
From Profession to Business: The Corporatizing of American Medicine

Richard G. Stefanacci

The 1990s witnessed an unprecedented restructuring of the American health care industry. Early on, these changes were fueled by unchecked increases in the cost of health care, advances in technology, and anticipation of national health care reform. When political pressure led to the failure of health care reform in the late '90s, the major drivers of health care restructuring became unbridled competition and corporatization in the industry and a tremendous growth in managed health care.

Now, in 2006, we are spectators to the largest expansion of the Medicare program since its inauguration in 1965. Reactions to the introduction of Medicare Part D and its broad coverage for prescription drug costs is causing another “unprecedented restructuring of the American health care industry.”

The article that follows was published 20 years ago by a third-year osteopathic medical student. That same student went on to become the Founding Director of the University of the Sciences in Philadelphia's Health Policy Institute and became a tenured CMS Health Policy Scholar. After reading his 2-decade-old predictions for the future of medical care in America, perhaps you and other readers of *MPM* will view Medicare Part D in a whole new light.

Expenditures for health care have increased more rapidly than those for most other goods and services, rising from \$11 billion annually in 1950 to over \$350 billion annually today.¹ By 1993 the annual bill for health care will top \$1 trillion if the present system is not changed.² The federal government, which spends more than \$100 billion a year, has been the major force in health cost containment until recently,³ but now this effort has a new leader—private corporations.

Health care costs have become a major expense to business. Cutting deep into profits, corporate health care spending is fast approaching \$100 billion a year.⁴ Chrysler Corporation says that health care costs add \$600 to the price of every new car.⁵ Today American business is losing in the international marketplace to the tune of \$123 billion a year. It can no longer expect to pass the cost of health care on to the consumer, and it can no longer wait for the government to control health care costs.

While the medical profession was able to beat the government's attempt to impose some form of socialized medicine, it is doubtful that it will have the same success defeating business' attempt to corporatize medicine. Government has been unable to control health care costs because it has been unable to limit the physician's decision concerning the number and the type of medical services performed. In most markets, consumers decide on the quantity, quality, and how much they are willing to spend, but because of market imperfection, most patients are unable to choose medical services appropriately. This article discusses these market imperfections, possible solutions, and the effect tomorrow's system of corporate medicine will have on the physician.

Patient Market Imperfections

The critical factor in the rising cost of health care is the fact that patients' out-of-pocket expenses, that part not covered by insurance, are far less than the cost of the services provided. In comparison with most other goods, for which the consumer carries the full burden of the cost, the low out-of-pocket price of medical care forces an overuse. Ninety-four percent of all hospital costs and 66% the costs of physicians'

services are paid by third parties, either the government or corporations.⁶ While it is true that patients do indirectly pay for all medical services through insurance premiums and taxes, their payments are so indirect that they have little effect on most patients' behavior.

The prevailing behavioral climate that encourages patients to demand a greater amount of medical care and to be less likely to take steps toward preventive medical care because someone else is footing the bill is called "moral hazard." Since the third-party payers reduce the costs of medical care that are borne by patients, they will consume more care and be more careless about their own health than if they had to pay the entire bill themselves. This scenario can be likened to automobile insurance with no deductible: the person insured under these terms is far more likely to appear at the service station for every little problem than to correct the problem himself or take care that the problem does not arise in the first place. On the other hand, a person without insurance will have a greater incentive to do everything in his power to see that nothing happens to his automobile (or his health).

A major problem of moral hazard is that it leads to a system where no one has an interest in cost containment. The payer, government or corporation bears the burden, yet has little influence on how much is to be spent.⁷ A study reported in the *New England Journal of Medicine* in 1981 indicates that persons fully covered for medical services spend about 50% more for them than do similar persons with income-related catastro-

In 1980, the AMA amended its code of ethics to state that physicians may advertise their services and fees.

phe insurance.⁸ Full insurance coverage leads to more people using services and to more services per user than would be the case without insurance.

Another market imperfection relevant to patients is their lack of medical knowledge. Theoretically, the principle of "consumer sovereignty" says that the patient will select those services which, given his or her income and the prices of different services, maximize satisfaction. It is assumed that patients make such choices rationally and that they have information about both the benefits to be derived from different services and the prices of those services.¹ Critics who question the assumption of consumer sovereignty do so because they feel that patients do not possess the knowledge needed to assess the true value of medical services. The patient, therefore, defers decisions concerning his or her medical services to the physician.

Physician Monopoly Power

By taking advantage of the market imperfections facing the patient, and by controlling the availability of information and the supply of medical providers, physicians are able to monopolize the medical care market. Physicians' fees for

similar services vary substantially, both between geographic areas and within individual areas. These variations in costs for similar services exist because patients are not seeking lower prices and because information barriers exist.

The usual market constraints, such as the effect of patients' seeking lower prices, are less and less operative in the physician visits and services markets as more physicians' fees are being reimbursed by third-party payers. The inability of patients to make appropriate cost-benefit decisions about their health care is due in part to the lack of knowledge concerning fee variations for similar services. However, even if the patient could find another physician whose services were "cheaper" than those of his or her regular doctor, the "cheaper" physician would be at a disadvantage in not having the special knowledge of the patient's medical history that the original physician had, and might not be as effective.⁹ The more restrictive the information to patients concerning physicians' prices, qualifications, and availability, the more likely it is that variations in fees will persist. Likewise, in terms of patients' time, the costs of searching for lower fees become too great. With the information barriers so great, and as more of physicians' charges are covered by third-party payers, the potential savings to the patient of searching for a lower fee declines.¹⁰

It is for these reasons that the medical profession has opposed advertising among physicians. Until recently, state medical societies have had prohibitions against advertising. In 1980, the AMA

amended its code of ethics to state that physicians may advertise their services and fees and thus solicit patients. This statement acknowledges that patients want more information and are willing to shop for price as well as quality. This action did not come about by itself; rather, it was the result of an FTC action of 1979 against professional associations of health providers that barred advertising of prices as a matter of "professional ethics."

In 1974, the AMA imposed rules governing the use of physician extenders. The result of this action was to restrict by licensure requirements substitution by less expensively trained personnel. If a greater use of physician extenders were permitted, the result would be lower costs for medical services. Estimates of the increase in the productivity of physicians derived from hiring additional aides range from 50% to 75%. Because the salaries of physician extenders are only about a third of those of physicians, their cost-effectiveness would be substantial if they were allowed to be used.¹⁰

Today's System of Health Care Delivery

Diagnosis-related groups (DRGs), which were developed in 1975 at Yale University, force hospitals to assume greater financial risk for the care delivered within their institutions. The state sets payment levels for all public and private payers on the basis of the kinds of cases that a hospital treats rather than the numbers of days that its patients are hospitalized.¹¹

The present governmental DRGs do not directly influence the remuneration that an attending physi-

During 1983, **HMO membership** **increased by 18%.**

cian receives for rendering inpatient care. There exists little incentive to be cost-efficient on the part of the physician, other than for altruistic motives. But, because hospitals are paid a predetermined amount, the traditional economic incentives under which hospitals have operated are reversed. Under DRGs, hospitals make their way by living within a fixed budget; if an institution operates under that budget it keeps the difference.

An HMO, on the other hand, is basically a prepaid health insurance plan where the organization and participating physicians accept contractual responsibility for the delivery of a stated range of health services to an enrolled population. Since 1977, the membership of HMOs has more than doubled, from 6.3 million to over 13.6 million. During 1983, HMO membership increased by 18%.¹²

Since the physicians are generally paid on a salary basis regardless of the services performed, there is an incentive to provide only necessary services. Moreover, the HMO, at risk for costs that exceed income, generally has an incentive to minimize hospital admissions, to limit the length of hospital stays, and to utilize physician extenders. The specific incentives facing an HMO may vary because of different organizational characteristics. Indeed, most studies have found HMOs to have lower costs than fee-for-service institutions, while holding quality of care constant.¹³

HMOs are able to reduce costs by using economies of scale and increasing productivity due to their large size. They are also able to reduce demand by switching from fee-for-service to salary reimbursement, thereby reducing the incentive for expensive and unnecessary procedures. Under a fee-for-service system, physicians, who have direct control over the services ordered, have financial incentives to encourage more frequent office visits, order more tests and treatments, and provide more hospitalization days for patients.⁶ Changing from a fee-for-service system to an HMO removes these incentives.

Tomorrow's System of Health Care Delivery

Tomorrow's system of health care delivery will be divided into three separate and diverse markets. One will be devoted to those patients who are dependent on government-funded health care. It will provide a minimal level of health care for the poor. Physicians will work on salary only and must be encouraged to restrict the services they can provide.

Another system will be a free market system, where physicians are paid on a fee-for-service basis. Part of the physician's fee will be paid by private insurance and the remainder by the patient. This system will have a large deductible, and the insurance company or the government will be responsible for a smaller portion of the cost than under current systems. Physicians in this market will be encouraged to provide the services that society wants at the price that society is willing to pay. In this system, the

(continued on page 46)

From Profession to Business

(continued from page 12)

market will dictate and the physician will conform or be forced out by competition.

The third system is the one that will employ the majority of physicians. This system, referred to as "corporate medicine," is now practiced by such corporations as National Medical Enterprise and Hospital Corporation of America. It uses business practices to provide the most efficient health care possible. Corporate HMOs are discussed from three points of view: those of business, the patient, and the physician.

Corporate HMOs work because they remove the market imperfections normally found in medical markets and replace them with incentives for efficiency. From a business point of view, corporate HMOs are efficient by using physician extenders to increase productivity. HMOs are also able to use their size to reduce the costs of the products and services they buy.

The corporate HMOs are able to provide efficient incentives to the patient by offering low deductibles, providing regular office visits and other preventive medical care, and basing the membership fee on the patient's own preventive health care. An example of the latter point is charging a higher fee for smokers than non-smokers, thus providing an incentive to quit smoking.

Incentives for ordering only efficient and necessary procedures are provided to physicians in the form of salaries and profit-sharing. The corporate HMO will also use the concept of DRGs by appointing a primary care physician to be a case

manager. In this role, the primary care physician will receive the DRG allocation to distribute as he deems necessary. So the primary care physician, acting like a governmental HMO, will be responsible for a percentage of the DRG pool of monies. Likewise, he will be responsible for a percentage of the loss, those monies paid out in excess of the DRG pool, as well as receiving a percentage of the profits.

In conclusion, the osteopathic physician has a great opportunity to utilize his or her knowledge of primary care medicine by becoming an efficient case manager. There is little question that the future of medicine will offer room for everyone, but the room at the top will be reserved for those with a workable knowledge of the medical marketplace. MPM

References

1. Feldstein P: Health Care Economics. Princeton, Robert Wood Johnson Foundation, 1979.
2. Trafford J: Soaring hosp costs – the brewing revolt. *U.S. News & World Report* 95 (Aug):39-42, 1983.
3. U.S. Department of Commerce: Survey of Current Business. Washington, DC, U.S. Department of Commerce, 1984, p 54.
4. Chapman J: Deciding who pays to save lives. *Fortune* May 27, 1985, p 59.
5. Domestic Policy Association: The soaring cost of health care. *National Issue Forum* 1984, p 6.
6. Controller General: Health Maintenance Organization Can Help Control Health Care Costs. Washington, General Accounting Office, 1980.
7. Thurow L: Medicine versus economics. *N Engl J Med* Sept 5, 1985, p 611.
8. Newhouse J: Some interim results from a controlled trial of cost sharing in health insurance. *N Engl J Med* Dec 17, 1981, p1501.
9. Ricardo-Campbell R: *The Economics and Politics of Health*. North Carolina, University of North Carolina Press, 1982, p 85.
10. Eastaugh S: *Medical Economics and Health Finance*. Boston Auburn House Publishing Co, 1981, p 110.
11. Inglehart J: New Jersey's experiment with DRG based hospital reimbursement. *N Engl J Med* Dec 23, 1982, p1655.
12. Iglehart J: Health policy report – HMOs. *N Engl J Med* May 3, 1984, p 1204.
13. Federal Trade Commission: *The HMO and Its Effects on Competition*. Washington, DC, Federal Trade Commission, 1977, pp 1-2.

Report to Congress

(continued from page 30)

since the payment system was developed that it is unlikely that the casemix system still accurately predicts the relative costliness of episodes. Ideally, case-mix adjustments should bring payments closer to costs. The Commission will continue to investigate improvements to the payment system.

Long-term Care Hospital Services

This year, for the first time, the Commission assesses the adequacy of payment for long-term care hospitals. LTCHs provide care to patients with clinically complex problems who need hospital-level care for extended periods of time. Medicare is the predominant payer for long-term care hospital services.

Medicare payments for LTCH services are more than adequate. The supply of LTCHs, the volume of services, and the number of beneficiaries admitted to LTCHs have all increased rapidly since 2001. Changes in quality are mixed and access to capital is good. Moreover, Medicare spending for these facilities increased twice as fast as volume, and in 2004 alone, spending increased almost 38 percent. Margins in this sector have been high.

The Commission concludes that long-term care hospitals should be able to accommodate cost changes in 2007 and therefore recommends that the Congress eliminate the update to payment rates for LTCH services for 2007.

(continued on page 47)

Report to Congress

(continued from page 46)

Inpatient Rehabilitation Facility Services

This year, also for the first time, the Commission is assessing the adequacy of payment for inpatient rehabilitation facilities. IRFs provide intensive rehabilitation services. **To be eligible for treatment in an IRF, beneficiaries must be able to tolerate and benefit from three hours of therapy per day.**

Indicators of payment adequacy were generally positive through 2004. Supply and volume increased, quality was stable, and access to capital was good. Medicare payments grew rapidly from 2002 to 2004, resulting in high margins for IRFs. A recent regulatory change—CMS's 2004 modification of the 75 percent rule—complicates analysis of this sector. This rule has led to decreased admissions in 2005 and will affect Medicare margins. However, **the Commission estimates margins will still be more than adequate and that IRFs can accommodate price changes without an increase in payments.** Therefore, the Commission recommends that the Congress eliminate the update to payment rates for inpatient rehabilitation facility services for fiscal year 2007. *MPM*

Reprinted from the MedPAC Report to the Congress: Medicare Payment Policy, March 2006.

The highlighted areas are based on those points that the MPM editorial staff feels are most important to our readers.

Opting Out of Medicare

(continued from page 34)

physician must file an affidavit with their carrier at least 30 days before the first day of the next calendar quarter. Private physicians are not permitted to submit a claim to Medicare for any patient for a period of 2 years. Because this is such a significant option, CMS provides a 90-day grace period after the effective date of the opt-out affidavit during which the physician may revoke their decision, thus returning as a Medicare PAR physician.

Specific information regarding the fee schedule, as well as the Medicare participation physician/supplier agreement is available through local Medicare carriers. In addition, all communications regarding participation need to be provided to local Medicare carriers.

The Decision

The decision to opt out of Medicare and become a private physician is significant. These types of practices are commonly referred to as concert practices. Choosing this option can limit the size of a practice and place a hardship on less affluent patients who are not able to bear physician fees outside of Medicare. Non-PAR status is much less extreme, since Medicare beneficiaries can still receive payment from Medicare. Unlike private physicians who can charge whatever the market can bear, non-PAR physicians are limited to charging just 9.25% above the Medicare-allowable fee, thus limiting the financial benefit of this option.

In conclusion, the level of Medicare participation requires a

Take-Away Message

- PAR—Participating physicians agree to accept what Medicare allows for payment in full for each service for all of their Medicare patients.
- Non-PAR—Non-participating physicians are then allowed to charge their patients above this amount directly, although there are limits on these charges.
- Private—Bill the patient directly, thus having no involvement with Medicare. This is only possible for those who opt completely out of Medicare, becoming private physicians.
- Physicians can only make a change in how they participate with Medicare within defined periods of time.

ROI

- Careful consideration is required based on one's desired practice type and lifestyle, as well as one's market situation before deciding on a change in Medicare participation.
- Clear understanding of the implementation of moving from a PAR Medicare provider to either Non-PAR or private provider is required to achieve the desired outcome.

very careful analysis of one's market potential, desired practice, and lifestyle goals. Clearly, as a new group of seniors is being found with increased wealth that they are willing to spend on their health care at the same time that Medicare is reducing physician reimbursement, many physicians may make this difficult decision and change their level of participation in Medicare. Only time will tell. *MPM*

Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD, is Editor-in Chief of *Medicare Patient Management* and the Founding Executive Director of the Health Policy Institute of University of the Sciences in Philadelphia, PA. He also held the position of CMS Health Policy Scholar 2003-2004.