Centennial Institute
POLICY BRIEF

# You Want Affordable Care?

## Common Sense from a Practicing Physician

**Centennial Institute Policy Brief No. 2013-2**

**By Jill Q. Vecchio, MD**

### OVERVIEW: WHY WORSEN THE DYSFUNCTION OF MEDICAID?

**The Patient Protection and Affordable Care Act, President Obama's prescription for reforming American health care, could not be more misleadingly named.**

**As the public is beginning to realize, with full implementation of the PPACA law now upon us, it neither protects patients – who face rationing, shortages, and delays – nor guarantees affordable care.**

**It only guarantees higher premiums, higher taxes, and worst of all, degradation of care for many in the most vulnerable groups – older people under Medicare and lower-income people under Medicaid.**

**And now Colorado is about to further overburden its already dysfunctional Medicaid system by massively expanding the rolls with what is perceived as "free money" under PPACA.**

**This policy brief is an attempt to step back and see the big picture on what has made health care unaffordable to so many, and how we can start making it more affordable once again – especially for America's poor.**

**The author writes from a quarter-century of experience in the practice of medicine, and with a physician's sworn purpose to act first and foremost "only for the good of my patients."**

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## WHY DOES HEALTH CARE COST SO MUCH?

We are consistently led to believe that greedy insurance companies and overpaid providers are the reasons for the high cost of health care. That's not so. Rather, the primary drivers of rising health care costs are unnecessary government regulation, onerous billing and coding procedures, state insurance mandates, and layers of bloated bureaucracy. (Medical malpractice liability and the resulting practice of defensive medicine, which also contribute heavily, will be addressed in a forthcoming Policy Brief.)

Perversely, PPACA will drastically worsen all these factors, thus making it even more expensive for providers to administer health care in Colorado and throughout the U.S. After which, the new law purports it will "control" costs… how? By decreasing payments to health care providers and by rationing the amount of care available to patients.

Instead of this Alice in Wonderland approach, why not find ways to lower the administrative costs of health care by cutting back on government regulation, simplifying the billing and coding procedures, eliminating state insurance mandates, and reducing the bloated bureaucracies?

### How Bureaucratic Overhead Crowds Out Patient Care

Medicaid is administered by the states, with each state having some flexibility in how its programs are managed. The costs are shared between the states (which pay 17-50%) and the federal government (which pays 83-50%). Medicaid expansion under PPACA – if a state opts for it, which Colorado appears likely to do – will be 100% funded by the federal government initially, stepping down to 95% in 2017 and 90% in 2020.

But remember that no matter how the costs are seemingly divided, it is all paid for by the taxpayers. The money that comes from the federal government just gets filtered through more bureaucracy and ends up delivering less patient care for more dollars spent.

The Colorado Department of Health Care Policy and Financing has 313 full-time-equivalent employees with a total salary cost of $21,290,686. So our state spends over 21 million dollars on government health care before a single patient has been seen or treated.

***Gone: 700,000 Colorado Medicaid patient visits this year.***

That's enough money for over 700,000 patient visits every year, considering that a typical Colorado Medicaid payment for a doctor's office visit is $30.

Colorado HCPF has increased its number of employees by 18% since 2008, largely because of the increased bureaucracy created by PPACA. Its staffing will increase even further when the PPACA law goes into full effect. Add to this the costs of buildings, furnishings and equipment, utilities, computers, travel expenses, paper and supplies, etc.

### How Government Virtually Sets All Prices for Care

Let me explain how the Medicaid system works from a physician's point of view. For both Medicaid and Medicare, the government decides how much money it will pay doctors for services they provide to covered patients.

The payments for Medicare, *about half the time*, do not cover our costs as providers– so that we frequently lose money when we see Medicare patients. Why is that? Because we have to pay employees to fill out piles of complicated paperwork, pay more employees to make sure that we abide by all of the government regulations, and then pay other employees to properly code for all of our services. Then we have to submit and often re-submit charges, hoping we will be paid within 90 days.

Medicaid is even worse. Doctors and hospitals lose money on *every Medicaid patient they see*. In other words, we pay to see Medicaid patients. Because of that, 30% of doctors no longer accept Medicare and Medicaid patients. (Notably, however, this means that 70% of doctors *continue* to care for such patients, notwithstanding the economic losses involved.)

Because private insurance companies know that we lose money on Medicare and Medicaid patients, they will pay us a bit more to see their patients. When we contract with private insurers like Blue Cross, we negotiate reimbursement for, say "1.4 of Medicare," or 1.4 times whatever Medicare pays us.

The vast majority of our reimbursements are therefore tied directly to Medicare. So, when the government threatens to decrease reimbursement to Medicare providers, it is automatically decreasing the amount we get paid by private insurers also.

***How can free care be fraudulent?***

As this illustrates, the government is actually fixing the price of nearly all health care in this country. Providers are limited in what they can charge and how competitive they can be because of the overhead expenses incurred in complying with an insane regulatory load and burdensome coding requirements.

We are even prohibited from being flexible in pricing. Not only are physicians unable to charge Medicare and Medicaid patients for the balance of the costs of their care, it is actually illegal to undercharge them! In some cases, it is considered "fraud" to provide free care to patients!

**How Breast Disease Illustrates Medicaid's Inhuman Dysfunction**

Consider the convoluted workings of Women's Wellness Connection (WWC; previously known as CWCCI and Waxman programs). This is the program through which dollars are provided for some women's health care – specifically breast disease, which happens to be my specialty.

WWC is part of the National Breast and Cervical Cancer Early Detection Program; administered by Colorado Department of Public Health; and federally funded through the Centers for Disease Control. (That's five layers of bureaucracy for a single government program in one state, and the patient hasn't even been seen yet.)

This system may include a Medicaid patient, if she is diagnosed with cancer. But the patient cannot qualify for Medicaid dollars for treatment unless she has been initially screened through WWC.

In other words, if the patient comes to my breast center with a lump in her breast, and it turns out to be cancer, she can only get Medicaid funding for her treatment if she was already enrolled in WWC on her first visit. But how was she supposed to know that?

Understand, however, that Women's Wellness Connection doesn't actually care for patients—they just decide who gets funding. WWC directs funds to about 120 different provider entities in Colorado, including Planned Parenthood, MCPN, Salud, Tri-Care, Denver Health, etc.

These clinics only provide very basic women's health screening through this program: breast and pelvic exams, PAP smears, etc. They then contract with other providers for services such as mammography, breast biopsies, breast surgery, cancer treatment, etc. (This brings the layers of

bureaucracy to *seven*, with who knows how much money spent, before a single patient gets a single mammogram.)

WWC requires that enrollees must be Colorado residents; in the U.S. legally; between the ages of 40 and 64; have limited or no insurance; have not had a PAP smear or mammogram in the past 12 months; and undergo income testing.

With respect to screening mammography, they abide by a mix of the USPSTF 2009 guidelines and the ACS guidelines: annual screening 50-64 years of age; (no screening below age 50); and patients with breast problems between 40-50 years of age.

To help fill in the bizarre gaps in WWC coverage, the Susan G. Komen Foundation (privately funded) provides grant money to pay the clinics for providing screening mammograms to 40-50 year olds; evaluation of breast problems for women under 40; breast problems in men; funding for patients that can't get Medicaid coverage; and patients in the U.S. illegally.

When the Komen funds run out (which they always do), these patients have real problems. Not because providers refuse to see or care for them. They just can't find a way through the complicated government requirements so they can get funding to pay the doctors who have cared for them.

My personal frustration as a doctor confronting this insane, inhumane bureaucratic tangle is hard to put into words. The system feeds on itself, multiplying complexity as the last unworkable solution begets the next equally unworkable fix.

***One woman, one mammogram, seven layers of bureaucracy.***

The system is supposed to be about the individual who needs care. But too often, instead, the system is simply about itself. Meanwhile, a low-income single mother with breast disease is left as collateral damage. It angers me.

### How Medical Coding Wastes Resources as Fraud Rolls On

Medicare, Medicaid and private insurers all require providers to use special codes relating to diagnosis and tests or treatments in order to get paid for their services. This exceedingly complex system was developed by the World Health Organization and made ridiculous by CMS, the U.S. Centers for Medicare and Medicaid Services.

There are currently about 17,200 test/treatment (CPT) codes used by Colorado Medicaid right now. That doesn't include the diagnostic codes (ICD). A newly promulgated set of those, the ICD-10 codes, increases the number of diagnostic codes from 15,000 to over 140,000.

> **An example of what is now considered "progress" in coding: According to an article in the Wall Street Journal, code W22.02XA is for "walked into lamp post, first episode," whereas codeW22.02XD is for "walked into lamp post, subsequent episodes." Don't you feel better now? It would be entertaining if it wasn't real.**

If the provider uses an improper code, or the diagnostic and treatment codes don't correspond, the provider doesn't get paid. Not that the provider was trying to cheat the system, or that they didn't provide the service.

All it takes is the transposition of two numbers, or a decimal point in the wrong place—simple human error—and the government or insurance company not only refuses payment. *The provider herself can be charged with fraud and ruined.*

According to the WHO website, "The International Classification of Diseases (ICD) is designed to promote international comparability in the collection, processing, classification, and presentation of *mortality statistics*." Yet obviously the vast majority of these codes have little or nothing to do with mortality statistics.

This raises the question: What *is* the purpose of these codes? Whatever that answer is, at least 20%, and perhaps up to 40%, of the overhead in physicians' offices is spent complying with this ridiculous coding system and mountains of ever-increasing government regulations.

***Coding drives 20-40% of doctors' office costs.***

In addition, whenever a new medical device or procedure is developed, a new reimbursement code needs to be developed by the government. This may take years. While waiting, the new technology or treatment, which will very likely improve the lives of patients, as well as saving time and money, will have limited availability – and patients will have to pay cash for it, or providers will use the technology and not be paid for it. Obviously, this limits the development and adoption of new technology, and adds to its costs.

The typical reason given for the coding requirements is "to prevent fraud by doctors and hospitals." This is logical enough. Since the government and insurers have developed a system of health care wherein the person receiving the service and the person providing the service are bureaucratically separated from the person paying for the service, there must be some way to assure that what is charged for has actually been done, right?

Yet the codes aren't stopping the crooks. In 2009 , the *Washington Post* reported that a high-school dropout with a laptop computer single-handedly cheated Medicare out of $105 million by electronically submitting 140,000 fraudulent claims for equipment and services over four years. In 1978, 15 officials in what was then the U.S. Department of Health, Education and Welfare were indicted by a grand jury for fraud.

For a more local example: In 2002, Rocky Mountain Health Plans in Grand Junction, Colorado, received a judgment from the state for about $21 million for underpayment of services by government programs that occurred between 1996 and 1999.

Such instances of fraud, underpayment, and overpayment – and there are countless others, costing untold billions of dollars – are all the inherent result of the unnecessary complexity and anonymity of the current health care system. The incentive to cheat is systemic. No amount of coding can remedy it.

### How State Mandates Needlessly Drive Up Costs

Each state requires that every insurance policy sold there have a minimum list of coverages, called "insurance mandates." This naturally includes the basics – such as emergency care, hospitalization, immunizations, etc. – but each state gets to make its own list from there. The longer the list, the higher the insurance premiums.

According to a study by the Council for Affordable Health Insurance, mandated benefits increase the cost of basic health coverage by an amount ranging from nearly 10 percent in some states up to more than 50 percent in the hardest-hit states (http://www.insure.com/insurance-news/state-health-mandates-grow.html).

In Colorado, a single male is required to have maternity care coverage! Why? Because he thereby subsidizes the premium costs of other people who do need maternity care. Why should so many people have to pay for services that they will never use? These mandates increase the costs of health care to all patients.

### How Managed Care Operations Work (or Don't Work)

Managed Care health provider systems budget a set dollar amount for the health care of each enrollee. If that person's care exceeds the dollar amount, the organization loses money. But if his or her medical expenses are less than the amount allotted, the organization is able to give bonuses to its member providers (doctors).

The organization keeps track of how many patients providers see, and how much care (testing and treatment) each provider orders. If certain providers are judged to have given excessive care to their patients, thereby causing financial losses, they may be administratively or even financially penalized.

Managed Care organizations typically use "Evidence-based medicine" to determine "appropriate" testing and treatments for their patients, and the member physicians are bound to comply with those guidelines.

Managed Care programs focus on cost-containment by limiting reimbursement to providers and limiting care to patients. Consider that it costs money for each administrator, each caseworker, and each employee whose task it is to develop these guidelines, write policy, enact a system to monitor compliance, keep track of compliance, and deal with violations of the guidelines.

The paradox is that while all of this activity certainly *increases* the managed care organization's administrative costs, it may not demonstrably *decrease* the cost of actual patient care – and it adds nothing to the quality of care.

***What? Required maternity coverage for men?***

### How Some States Have Reached for Change

Several states have proposed or enacted various programs aimed at Medicaid reform and/or public employee health care reform. Florida and Rhode Island have requested and received waivers from HHS and have gotten their Medicaid dollars in a form of block grant, whereby the federal government gives the states a lump sum of Medicaid money that they can then spend in developing and operating their own system of health care and reimbursement.

However, these innovations depend heavily on Managed Care organizations in various forms, with capitated payment arrangements to providers. While these models may appear successful in temporarily decreasing costs, their "side effects" include higher administrative costs, the rationing of care to patients, and interference with the decision-making that must be preserved in the doctor-patient relationship.

***Epiphany members save over two-thirds on primary care.***

Bottom line: Is the tradeoff worth it?

### How Private Innovators are Making Dollars Go Farther

A small group of primary care physicians in Florida had a revolutionary idea: they would specialize in providing primary care services at very low direct-pay prices to patients who couldn't get insurance either due to pre-existing conditions, lack of employer insurance, or chronic illness. They call themselves Epiphany Health (http://www.epiphanyhealth.net).

Patients "join" the practice by signing a twelve-month membership agreement. This is *not* insurance. For $83 per month, with a smaller additional amount for spouse and child memberships, the Epiphany member receives some basic services, such annual physical examination, annual labs, EKG, flu shot, and up to 25 additional visits.

If patients need additional tests, these doctors have gotten special pricing arrangements with local imaging and laboratory services. Here is a partial listing of their comparative prices:

| Test | Regular Charge | Your Cost as a Member |
|---|---:|---:|
| Nuclear Stress Test | $1,470 | $520 |
| CT of the chest w/contrast | $940 | $211 |
| Carotid ultrasound | $425 | $120 |
| MRI lumbar spine | $1,305 | $291 |
| X-ray of the knee | $130 | $21 |
| Bone density test (DEXA) | $175 | $25 |
| Additional labs | $70-180 each | Most around $10 each |

How is Epiphany Health able to provide so much service for so little money? It's very simple, and a concept that any businessperson could explain: excellent cash flow and low overhead. The reason they get such low pricing on imaging and lab tests is that they pay the imaging center and

lab directly for all of the services their patients have received at the end of each month. The providers don't have to bill each patient, or bother with keeping track of receivables for anyone other than Epiphany.

Epiphany has steady income from the monthly premiums, and they don't have to pay employees to comply with government or insurance company paperwork, coding, or overbearing regulations. Health care decisions are made between the doctor and the patient, as it should be. If a patient needs or wants to see a specialist, they can choose from a list that gives Epiphany patients special discounts, or they can go elsewhere. Patients with HSAs and catastrophic coverage can be members as well.

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## SIX SIMPLE STEPS FOR TRULY AFFORDABLE CARE

### 1. Offer Health Savings Accounts and Catastrophic Coverage

A popular (but politically embattled) way to markedly decrease the costs of insurance premiums is by using Health Savings Accounts with coverage for catastrophic medical events. Our car insurance doesn't cover oil changes or new tires; it is there for major events like collisions and personal injury resulting from them.

When insurance covers all of our medical "needs," we are more likely to overuse it, eventually coming to believe that we should never have to pay out of our own pocket for anything. When we do pay out of pocket, we re-examine our "need" for that service.

***Health insurance isn't auto maintenance.***

Why not offer Medicaid patients a plan that gives them a set dollar amount in a personal health savings account—one that can only be used for medical expenses? They can use that money to purchase an insurance plan that best fits their needs. Options could include managed care plans, plans like Epiphany Health that could be set up, or an HSA with catastrophic coverage.

After the client pays her premium, whatever is left over stays in her account. She can use it for out-of-pocket services or future premium payments. Arrangements could be made for clients to take any leftover monies with them in this account when they get on their feet and leave Medicaid rolls. This would allow them to continue their health care coverage and have a base for ongoing insurance.

### 2. Post Prices for Services

Fellow doctors, here's an idea: Instead of our current system of hidden costs and prices, let's all just post our prices for the services we offer. We post our prices, and that's what we get paid.

Let the patients decide what they are willing to pay for—let the patients, through their purchasing decisions, ration their own healthcare.

***Competition always benefits consumers.***

If the doctor recommends a test or medication that's too expensive, the patient can ask them to consider alternatives that cost less. If one hospital charges $1,000 for a CAT scan and the center a few miles away charges $400, guess what—the patient will go where it's less expensive. And we all know what happens to prices when everyone can see them—they go down.

Some pundits claim that the free market has failed in health care, and that's why we have to have ever-greater government control of it. But actually, the reverse is true. The free market hasn't been allowed to operate in health care for over 50 years – and that is why we are in our current situation.

### 3. Eliminate Coding Requirements

As explained earlier, these codes burden providers, increase health care costs, and do not prevent fraudulent charges. Again, consider the analogy with automotive repair. When I take my car in for service, the mechanics do an evaluation, make recommendations for service, and give me an estimate of what it will cost to perform those services. I can choose which services I am willing to pay for. When the service is complete, I confirm the charges and pay my bill.

It's the same with most service industries, and there is no reason it can't also work for health care. Patients are not going to pay for a service they did not receive. If they are not satisfied with their care, they can complain directly to the provider. If there is a complaint under the current system, the patient has to try to navigate an incredibly complicated government maze. Visit a Medicaid blogsite some time and read the comments posted by patients.

An additional benefit to the elimination of coding requirements, and allowing Medicaid patients to purchase insurance from private providers, will be the ability to eliminate most of the administrative positions in the Medicaid state offices. No more fee-for-service paperwork and no more coding confirmation requirements.

### 4. Eliminate State Insurance Mandates

We've seen how state mandates force patients to pay for coverage they will never use. Instead, let patients choose the plan that best fits their lifestyle and budget. This would decrease premium costs significantly, allowing more people to afford basic insurance. It will also help minimize costs for patients who make healthy lifestyle choices such as weight control and smoking cessation.

### 5. Put Decisions in the Hands of Patients and Physicians

Health Savings Accounts allow patients to make their own decisions about their health care, rather than an insurance company or the government. Of course, if the patient chooses a

managed care organization for his care, he will be subject to its rules and rationing, but that will have been his own decision. If the patient wants a specific medication or service, he pays for it.

And since providers will have the prices for their services posted for all to see, patients know how much their care will cost. They will be able to negotiate with providers and shop around for the best deal, just like they already do with other consumer purchases. Since providers' prices will be public, competition for business will drive those prices lower and lower, just like other consumer industries.

An additional benefit to this system is that of cash flow. When providers know that they can be paid for services at the time those services are rendered, they will be far more likely to want to participate in the program, and access to providers will expand. Decreased overhead from elimination of coding and time-consuming government paperwork will allow providers to decrease their costs even further, generating savings that can be passed on to patients.

### 6. Don't Entrust Pre-existing Conditions and Chronic Illness to Bureaucrats

HSAs and concierge practices like Epiphany Health are excellent options for those patients with chronic illness. And for such situations, the law should provide that insurance companies cannot charge higher premiums for pre-existing conditions if the patient has had continuous insurance coverage and is only changing carriers, or if he is a first-time Medicaid enrollee.

If premium bids for some patients with high medical cost needs exceed the available allotment, why not enlist community churches, hospital foundations and private charitable organizations to subsidize those premium cost? In addition, remember the example of Epiphany Health that actually *specializes* in patients with chronic illness and pre-existing conditions.

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## CONCLUSION: OUR MORAL OBLIGATION TO DO BETTER

Finally, consider how all the common-sense reforms we have discussed would benefit the less fortunate among us – those for whom the Medicaid program was originally established in 1965, and whose needs were so often cited during the Affordable Care Act debate in 2010.

Overall health care costs would be brought down by reducing the costs of providing care and allowing patients more flexibility and control over their health care dollars. Competition would drive prices even lower, similar to what has happened to cosmetic surgery and Lasik eye surgery over the past 15 years.

Patients with chronic illness and Medicaid patients could have a Health Savings Account with which they could purchase a membership in a practice like Epiphany Health, as well as a private insurance policy for catastrophic events. Pre-existing conditions would cease to be a problem.

And suppose that charitable organizations, churches, or even individuals could set up HSAs and donate money from them (only to be used on medical expenses) to those in need. Let Americans get

***Don't forget the less fortunate.***

back to taking care of their neighbors—without a wasteful government middleman.

In short, if Colorado were to take the six simple steps recommended above, we'd find there were plenty of providers willing and eager to care for our Medicaid patients. We'd restore to Medicaid patients the self-determination of controlling their health care dollars and decisions, and the dignity of being responsible for the consequences of good or poor lifestyle choices. *And we'd see overall health care costs go down.*

Most Medicaid patients could then be moved into the private sector of health care providers. Most administrative positions in the state Medicaid offices would no longer be needed, freeing up more money for direct patient care.

In addition to positions no longer needed because we are posting our prices and freed from using ICD and CPT codes, there would be no more filing for federal Medicaid dollar matching, since we'd be under a block grant. There would be no more complicated contracting with providers and no more confusing programs with multiple layers of bureaucracy.

I am not the first to propose the privatization of Medicaid, nor to suggest block grants and many of the other ideas presented here. As a physician, however, I have seen how the current system operates, and I've talked to the patients who have to deal with it every day.

> **Not only can we do better, I put it to you that it is our moral obligation to do better. Better for the patient, not for the bureaucracy.**
>
> **The government created most of the problems with the current system. We should not be looking to them to fix it.**

The government is great at adding more programs, while at the same time touting the need to "streamline" and "add efficiencies." It's a shell game. What I am proposing here is real streamlining, real efficiency, and something that could really work, while maintaining the most sacred aspect of health care: the doctor-patient relationship.

Administrators don't give quality care, physicians and nurses do. Forcing providers to lose money caring for government patients in the name of "moral obligation," when the government bureaucracy that administers these programs is bloated and wasteful, is hypocrisy. Providers will stop participating in these programs, and patients will have an even more difficult time getting access to appropriate care.

Real reform is best accomplished at the state level, where administration can be kept in check and solutions can be tailored to the unique needs of the communities. Let's create an environment that is financially sustainable, minimizes expense, minimizes bureaucracy, and provides the best care possible.

**Want affordable care? There you have my common-sense prescription.**

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