

Chapter 1

[R]evolving Health care Industrial Complex

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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

INTRODUCTION

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 health care administrators. Nevertheless, to the informed cognoscenti, they served as predecessors to the modern health care 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 health care industrial complex is in flux. Physicians are frantically searching for new ways to improve office efficiencies and revenues and grow personal assets because of the economic dislocation that is to say managed care, not to mention the 2007 to 2009 meltdown of the domestic economy. Increasingly, the artificial boundaries between medical practice management, health economics, finance, banking, and technology is blurring in 2010 to 2011 and beyond.

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Mix modern social media and new-wave health 2.0 collaborative business skills, and a disruptive—even transformational—paradigm shift becomes evident. Patients are empowered by it, and doctors are worried because of it. Initially noted by grassroots medical practitioners, then elucidated by electronic citizen journalists like Matthew Holt (<http://www.TheHealthCareBlog>), and finally codified by the Institute of Medical Business Advisors and others (<http://www.MedicalBusinessAdvisors.com>), this emerging philosophy is now engrained in the popular culture. The \$20 billion American Recovery and Reinvestment

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Act (ARRA) of President Barack H. Obama in 2009 provided further political support for health information technology and related management initiatives by physicians to going forward. With the recent retirement of Dr. Robert Kolodner, the National Coordinator for Health Information Technology's, David Blumenthal MD leads the pancollaboration of stakeholders today.

An Imprecise Science

A basic, but hardly promoted premise of this new wave, and all health care business, is imprecision. Nevertheless, we may define traditional health care economics as how the medical industrial complex allocates its limited resources (cerebral input, equipment, IT, infrastructure, time, and financial assets, etc.) to the insatiable appetites of the U.S. consumer, through the natural competitive laws of supply and demand. This occurs because physicians are willing to sell their services, and patients are willing to buy. 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 practices of Dr. Jane Smith and her competitor Dr. Harry Jones. When the price of a noncovered Medicare service is lowered by Smith, her patient load increases and Dr. Jones' volume slows. Conversely, if she raised her fees, Dr. Jones' practice would flourish. This phenomenon, illustrated by market forces or by the "invisible hand" of Adam Smith, can be reviewed from the traditional, contemporary, and futuristic health care economic perspectives outlined below.

TRADITIONAL HEALTH CARE 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 as very few, or 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 service 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 are left at the point where $MR = MC$. This standard business concept holds true absent situations such as monopolies or oligopolies. Once satisfied, health care 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 when 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 MU 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 opt 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 to \$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 health care 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 noncovered service will have its own level of pricing elasticity, and every doctor should estimate that level for all fees, 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 the phenomenon in ratio form:

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

For instance, if a 20% increase in an office visit charge resulted in a 30% increase in quantity of services supplied, the price elasticity would be $30/20 = 1.5$. Therefore, a high elasticity coefficient equates to higher price elasticity. Generally, a coefficient greater than 1

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is considered elastic, and a coefficient less than one is inelastic. Interestingly, exact unity prevails when elasticity of supply is exactly equal to 1.

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 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 types of medical market places.

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, preclude that patient buyers are large enough to 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 earlier 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 does 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, although efficient, are not necessarily timely or applicable in health care. 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 health care practitioner, include, but are not limited, to the following:

1. **Barriers to Entry:** Physicians and other “learned health care professionals” receive an extended formal education. This not only ensures competence and protects the public but also reduces competition. Certificate of Need 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 also raises barriers to entry, making 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:** After medical school, internship, residency, and/or fellowship training, a medical degree and license to practice is an effective strategic advantage over a nondegreed practitioner. AQ2
3. **Monopsony and Oligopsony:** These occur when discounts are extracted from health care providers because of supply and demand size inequalities, and may run afoul of antitrust 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 lifestyle that drive up health care costs for society as a whole.
5. **Mortal Turpitude:** Because 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.
6. **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.
7. **Barriers to Exit:** The increased cost of doing business, effectively precludes many physicians from terminating practice until all fiscal investments are recouped. Observe that few doctors can practice part time today and still afford their overheads. This protects low-quality providers.
8. **Political Fiat:** The government is the largest purchaser of health care 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 health care are well known, but not easily changed.

First, most Americans have group insurance through their employment, and do not even buy 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 by the patient consumer, and hence the doctor has a vested interest in increasing service demand. Lastly, which well-informed person would be a tough bargainer when their health is at stake? Who is going to negotiate with a neurosurgeon?

During the so-called *Golden Age of Medicine*, approximately 1965 to 1990, 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. In addition, the imperfect fee-for-service marketplace, which became a bit more perfectly competitive in the managed care era, will become even more competitive as health care 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 health care 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 Managed Care Organizations, Medicare, Medicaid, etc.), because they’re working for a living”. Women and younger doctors under 40 are especially inclined to work for less, than others, because 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, as one of the fastest growing areas of specialization is hospital medicine. Alternatively, consider the potential economic effect 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 to receive a medical license?
2. Physicians have an increasingly smaller share of the medical marketplace because of extended care providers. Does this help or hinder them? Price information is freely available to all Managed Care Organizations (MCOs) because of computerization, yet doctors cannot collude. Recall the fee schedule surveys that were popular several years ago, or the Internet transparency today. How does this knowledge effect contemporary medical care pricing?
3. Doctors have been defeated in their ability to influence the marketplace by selling a quality, nevertheless standardized, service. Consider the economic effects of practice guidelines and standards, evidenced-based medicine and comparative medical effectiveness 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 because patient demand becomes perfectly elastic at the Health Maintenance Organization’s (HMO) (payer’s) set price. This being the case, there is no incentive to lower fees in an attempt to attract more patients, as doctors would not be able treat any more patients than they would otherwise. The price decrease just lowers income, but has no effect on the number of patients treated. It simply decreases profits.

5. Because MR is the fee obtained from seeing one extra patient, MR becomes equal to HMO price, and marginal profit is zero when MR just equals MC. 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. However, just how long is "short term" anyway?
7. Efficiency prevails when medical services are made available just up to the point where marginal benefits equal MCs. 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 the physicians who are 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 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 versus a local for-profit medical center? Price ceilings often result in an underground black market economy that exceeds legal limits.

Nonprice rationing (i.e., free medical care) on the other hand distributes available services to patients on a basis other than the ability to pay. The most common nonprice 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 macroeconomic 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 Health Care Delivery

Prior to 1970, the health care reimbursement system was not a monolithic complex and most Americans received their health care through one of five third-party organizations: (1) Blue Cross/Blue Shield (prepaids), (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 to 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, 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; however, 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 U.S. Federal Budget will generate a deficit of almost \$1.4 trillion for fiscal 2011 or greater than 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 interoperable 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, paraprofessionals, 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, the Institute of Medicine (IOM) estimated that more than 1,000,000 hospital infections, accidents, and adverse events occurred in 2000. 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. 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 Health Care 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 MDs great incentive to supply care, but the insurers have little control over the care rendered and its associated

costs. Health care cost estimates skyrocketed to more than \$1 trillion, or 18% of GNP, crippling U.S. 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 U.S. population.
- The average life span increased from 70 to 78 years.
- The Medicare Trust Fund ballooned as an accounting fiction because technically the fund holds interest earning U.S. government bonds, representing an accounting surplus of payroll taxes collected minus benefits paid. However, these are very special government bonds, as the trustees cannot sell them on Wall Street and can only hand them back to the U.S. Treasury. This does not increase the size of Uncle Sam's wallet as 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 7 years. The federal portion of Medicaid is growing at 21% each year.
- From 2000 to 2009, Medicare Part B premiums went up by an average of 8% a year. In 2010, Part B premiums were about \$110.50 a month, up from \$96.40, but for only about 27% of those in the program. Most people didn't have to pay that increase due to a "hold harmless" provision in the law. Because 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 health care can be contributed to wide variability in treatment patterns, which could be ascribed only to style and not to patient differences. For example, studies by John (Jack) Wennberg, MD, in the early 1970s at Dartmouth Medical School, shocked the health care community when he discovered that differences in hysterectomy, tonsillectomy, and prostatectomy rates in one county were 30% to 50% higher than rates in adjacent counties. By the early 1980s, Wennberg's studies concluded that new physician incentives 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. These valuable data form the foundation for many of the ongoing efforts to improve health and health systems across United States (<http://www.dartmouthatlas.org>).
- Other causes of spiraling health care costs include voracious consumer appetite, lifestyle drugs, Durable Medical Equipment (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 proactive, rather than retroactive, medical care.

Additionally, iatrogenic factors contributing to health care costs continue to escalate in this new decade. For example, it is now estimated that:

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

Medicare Cost Containment Policies

In the past, Medicare controls to stymie the cost spiral including: (1) increasing Medigap 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 premiums, co-payments, and deductibles (cost sharing); (3) lowering physician assignment fees; (4) screening out unhealthy patients (“cherry picking” and “adverse selection”); (5) reducing the benefits of beneficiaries (rationed care); (6) incorporating utilization review (prospective, concurrent and retrospective) programs; (7) precertifying hospital and ambulatory surgery center admissions with reduced Diagnosis-related group (DRG), Medicare Severity Diagnosis-related Groups (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 prepaid managed care organizations; (14) encouraging the use of high deductible Health and Medical Savings Accounts; (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 health care 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 lose money and benefits. Moreover, as the U.S. 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 unprocessable “dirty” medical claims submissions.
- Provider registration fees and Health Insurance Portability and Accountability Act (HIPAA) electronic data interchange fees.

- National Provider Identifier number fees.
- Electronic medical record (EMR) implementation costs estimated at \$35 to \$7500 per medical practitioner, with proposed ARRA 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, similar to the following formula:

$$\text{Hospital Cost} = \frac{\text{Costs Per Service} \times \text{Services Per Patient}}{\text{Per Day} \times \text{Days Per Admission} \times \text{Number of Admissions}}$$

That is to say, third parties reimbursed hospitals for expenses already incurred, on some retrospective formula based on lower 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

During 1983 to 1984, the Federal Government introduced a prospective payment system for hospital, known as DRGs for Medicare patients. According to this system, all charges were reimbursed on a per diem diagnosis case basis. The model suggested that hospitals would minimize costs because 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, CMS) 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-DRGs. Hospitals that normally discharge faster than average have two choices: (1) to retain the patient until the national average is reached (most likely) or (2) to 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 health care delivery system needed more dramatic changes. A new strategy, known as *managed care*, which is an approach that links the delivery and financing of health care to coordinate 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. However, whether this lofty goal of reducing federal Medicare and state Medicaid spending has indeed been achieved is still debatable (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 APCs, originally termed Ambulatory Payment Groups, that replaced cost-based, or cost-plus reimbursement for outpatient services. Much like DRGs, they changed the hospital and Independent Practice Association (IPA) landscape forever. The Federal Government planned this shift to prospective payments through its Outpatient Prospective Payment System as a result of the Omnibus Budget Reconciliation Act 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 included 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

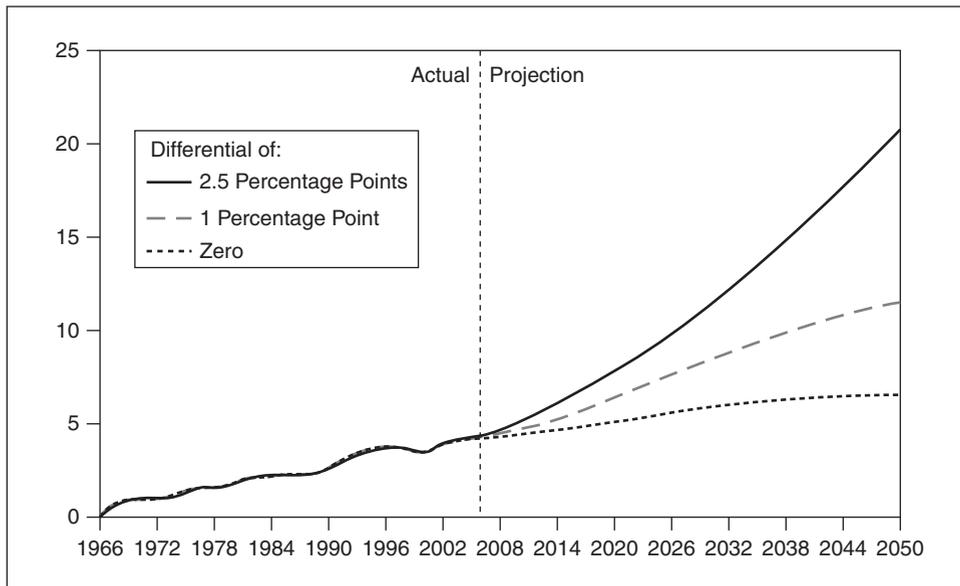


FIGURE 1.1 Total Federal Spending for Medicare and Medicaid under Current Assumptions about the Health Cost Growth Differential. [Source: US CBO 2010].

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 centers, occupational and speech therapy services, mammography centers, and 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 (<http://www.the-hospitalist.org/blogs> and personal communication), who is widely regarded as a leading figure in the modern patient safety movement, and 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. AQ3

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 more than 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. However, 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 cofounded the Society of Hospital Medicine and remains an active figure today in the evolution of hospitalist practice nationally (<http://SHMPPracticeManagementBlog.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>).

AQ4 Grass roots medical practitioners like Brian J. Knabe MD, CFP®, CMP™ (personal communication), suggest that hospitalist care is more rightly delivered under the traditional auspices of admitting primary care physicians.

Moreover, critics may ask where does an MD's "duty" rest in this model: to the patient or the hospital? Thus, 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 and coined the term, 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, outpatient 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.

Prepaid 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 the passage of the HMO Act in 1973, the growth of HMOs and MCOs has increased enrollment to more than 100 million. This represents an increase of 20-fold within the past decade, with a 10% 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.

AQ5 Structurally, HMOs are often divided into two types and six subtypes. The two basic HMO types include the *command control* and *empowerment* models. In the former, it is assumed that the 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 **AQ6** R. Kongstvedt (personal communication, PR Kongstvedt Company, LLC, McLean, VA), the six traditional HMO subtypes 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 its 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 to 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% in the past decade for co-payments alone.

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 preclude discrimination on the part of insurance companies. Because 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 nongovernmental health plans from punitive and compensatory damages in state courts. This is known as the "ERISA exemption" and has allowed MCOs to flourish. Moreover, the antitrust 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>).

TABLE 1.1 HMO Co-Payments Rise (1999–2010)

Co-payment (\$)	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

AQ7

Preferred Provider Organizations (PPOs)

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 nonrisk cost reductions seen in HMOs.

Two similar entities, known as Exclusive Provider Organization, or Point of Service (POS) or Swing Out 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 given type of 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:

Health care 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

Per Member/Per Month Capitation

The Per Member/Per Month medical capitation (PM/PM) 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 HMOs and MCOs.
- 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 subacute 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

Because MCOs 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) 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/year or 41 visits/month or 10/week
- \$10,000 × .30 = 3-K/month or 36-K/year
- \$72 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 × 3 patients/hour = \$72/hour
- 72 patients × 8 hours = \$576/day
- \$576 × 5 days/week = \$2,880/week
- \$2,880/4 weeks/month = \$11,520/month
- \$11,520 × 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 patients/hour/48 day = \$276, 480/year
- 9 patients/hour/72 day = \$414, 720/year

Moreover, realize that many times the doctor does not even derive the full \$72 economic benefit from new patient visits, as 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 contracts. 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 reinsurance.
- 25 to 75 mile coverage radius.
- Subcapitated medical specialists with deep discounts.
- 25 to 100 providers in the network.
- 100 to 250,000 patient population, or more (more patients mean less risk)
- Subcapitated hospitals, surgical centers, pharmacy, and DME vendors with discounts.
- Encompass a small (<20%–25%) portion of the practice.

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

AQ8

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Microcapitation, or other forms of prepaid care, can create alignment between the patient, the physician, and the payers. However, 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 Capitation 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 because 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).

POS Plans

Capitation offers the same advantages to 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. Reinsurance is useful; however, these plans tend to be chronically short of capital and, as a result, should expect higher operating costs than traditional HMOs.

HEALTH CARE ORGANIZATIONAL DELIVERY MODELS

The following health care delivery models have developed over the last two decades with mixed results.

Physician Hospital Organizations (PHOs)

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 MDs are still not currently aligned with many PHOs, because surgical care is increasingly being delivered in private offices or Ambulatory Care Centers. 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 IPAs

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 (<http://www.TIPAAA.com>). Some of the benefits of these organizations include the following: (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 the following: (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 here. (3) Administrative fee, 10% to 20%, 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; and (6) sparse interest statements or financial information.

Management Service Organizations

Most Management Service Organizations (MSOs) for doctors are organized as IPAs. Under such plans, the MDs make the rules, regulations, and medical care guidelines, and MSO executives administer these policies. Centralized data are 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 MDs unfettered to provide patient care for a price that is typically 10% to 18% of net patient revenues, per month.

A practitioner may be a candidate for an PHO, IPA, MSO or a similar organization if she or he possesses most of the following characteristics: excellent medical education, management, and leadership skills; practices in a large multi doctor group with rising net income; possesses current management information and technology systems with gross margins exceeding 60%; provides 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 be business savvy and practice in an area with relatively weak MCO market penetration. A provider should also consider joining an MSO if his future professional outlook is optimistic and positive.

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 any-time by phone or email, without having to go through receptionists, nurses, or other gatekeepers. Often, these interactions substitute for face-to-face 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 their medical records (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.

DISENFRACTISED MEDICAL PRACTITIONERS

Despite the above historical review, reimbursement schemes and purported health care delivery model benefits, more than anecdotal evidence suggests that MDs 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.
- Health care 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 became known as the CMS. It is reorganized 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 Health and Human Services investigation, 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 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 advertising results in appropriate prescription patterns, frustrated patients, and increased costs.
- Almost one-quarter of U.S. 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 nonsubsidized loans, whereas 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 known for sparse compensation and long hours.

 (Source: New York Times, December 19, 2008).

RECENT HEALTH CARE 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 United States. 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 health care 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.

Hence, a review of several prominent but flagging health care 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 predefined range, preventing lowball underbidding (promoting under utilization) or overbidding (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 health care, such as transportation and in-home day care, which are not covered by traditional MCOs. Many are now extinct.

Proliferation of Fraudulent Faux (“Mirror”) MCO Schemes

A silent, nondirected, ghost, blind, faux, or “mirror” PPO, HMO, or other provider model is not really a formalized MCO. 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. Obviously, 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. Sometimes, 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 forms. Physicians should not fall for this ploy, because 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, as these virtual organizations do not exist, except as exploitable arbitrage situations for the middleman.

Collapse of Medical Labor Unions

Health care journalist William F. Shea opined a decade ago that there were numerous psychological barriers against the formation of physicians union (personal communication). AQ10

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 reengineer 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 redeployment 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 health care services can indeed be delivered through 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.

AQ11 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 steamrolling over those who are too weak or risk adverse to 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: <http://www.BusinessofMedicalPractice.com>

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AQ1	Page 1, 2nd para, 4th line	Change correct?
AQ2	Page 5, list no. 2	Please check if the edits to the sentence "After medical school, ..." are correct.
AQ3	Page 13, 3rd para, 3rd line	Please check that all the personal communications carry date, month and year.
AQ4	Page 14, 2nd para, 1st line	Please check that all the personal communications carry date, month and year.
AQ5	Page 14, 8th para, 2nd line	Please check the sentence "In the former, it is ..." as the phrase "need strictly controlled, dominated, and micro-managed because" seems incomplete.
AQ6	Page 14, 8th para, 7th line	Please check that all the personal communications carry date, month and year.
AQ7	Page 15, Table 1.1	Please Table is not cited in the text. Table title has 1999-2010, but the entries have 1999 and 2009. Please check
AQ8	Page 18, from page last, 4th line	Please check that all the personal communications carry date, month and year.
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AQ11	Page 24, 3rd para, 5th line	Please check that all the personal communications carry date, month and year.
AQ12	Page 01, chapter title	Ok to change brackets in title from "R[e]volving" to "[R]evolving"
AQ13	Page 03, 2nd line from bottom	Its not clear how "30% increase in quantity of services supplied" equals to the numerator "% change in total Revenue." Is this correct?
AQ14	Page 03, 2nd line, from bottom	Should these numbers be "30/22 = 1.5"