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National health care reform: Choice Opportunities.  
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# National Health Care Reform: Choice Opportunities

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This issue of the *Journal of Health & Social Policy* will attempt to address the complexities of National Health Care Reform which were presented at the 4th Annual Conference on *Health Care for the Poor and Uninsured*. This conference is composed of academicians, policy makers, administrators and, most important, primary care providers in the form of social workers, nurses, nurse practitioners and medical doctors. From this wide range of perspectives and experiences diverse and conflicting concepts regarding health care reform emerged. This article will attempt to summarize these concepts and meld them, as with a stroke of an artist's paint brush, into a fluid coherent theme. Following this summary will be papers written by the conference's keynote speakers: Dr. Joycelyn Elders, Dr. Marvin D. Feit, and Dr. Michael R. Skeels.

## ***THE PROBLEM***

As almost every citizen in the United States realizes, health care costs are spiraling-a process which the *N.Y Times* described as a "Medical Arms Race." In seven years, Medicare will exceed the defense budget. Thirteen and one-half percent of the Gross National

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Product is spent on health care, as compared to less than 10% for many other industrialized nations<sup>4,5,11</sup> Insurance premiums are so high that they would consume nearly 20% of a family's income that is living at twice the federal poverty level.<sup>9</sup> The goal is obvious: to lower the cost of our health care and bring it in line with other industrialized nations. A simplified approach is to mandate the reduction of all fees by 25%. Unfortunately, many components of the health care system are operating with much less of a profit margin.

Medical care can be divided into several components, each of which contribute equally to a very large and expanding pie. These components are: hospital care, long term nursing home care, pharmacy/prescriptions, allied health and physician care.

The physician component comprises up to 20% of the expenditure pie.<sup>6</sup> The average physician has a 50% practice overhead (not including the physician's salary, and laboratory costs) which includes office rent, malpractice insurance, salaries for an average of three employees, medical and laboratory equipment, computers, electronic billing equipment and disposable supplies. Thus, eliminating all physician salaries would provide less than a 10% reduction in total health care costs, which is only a little more the annual growth in all health care costs in 1991. All the components of the health care system must be addressed in order to accomplish national health care reform.

### ***THE TRIPLE THREAT: SUBSIDIZING MORE PEOPLE AND PROVIDING MAXIMUM CARE WHILE THE COST OF EACH UNIT OF CARE ESCALATES***

#### ***Subsidizing More People***

Never has more government subsidized health care been delivered to the people of the United States. In the minds of most citizens, health care has evolved from a privilege to a right. Recent federal mandates have expanded Medicaid coverage to include 100% of poverty level for mothers, children and certain other segments of the population. Medicare expenditures are also slated for

rapid growth as the aged population increases. At the same time, recent studies estimate that despite our efforts to date, 25% of Americans are still uninsured or grossly underinsured.<sup>11</sup>

Providing care to AIDS patients is another emerging source of expansion and cost in the health care system. AIDS has afflicted more than 230,000 citizens and will cost an average of \$75,000 per patient in treatment costs. The total cost will be over \$17 billion.<sup>10</sup> The illicit use of drugs by pregnant mothers will expose 375,000 babies and will create a projected medical cost of over \$24 billion.<sup>10</sup> And, the Americans with Disabilities Act (ADA) will extend medical care to many additional individuals because the ADA defines disability so broadly as to include heart disease, diabetes and alcoholism under the definition. Further, this act may prohibit insurance companies from using medical criteria as a means of denying coverage to individuals and it prevents rationing of health care based upon type of illness. For example, it may prohibit the withholding of a bone marrow transplant in patients with severe coronary artery disease or AIDS. The ADA was the basis for rejection of the Oregon Health Plan by the Bush Administration.<sup>8,3</sup>

### **Providing Maximum Care**

Over the past four decades health care technology has developed rapidly. Advancements in medical care make excellent press and the American Public demands the application of each new development covered by the media. For example, neonatal intensive care is saving lives. Many babies who would have died in earlier times are now saved. Some lead normal lives, others do not and require lifelong support and habilitation. All of these children receive intensive, even heroic care as they come into our world. On the other end of the life cycle, maximum intervention is often rendered to the aged and terminally ill, creating a situation in which 90% of the Medicare dollar is spent during the last three months of life; and nursing homes, unheard of in the 1800s, represent an increasing population of the health care dollar.

At the same time as the changes just cited above have created more exciting health care and have helped more people to survive and receive it, the American family has become less capable of direct involvement in the care of its members who fall victim to

illness. More Americans are at work today than at any other time in our history. This means that the American family is often composed of two working parents and the multigenerational family is highly mobile with multiple new commitments. For example, lifelong learning is now a fact of life. Most universities report an ever-growing number of nontraditional "older students" and the midlife career change is rapidly replacing the midlife crisis.

Unfortunately, many of these changes mean that the American family has evolved into a social entity which cannot care for its members without contractual arrangements with outside agencies. Furthermore, our culture is not one that makes effective use of the extended family, a family concept that includes not only blood relatives but also a broad support network of others. Although extended families can be found in Amish colonies and certain other church groups, for the most part such arrangements are not viewed as "mainstream American." Neither the traditional family nor the extended family are powerful weapons in our fight to contain rising health care costs.

### *Escalating Health Care Costs*

This third component of our health care problem, escalating costs, is fundamentally different from the first two. While it is possible to understand and accept as humane our society's desire to serve more people and provide maximum health care, no such acceptance is appropriate where escalating costs are concerned. It is very clear that the people of the United States must examine the assertion that they get less than they should for each health care dollar expended. The contributors to this conference offered some food for thought.

### *Medical Malpractice*

Malpractice insurance has become extremely expensive and malpractice reform is needed to accomplish health care reform. At a minimum, a filing of nuisance suits must be prevented and a system must be instituted which allows the majority of the malpractice dollar to go the plaintiff and less to the legal profession. An excel

lent start in this regard would be the adoption of Medical Review Boards (MRB). The MRB would arbitrate disputes and any party which ignored the arbitration by proceeding with a suit would be obligated to pay the other party's legal costs.

An even more pressing issue is the pursuit of higher and higher diagnostic accuracy, irregardless of cost, which is being driven by the threat of litigation. We would like to illustrate the physician's dilemma with respect to avoiding malpractice liability. An example involving the diagnosis of an acoustic neuroma (a tumor of the nerves to the inner ear) is informative.

This tumor is benign, very slow growing, but because of its location, it can slowly compress the brain, eventually over many years killing the patient. In an average month an ear, nose and throat physician evaluates several patients with unilateral hearing loss, one of the symptoms of an acoustic neuro- There is a 0.8% chance of having an acoustic neuroma and good medical practice mandates that the neuroma be "ruled out." There are two tests to "rule-out" this condition, one is to obtain a Magnetic Resonance Scan which is 100% accurate and costs \$1200. The other is to order a Brain Stem Evoked Response, which is 95% accurate and costs \$150. The standard of care, as widely quoted in the literature, is to obtain the MRI scan. However, if a normal ABR is obtained, the chance of having an acoustic neuroma is 1 in 4000. Do we spend the extra \$1000 to obtain an early diagnosis in the " 1 in 4000," or should we wait to see if the hearing loss progresses or other symptoms develop? Should we just repeat the ABR in a year? What if the patient has no medical insurance and must pay for the NM out of much needed family resources? If the physician does not consistently order this test, he runs an increased risk of missing the diagnosis and being sued. This results in many costly procedures being ordered for a small gain in diagnostic effectiveness.

Unfortunately, situations like the one just described occur repeatedly to most physicians and illustrate the pressure placed on physicians in their day-to-day decision making. Dr. Elders, Dr. Feit and Dr. Simmons all expressed concerns about the inefficient use of

expensive technology. Implementation of outcome analysis and "national practice guidelines"<sup>11,12</sup> will help in determining the cost and benefits to the patient along with the usefulness of expensive technology, and will set guidelines as to when this technology should be applied or withheld.

### ***Regulations***

There has been a massive increase in regulations during recent years. Pre-certification, mandatory second opinions, contracts with third-party payers, and intricate requirements for filing claims have all added to health care costs. The most familiar example of this problem is the infamous 52 box form known as the HCFA-1500. This form must be submitted to Medicare using typewritten print, without any errors or corrections, in order for a physician to be reimbursed. An average practitioner might prepare 500 of these forms in a single month.

*It is estimated by the General Accounting Office, that completing the HCFA-1500 form takes 15 minutes, a longer time than health care providers spend with many patients.* Extensive patient information (including date of birth, sex, and age) must be re-reported on every patient for every visit. HCFA can reference other claims for a given patient to monitor health care utilization. In fact, the HCFA keeps track of every doctor visit and every diagnosis. Despite real concerns about confidentiality when the federal government maintains a large database of confidential medical information on all its citizens, it makes little sense to try to run a health care delivery system without monitoring patient health care utilization.

A word of caution is in order at this point. While new governmental requirements do add to the cost of health care, some are well worth the cost. The new OSHA requirements on blood borne pathogens, for example, were desperately needed. Training of office personnel, separating of garbage and the cleaning of medical gowns have added to the cost of each patient visit. To comply with these regulations, some rural physicians may have to send their lab coats great distances to industrial cleaners and many have to pay up to \$50 per box for medical waste disposal. Nonetheless, these procedures result in the delivery of a higher quality of safer medical care.

### *Cost of Medications*

In the last decade, the cost of new medications has increased at an alarming rate. Generic drugs offered only temporary relief from cost escalation. To offset the low cost of generic drugs, the current generation of pharmaceuticals is marketed at a very high cost. A prescription for antibiotics will often cost between \$50 to \$75. Much of the cost is caused by extended research protocols and approval procedures which new medications must pass before marketing. While these are legitimate costs, pharmaceutical companies also spend much on marketing to doctors, including free trips and lavish parties. Obviously, these latter practices deserve careful and relentless scrutiny.

### *HOW TO FIX THE SYSTEM*

To many, National Health Care Reform's only issue is the financing of health care. Although cost issues are important, National Health Care Reform must also address issues of access and health care utilization. Just because health care is affordable to a patient living in rural America, does not mean that a physician will be practicing in the community. There are many disincentives to practicing in a rural setting. *"Everything from the difficulty in cleaning lab coats under the new OSHA standards, to the inability to share the cost of medical practice administration, all add to the frustrations often experienced by the rural physician. To make matters worse, in many states . . . Medicare pays metropolitan physicians up to 25% more for the same services that are also provided by physicians in rural areas."*<sup>7</sup>

Health Departments will still be needed, even if every patient can afford to see a doctor. It is important to remember that just because a child's doctor bill is funded, that does not mean that the mother realizes the importance of the health care visit, can read to fill out the forms, has a phone to call for an appointment, a car for transportation or the willingness to comply with the recommended therapy. Health Departments coordinate not only medical care but also case management services. They offer a different form of service

which is often tailored for the poor and uninsured. Interestingly, doctors, health departments, and indigent care clinics all feel threatened by National Health Care Reform.<sup>13</sup> The doctors fear the loss of their practice. Health departments and indigent care clinics fear the loss of their funding because of the misconception that they will no longer be needed.

Financing issues are very important. Many politicians look to National Health Care Reform as an avenue to pay for and solve the Medicare crisis. However, we must accept the premise that we do not have the ability, under any circumstances, to provide limitless care for everyone. Politicians have now conceded that "Basic" health care should be available to all. Few have attempted to define "Basic." Its definition is elusive and is becoming a political issue.<sup>2</sup> However, the term's use is an admission that we cannot provide all for everyone and tough decisions must be made. Benefits can be assigned politically, based upon issues presented to legislatures by patients, support groups and other organizations, or by a logical methodology based upon an impartial triage system such as the Oregon Health Care Plan. At present "non-basic" services are cut by an ill-defined bureaucratic process analogous to "High-Altitude Bombing."<sup>13</sup> The impact of the Americans with Disabilities Act is just being felt in this area and may make "*High-Altitude Bombing*" the law of the land by prohibiting the withholding of care based upon type of medical illness.

In addition, we must realize that the citizens must pay for the health care they receive, whether through taxes or via policies. Many other financial issues concerning the covering of preexisting illnesses, dropping of insureds because of illness, raising of premiums because of illness, and the inability of small business to negotiate competitive rates must also be addressed<sup>4,12</sup>

*Cutting entitlement programs equally for all services.* Today many physicians operating in depressed areas of the nation rely on Medicare and Medicaid as their main source of income, while those whose practices operate in affluent areas collect relatively large fees from private insurance. In Somerset, KY, the Medicare allowable charge for a return patient office visit is \$16.70 (CPT 99212 estimated to require 10 minutes of face to face contact with patient).<sup>1</sup> If a single practicing physician saw 6 patients an hour for 35 hours a

week for 50 weeks a year, a total gross practice income of \$175,350 would be generated. Once office rent, malpractice, equipment expense, staff salaries, benefits, and time off for physician participation in continuing education courses have been deducted, little will be left over for the physician's salary.

Cutting entitlements, which for many specialties are near or below the cost of delivering care, will tend to drive more physicians out of primary care and private practice in rural communities. The concept of cutting entitlements to cut the cost of health care is seriously flawed.

*Shifting of care to paramedical professionals.* One way to save costs is to shift the delivery of routine medical care from highly trained medical doctors to associate and baccalaureate-trained personnel, supervised by medical doctors. An example of this strategy is the use of nurse anesthetists in the operating room and the use of nurse practitioners in the health departments. In addition, the long training time of physicians, 13 years post high school for many surgeons, could also be shortened.<sup>3</sup>

*Controlling legal costs.* No solution to the nation's health care crisis will be successful without control on medical malpractice and legal costs. The cost of malpractice is not just in insurance premiums but in the need to be "Sure." We must develop criteria for when we should stop searching for categories of disease. For example: We may wish to stop the search for an acoustic neuroma when there is only a 1/2000 chance of having the disorder and only restart the search if symptoms progress or new symptoms develop. The criteria would be the basis of the "national practice guidelines" proposed by the National Leadership Coalition for Health Care Reform.<sup>4,12</sup>

The withholding of care is a difficult practice in today's society, even if the patient requests the care to be withheld. By definition, if one provides basic care, then one withholds advanced care. One must be allowed to let a patient die without the risk of being sued by a distant relative. Ethical issues such as the right to die and the ability to withhold care must be addressed.

*Controlling administrative expenses.* Administrative expenses are skyrocketing and few have a direct effect on the administration of health care. All of these expenses must be carefully scrutinized.

Some expenses can be trimmed, others eliminated. The following are several recommendations which illustrate this point:

1. Requiring non-indigent patients to pay for invoices whose initial, or remaining balance after insurance payment, is less than \$30. It costs the physician between \$4 to \$7 dollars to generate an HCFA form. It makes no sense billing Medicare for a \$15 dollar charge, receiving \$12, and then billing the supplemental insurance company \$2. Not only would this recommendation markedly reduce administration costs, but it will require a co-pay to help reduce over utilization of services. In addition, the idea of any insurance policy is to take care of extraordinary expenses, not day-to-day expenses. For example: No one buys auto insurance with a deductible under \$30.
2. Although a standard billing form is used by almost all carriers, the information reported on the form is not standardized. For example: Some state Medicaid agencies require that billing information always be placed in the "Secondary Insurance Fields" even when Medicaid is the only third party payer. This needs to be standardized.
3. Providers should not be required to provide patient demographic information; only the patient's insurance number, and possibly the birth date for a data check. Additional demographic information only causes claim denials when absent, and increases administrative costs to provide. In addition, the carriers already have this information.
4. Standardization of numbers. The insurance company, patient, and health care provider should have one and only one number used to report all information to all carriers. For example: The doctor presently has a UPIN, Employer ID, Federal Tax ID, Social Security and Provider Number, any or all of which may have to be reported on the HCFA form.
5. Simplified electronic billing. All carriers should be required to accept an image (or spool) file of the HCFA form transmitted by modem and to be able to electronically receive HCFA forms transmitted via FAX.

Approximately 1/3 of the HCFA forms could be eliminated by implementing the first recommendation. The amount of information

keyed into the HCFA form would be reduced by one half with only requiring the reporting on a patient number, birth date, physician number, referring physician number, and insurance company numbers. They could then be easily transmitted as image files, obviating the need for expensive computer systems and electronic clearinghouses.

### ***SUMMARY***

We must educate our politicians to the fact that simply rolling back prices will not provide enough savings to allow expansion of entitlement programs to cover the uninsured. In order to bring our health care system in line with other industrialized nations, total costs would have to be cut by 25%, and the delivery of care increased by 33% (to cover the 25% of US citizens which are grossly uninsured). At the same time our elderly population is increasing, as is the number of uninsured, as unemployment rises. Needless to say, forming a workable system for universal health care is a Herculean task.

Accomplishing this by simply decreasing reimbursements and payments will not, by itself, work. We must make fundamental changes in the health care system. We must make hard choices involving:

1. The triaging of care which will deny care to some. The Americans with Disabilities Act may make triaging illegal when based upon type of disease or type of care that is to be delivered.
2. The curbing of malpractice suits which carries the risk of preventing the wrongfully injured from recovering damages.
3. Reducing the extensive testing of drugs which carries the risk of injury from adverse drug reactions.
4. The delivery of care by less-trained personnel which carries the risk of delivering substandard care.
5. The elimination of much of the bureaucracy in filing of patient claims which carries the risk of loss of patient confidentiality with the increased access and transfer of this information.

If we do not make these choices, we then must live with the fact that an ever-enlarging portion of our citizens will continue to have no or significantly reduced access to health care.

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