Politics and Healthcare

Here's how legislative actions have affected medicine.

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In order to accurately assess the rising costs of healthcare, we need to go back 110 years and follow the economics along with the politics. The real healthcare crisis in the United States did not start until 1965. The government increased demand with the passage of Medicare and Medicaid while restricting the supply of doctors and hospitals. Healthcare prices responded at twice the rate of inflation. Milton Friedman, the Nobel prize-winning economist, wrote that medical price inflation since 1965 has been caused by the rising demand for healthcare coupled with restricted supply. Policymakers in Washington either support the monopolization or the rationalization (Single-Payer System) of healthcare.

Since the early 1900s, medical special interests have been lobbying politicians to reduce competition. By the 1980s, the U.S was restricting the supply of physicians, hospitals, insurance, and pharmaceuticals by subsidizing demand. Since then, the U.S. has been trying to control high costs by moving towards something perhaps best described by the house budget committee by stating the following: "Into many areas of the economy, especially energy, housing, finance, and healthcare, free enterprise has given way to government control in 'partnerships' with a few large or politically well-connected companies." Looking back, we see major laws and other policies implemented by the federal and state governments that have interfered with the healthcare marketplace.

The American Medical Association, back in the year 1910, lobbied the states to strengthen the regulation of medical licensure and allow their state AMA offices to oversee the closure or merger of nearly half of the medical schools and reduce the class sizes. The states were subsidizing the education of the number of doctors recommended by the AMA in 1925. Prescription drug monopolies began after the Federal government started allowing the patenting of drugs. Drug monopolies have been promoted by government research and development subsidies targeted to favored pharmaceutical companies. Buyer monopolies began in 1945, after the McCarran-Ferguson Act was passed, exempting the business of medical insurance from most Federal regulation, including antitrust laws. By 1946, institutional provider monopolization began after favored hospitals received Federal subsidies provided under the Hospital Survey and Construction Act. States also began exempting nonprofit hospitals from antitrust laws.

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From Medicare/Medicaid to Managed Competition

In 1951, employers started to become the dominant third-party insurance buyer after the Internal Revenue Service declared group premiums to be tax-deductible. Nationalization of insurance was started in 1965 with the passage of Medicare and Medicaid, which provided health insurance for the elderly and the poor. In 1972, institutional provider monopolization was strengthened by restricting the supply of hospitals by requiring Federal certificate of need permits for the construction of medical facilities. Buyer monopolization was strengthened in 1974 after the employee retirement income Security Act was passed, which exempted employee health benefit plans offered by large employers from state regulations and lawsuits.

Prescription drug monopolies strengthened in 1984 after passage of the Drug Price Competition and Patent Term Restoration Act, which permitted the extension of drug patents beyond 20 years. At the same time, the government also allowed pharmaceutical companies to "market" to physicians so they would prescribe more expensive drugs. This allowed for further strengthening of prescription drug monopolies, which occurred in 2003 after passage of the Medicare Prescription Drug Improve-

Continued on page 90

Politics (from page 89)

ment and Modernization Act, which provided subsidies to the elderly for medications. Then in 2014, further strengthening of nationalization was evident after the Patient Protection and Affordable Care Act of 2010 was passed, which provided mandates, subsidies, and insurance exchanges and the expansion of Medicaid.

bursement continues to decline. The overwhelming increase in physician associates and nurse practitioners is the government's and insurers' answer to cost containment.

When Obamacare was enacted, it covered about 22 million people and provided subsidies for another 17 million people through Medicaid. Once again, demand skyrocketed without increasing supply proportionately.

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The history of medical cost inflation and government interference in healthcare markets appear to support the hypothesis that prices were set by the laws of supply and demand before 1980. Even the degree of monopolization and nationalization promoted by politicians before 1965 was not enough to cause significant cost inflation and spending increases until demands created by Medicare and Medicaid outstripped the restricted supply of physicians and hospitals. Since the 1980s, the government has used its buyer monopoly power, through its Medicare and Medicaid programs, to effectively set prices and quality controls on physicians and hospitals (underpayments). For the same purpose, the federal and state governments promoted the concentration of private insurance into buyer monopolies (HMOs). The government has also encouraged clinics and hospitals to respond by merging into concentrated provider monopolies while continuing to limit the supply of doctors and hospitals.

These government-private partnerships, called "managed competition," do nothing but control physician reimbursement. When the government sets prices, it has predictably led to reduced quality and rationing of healthcare. Moreover, the bureaucracy has brought standardized care, higher administrative costs, and high executive salaries. Costs continue to rise at double the rate of inflation; meanwhile, physician reimbursement continues to decline. Higher prices and costs with lower quality resulted in calls for nationalization (single payer) by Democrats while Republicans countered with private insurance and tort reforms.

Unmet Demand for Physician Services

Other factors that also contributed to an escalation in demand for physicians and hospital services before and after 1965 have included a growing and later aging population, rising personal incomes, private health insurance, breakthroughs by the American pharmaceutical industry, and advances in electronic and mechanical devices. Unmet demand for physician services has persisted in the following areas: rural and poor urban areas, preventive care, geriatrics, public health services, prisons, drug rehab programs, and military service.

The economic turning point began around 2013, where physician services became the number one growing industry. Healthcare was rendered or overseen by physicians. Physicians controlled an estimated 80% of all healthcare expenses including 70% of hospital costs. The healthcare insurance industry along with the government had to find alternative healthcare providers—enter non-physicians (PAs, NPs).

Between 1965 and 1980, it is unlikely that physicians and hospitals were creating their own demand, since they were busy meeting the additional demands created by the government. In addition, patients subsidized by Medicare remained concerned purchasers who spent an average of 20% of their income on medical care, including purchasing insurance.

Many blame third-party insurance for making consumers less accountable for spending. However, consumers seek to spread risk by purchasing health coverage from third-party payers. Moreover, third-party insurance existed long before the healthcare cost crisis. Since the 1930s, hospital groups like Blue Cross and physician groups like Blue Shield had been offering fee-for-service insurance programs to employers, who then offered them to their employees for premiums.

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Consumers want the most benefits for the lowest healthcare premiums. Insurance companies and self-insured employers want to pay the lowest amount possible to physicians and hospitals. If the healthcare industry was indeed competitive at all supply levels, suppliers would aggressively offer insurers competitive prices for high quality services.

Physician Fees and Hospital Costs

Since 1965, medical prices had exploded with physician fees. From 1965 to 1995, the price for medical care increased by 702% and physician fees 675% compared to only

Continued on page 92

Politics (from page 90)

360% for all goods and services measured in the Consumer Price Index. The lack of competition between hospitals and other healthcare institutions also limited cost control incentives placed on executives. The lack of competition between both medical institutions and the doctors that control most of the spending could explain why hospital costs were inflating twice as fast as physician fees. Hospitals are loaded with waste and inefficiency, and not until recently, with government subsidies declining, have the hospitals started to tighten their belts. In addition, in the last 10 years, a new competitor emerged, in the form of ambulatory surgical centers, forcing hospitals to check their spending.

With the advancement of technology, healthcare insurers and the government began harvesting data. Through electronic medical records and electronic billing, data started to highlight cost-effective providers within healthcare systems. The government instituted alternative payment models, which is a payment approach that gives added incentive payments to provide high-quality and cost-effective care. Alternative payment models can apply to a specific clinical condition, a care episode, or a population.

Alternative Payment Models

Alternative payment models have been evolving with the final goal of reducing or eliminating the fee-for-service model. Merit-based incentive payment system (MIPS) was started, which is a program that determines Medicare payment adjustments using a composite performance score from four performance categories: quality, cost, promoting interoperability, and improvement activities. In 2015 The Medicare access and CHIP reauthorization act was passed (MACRA) which created the quality payment program (QPP) that repeals the sustainable growth rate formula. This changed the way that Medicare rewards physicians for value over volume. Other programs qualified as advanced alternative payment models, e.g., Medicare shared Savings Program, Next Generation Accountable Care Organizations, and Bundled Payments for Care Improvement.

As the new payment systems came into place, private health insurance companies began to use Medicare reimbursement as their base for physician payments. Negotiated rates between the insurer and the physician were being set at a percentage of Medicare reimbursement.

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Between the years 2016 and 2018, data was obtained from five-year studies on the impact of mid-level providers in Healthcare Cost Containment. Data showed a cost savings from 20% to as high as 60% when using physician associates and nurse practitioners. Licensing restrictions for the mid-level providers began to lessen, and nurse practitioners were being given full independent practice privileges in some states. Physician associates and nurse practitioners who have full licenses were given more responsibility.

The insurance industry pushed the government to open more physician associates schools and nurse practitioner schools. As of 2022, there are 287 physician associate schools and 405 nurse practitioner schools. There are 123,644 PAs in practice and 357,000 NPs in practice. The evolution of each is moving at a rapid pace with PAs now doing "residencies" in emergency medicine, acute care and trauma, pediatrics, surgery, oncology and orthopedics surgery, to name a few.

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We are amidst changes in how patients receive their healthcare and how physicians will be receiving reimbursement. Private practice for physicians has slowly withered away. Group practices are starting to see the new changes affect their practices. Whereas at one time healthcare was controlled by 80% of physicians in practice, 70% now work as employees for a hospital corporation. Healthcare provider association's (AMA, AOA) and their petitions, resolutions, and demands are falling on the deaf ears of the government and insurers.

Those providers who have a full license to treat patients will find employment while those with limited licenses will find it difficult to survive financially. Patients will need to be even more aware of who is treating them and if they are receiving proper care. The changes are not over. Patients will continue to pay a heavy price in the form of poor care and expensive premiums with high deductibles. Economic numbers do not lie. **PM**

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