports, a hospital has two rates: outpatient and inpatient. He pays a small amount and the government pays the rest. As in Britain, the government owns the hospitals and everyone is salaried; the focus is on the job. As in the United States, people wait for non-emergency care but that wait is based upon need not money – or lack thereof. By every measure -- access, patient safety, efficiency, equity, and health outcomes, as well as traditional measures such as infant mortality and longevity, the United States pays far more for far less than other industrialized countries. Canada pays less than 60% of what the US pays per capita and the average industrialized country less than 50%.

Not only is a government-owned and run program the best option, below the radar of most Americans, the US Veterans Administration is already running just such a low-cost, efficient, and effective health care program. The VA owns its own hospitals, employs its own doctors, and, over the last decade, computerized its records. The VA program was, for Republicans, so successful, it was too successful. As veterans of Iraq and Afghanistan poured into the system, the Bush Government under-funded it, undermining the possibility that it would become a model for systemic change.

Although a single-payer "Canadian" plan would be a second-best option to government-owned health care, extending Medicare or even adopting a common payment schedule for all insurers would be steps forward. I have found Medicare astoundingly efficient within its own sphere; it only becomes messy and costly where it intersects with private insurance and greedy providers in Plans B, C, and D – e.g. the drug companies and the non-competition drug pricing rule for Part D. Medicare is inevitably subject to the political pressures of lobbying in any public system which preserves private interest groups But Medicare works and works predictably, has an excellent web site where I can check payments, and covers everyone (over 65).

I appreciate what Obama has accomplished and am not going to join the assault from the Democratic Left. I understand that the Democratic Party came to power in part because, under Obama's leadership, it attracted more moderates. I understand that Obama instinctively opts for compromise wherever possible. But on health care, systemic change will only come about if he pushes the envelope. Up to now, he has done some pretty amazing things but at little cost to his political capital. The overwhelming majority of Americans know that drastic things had to be done to get the economy going. The overwhelming majority is glad for his environmental initiatives and that he has changed the face of the country to the world. Now, in health care, it is time to take more of a political risk.

The Political Juggernaut

I am not sure whether Obama understands the kind of structural change that is required, but even if he does, Congress is a huge stumbling block. It is a creature of its lobbyists and an electoral system which, with every state having two senators, is skewed in favor of red states and moderate blue states. California has more than 70 times as many voters per senator as Wyoming. Within the Democratic Party, it is the moderate states of the South, the Middle, and the Mountain West which gave the party its almost 60-vote majority in the Senate. It is ironic but also inevitable that as the Democratic Party broadened its appeal to more moderate voters, those voters, and the people they elected, would increase the drag on progressive policies. The alternative was the one the Republicans seem to have chosen: ideological purity in a shrinking party.

Max Baucus, as chair of the Senate Finance Committee, is the leading force in health care "reform." Over the past five years, he has received $11,600,000+ in campaign contributions to run as an incumbent in that famously expensive national media center called MONTANA -- with 1/40th the population of California! The largest business sector contributor to his campaign coffers is Health Professionals/ Pharmaceuticals-Health Products." He is adamantly opposed not only to a government owned health care program but also to a single-payer program like the Canadian which preserves private practice within a government-run payment plan.

In this political environment, Democrats aren't talking about the Canadian-model. Not even a common set of rules. The best they can propose seems to be: (1) an extension to the uninsured of the federal health plan which I have been a part of and, like the New York State program I belong to now, includes 10's of different plans, and (2) a government-run option to private health insurance, like Medicare and Medicaid with its own set of rules.

The health insurance industry has made a big show of promises to support Obama and cut costs but is already planning to lobby viciously – a la the Hillary Clinton smear – against any government-run alternative: "Do you want the government making your health care decisions." The answer is, it sure beats private insurers making those decisions. The industry will go all out to crush the government-run option for the same reason the Republicans under-funded the Veterans Administration.

I understand the difficulties Obama is looking at but right now, systemic change in the American health care system looks like both a failed opportunity and an impossible dream. I know what happened to the Clinton plan so, if I had to pick a minimalist proposal, it would be a common set of payment rules and amounts for all insurers, leaving it up to them to make a profit by efficiency in administration. My proposal would certainly not be an extension of the federal/New York-style multiplan. Without systemic change, I fear not simply for Obama but for the country and all of Obama's grand plans to transform the American social, economic, and environmental infrastructure.

Ronald Woodbury is the writer, publisher, editor, and general flunkey for all of *Downside Up*. While publication benefits from the editorial advice of one of his daughters, a friend, and occasional other pre-publication readers, they will, for their own privacy and sanity, remain anonymous.

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