The American health care system is broken: It can and must be fixed

Barbara L. McAneny, MD, MACP; Introduction by Richard L. Byyny, MD, FACP

Dr. McAneny is Chief Executive Officer, New Mexico Oncology Hematology Consultants, Ltd., Albuquerque, NM, and former president of the American Medical Association. She is a member of the Alpha Omega Alpha Honor Medical Society Board of Directors.

Introduction

Richard L. Byyny, MD, FACP

Health care is the largest industry in the United States, spending $4.1 trillion in 2020, which is equal to 19.7 percent of the nation's gross domestic product. To think of it another way, it equates to $11,072 per person, or more than twice the amount on average ($5,242) for 13 other developed countries.[1]

All of this spending, yet life expectancy in the U.S. in 2018 was 78.7 years, which is lower than all 13 other developed countries which averaged 82 years.1 In addition, the U.S. has fewer doctors and nurses per 100,000 population than in those 13 other countries.[1]

Furthermore, the U.S. population is sicker with a higher prevalence of chronic conditions and insufficient access to care than populations in the aforementioned 13 developed countries.[1]

Each of these 13 countries provide universal health care coverage and deal with cost barriers so individuals can get care when they need it and where they need it. Most invest in high value primary care systems that are available to all communities; they reduce non-clinical burdens, administrative barriers, and medical record keeping which can take away from patient care. They invest in social services; they prioritize maternal health to reduce maternal and infant mortality; and they support a substantial work force.

Unfortunately, the U.S. does not have a national health care system. Instead, the U.S. continues to muddle along despite the importance of high-quality health care for all. As a country, the U.S. tends to develop health care law and policy without a clear concept or agreement of the systemic goals and responsibilities. Uniformity of access to health care has not been accomplished and remains a primary national concern. The predominant question is: In the U.S. is every person guaranteed some level of health care? Do they have a right to health care? Or, will the U.S. continue with a publicly tax-payor-supported system for about half of the population (Medicare, Medicaid, Veterans Administration, Indian Health Services, Tricare, and those who are incarcerated), and about half where health care is for those who can afford it through employment-based or private insurance, or those who cannot afford any health insurance at all?

The current U.S. non-system of health care has evolved and changed, especially in the 20th and 21st centuries. At the turn of the 20th century, physicians were trained in proprietary and apprenticeship programs to become a physician. Medicine was rudimentary and based on a negotiated (bartered) fee-for-service arrangement.

In 1910, medical education began to change due to the Flexner Report, which further enhanced university and teaching hospital education with an emphasis on medical professionalism. Then, beginning in 1918 the U.S. was hit

with World War I, the Spanish Flu Pandemic, the Great Depression all of which impacted people, patients, medicine and health care. Congress created the U.S. Veterans Bureau in 1921 to provide medical care for battle-injured WWI soldiers which later became the Veterans Administration. Congress also passed the Maternity and Infancy Act of 1921, and the federal government provided states with funds for prenatal and maternity care.

Industrialization and urbanization rapidly developed in the U.S. which only exacerbated the nation's inability to respond appropriately in the development of medical policy and payment systems. States began to turn to the federal government to care for indigent patients, and city and county public clinics and hospitals were established in urban areas and cities.

The Truman Administration and Congress attempted, but failed, to get health care included in the Social Security Act, and/or the National Health Act, because they were labeled as "socialized medicine" (accepted by many as a generalized pejorative term), which continues to be an insurmountable obstruction to universal and national health reform. Initially, the courts confirmed that health care could be handled as a "matter of law" and as a national rather than a state or local problem, and the Supreme Court ruled that insurance was national commerce and could be regulated by Congress nationally. However, these rulings were reversed by Congress' interpretation that the Act created the presumption that the regulation of insurance remains with the states unless Congress explicitly states otherwise.

Concurrently, several other developments were transpiring. Following WW II, wage controls were instituted that did not apply to fringe benefits, e.g., insurance, and the National Labor Relations Board upheld unions' engagement in collective bargaining for benefits so that employer-based health insurance would not be taxable income for the employee. (Employer-sponsored health insurance continues to account for about one-half of the health insurance coverage today.)

On July 30, 1965, President Lyndon Johnson signed Medicare into law, drawing attention to the 20 years it had taken Congress to enact government health insurance for senior citizens after Truman had proposed it decades before. Medicare was designed to be a different approach for the elderly with a fully nationalized program to offer what was then comprehensive health insurance, including hospital and physician care. This was a totally federalized health care program funded by the federal government with no role for the states.

Medicaid was enacted at the same time as Medicare, however, Medicaid was structured to provide federal funding and requirements with shared state financing for a welfare-based approach to health care for the poorest and most needy.

Most recently, the Affordable Care Act provides multiple structures to various populations for access to care and payment in myriad ways. The result is an overly complex, disorganized system overseen by Congress and with multiple state bureaucracies, cultures, and health care needs. This includes fiscal intermediaries that amass a profit. It is estimated that there remain approximately 30 million uninsured people, and about 40 million underinsured.

In medicine and health care, the federalism approach in the U.S. is a cumbersome, limiting factor without uniformity and equality of access and cost of care. Access to care in this unwieldy system remains the U.S.'s primary challenge.

As a result, smaller, physician-owned practices are finding it difficult to sustain their office, and are regularly faced with burdensome bureaucratic requirements often meant for larger, multifaceted health care systems. This is a worrisome trend with uncertain effects and outcomes for health care, patient care, and the doctor-patient relationship.

For the first time in centuries, possibly ever, the percentage of physicians working in physician owned practices has dropped to less than 50 percent—49.1 percent in 2020.[2] The reasons are complex, but private practice physicians must deal with ever-changing boundless administrative, financial, and clinical requirements that are thrust upon them thereby creating an unmanageable, disorganized, costly system under which they are trying to provide care with reimbursement that has not kept up with the cost of doing business while hospital outpatient prospective payment systems increased by 60 percent. These difficulties result in the merger or take-over of smaller physician-owned private practices by larger, corporate hospital systems and/or for-profit entrepreneurs. This occurs even though data demonstrates that total spending and quality measures are equivalent or better in smaller physician-owned practices than other models of care.[3]

Independent practices offer benefits for physicians and patients, wherein physicians are able to value their autonomy and flexibility and appreciate accessible relationship-based care while ensuring medical professionalism, all of which are advantages for patients. Threats to these independent practices include administrative burdens; low and declining payment rates threatening practice viability; lack of leverage in negotiations; costly recruitment; myriad insurance company requirements; prescription restrictions;

and continuously changing electronic health record systems. These independent practices are in contrast to investor-owned health care facilities or organizations that focus on revenue and investor profits. They represent what has been referred to as a "medical-industrial complex that threatens to use its economic power to exert undue influence on public policy concerning health care."[4]

Traditionally, mergers and takeovers were formed to horizontally integrate care for patients in a corporate system that acquired or merged with other organizations to provide the same or similar services. Over time, this has changed to a vertical integration where organizations acquire or integrate with other organizations offering different levels of care, services or functions, e.g., hospital ownership of private practices. While this may seem like progress, it does come with a cost. Hospital owned practices have higher expenditures and higher costs for patients and insurers, which exacerbate the problem of access to health care; and many treat health care as a commodity rather than a right. Health care has become increasingly business-oriented rather than patient-oriented with more for-profit entities and private equity organizations.

The American College of Physicians recently published the policy report, "Profit Motive in Medicine May Contribute to a Broken Health Care System," which states, "We have seen health care become increasingly business-oriented and more for-profit entities and private equity investments. We need to be sure that profits never become more important than patient care in the practice of medicine." [5]

The report details a series of recommendations that the U.S. health care system should make in order to protect patients over profits. Profit should never become more important than patient care. We must understand and continually commit to always providing the care for patients that is in their best interest. We must understand that medical professionalism requires physicians to fulfill their professional requirements to patients and communities no matter what organizational and financial structure they are working in, or, in the words of William Root, "be worthy to serve the suffering."

Dr. Barbara McAneny (ΑΩΑ, University of Iowa Roy J. and Lucille A. Carver College of Medicine, 1977), is a private practice physician with clinics in Albuquerque and Gallup, New Mexico, the first physician-owned multidisciplinary cancer centers in the state.

She is the founder of the board of the National Cancer Care Alliance, a group of independent practices collaborating to use innovation to deliver high-quality, high-value cancer care and to develop new alternative payment models based on sound data-driven principles.

"We work in a system that too often benefits hospitals, health plans, pharma and device companies, at the expense of physicians and patients. Physicians are frustrated when their concerns go unanswered. Physicians who actually treat patients should design the systems of health care," she explains.

The Pharos is honored to have Dr. McAneny write the Spring 2022 editorial depicting the plight of today's private, physician-owned medical practices, and call out to new physicians on why it is so important to consider a career in private practice medicine, especially in rural parts of the U.S., and the need to reform the system in order to respond effectively for doctors, patients, and society.

The American health care system is broken: It can and must be fixed

Barbara L. McAneny MD, MACP

We love to believe that we have the best health care in the world: the best trained physicians and personnel, always on the cutting edge with the most modern equipment, the most up-to-date research, the availability of new treatments, and the best outcomes. We have amazing researchers, some of whom can get the grants they need to do the science that matters to them. We insist that our health care system is there for all Americans.

In fact, when I was President of the American Medical Association (AMA) several years ago, representing the AMA to other countries' medical societies, I listened to complaints by physicians from other countries about their medical systems, almost always ending with the comment, "At least we are not as bad as the U.S. health care system."

How is that possible? Not surprisingly, it's all about money. The U.S. health care system is perfectly designed to get the results we have: highly profitable consolidated systems of hospitals; very profitable insurance companies and pharmacy benefit managers merging and acquiring each other, pharmaceutical companies making billions, and armies of well-paid consultants telling everyone how to play the game for bigger and better profits.

What we don't have is a health care system that makes it easy for people to get the care they need at a price either they or the country can afford.

We don't have a system that allows physicians to make a living delivering primary care, even though everyone agrees that primary care is essential for a well-functioning system.

We don't have a way to take research results and newly developed drugs and deliver them affordably to the people who need them.

Yes, we have dedicated physicians who care and really want to take care of people, but we burn them out with paperwork and meaningless quality measures. We teach our younger physicians that they need time off to achieve work life balance, but we never show them the joy of going home at the end of a long day feeling like you made a real difference in someone's life. For those of us who define success as being paid to do something we love, burnout is not an issue.

Unfortunately, the U.S. system does not allow the type of care we all envisioned ourselves providing. For example, internists live on evaluation and management codes. The usual code pays $121.45 for a Medicare patient, possibly $150 for a privately insured patient, and less for Medicaid or the Indian Health Service. Overhead for an internal medicine practice runs about 50 percent, with prior authorization costing the average physician $75,000 per year. We pay people to play "Mother May I" with the insurance industry, and we pay people to bill and appeal denials. An internist who sees 16 patients per day, 5 days per week, 50 weeks per year bills around $464,000 per year and takes home about $232,000.

The Physician Fee Schedule

An internist will spend three to four hours each day filling out paperwork, trying to stay current, and maybe getting some sleep. Every year, The Centers for Medicare & Medicaid Services (CMS) lowers the amount that is paid on the Physician Fee Schedule for independent physicians, and increases what is paid to hospitals for outpatient work.

If, for example, I sold my practice to a hospital and saw the same patients in the same exam rooms with the same staff and the same outcomes as provided by independent physicians, CMS would pay the hospital between 1.5 and two times what they pay my independent practice under the Physician Fee Schedule.

Can we really afford to pay double for the same service? Is a hospital truly the right setting to manage chronic disease?

Ninety percent of health care dollars in this country are spent on chronic disease management. Hospitals were designed to handle acute care: emergencies, failures of the chronic disease management system to keep people healthy, a workspace for complex surgeries and multidisciplinary care and ICUs.

The road to disaster

What happens to us in 2026 when the Part A trust fund runs out of money, and we can no longer pay hospitals? When that happens, we will likely borrow more money from China, but after 25 years of running a practice, I know that borrowing money to fund operations is the road to disaster. Private equity groups and venture capitalists are happy to purchase our bloated systems, but what happens when they want their five times earnings before interest, taxes, depreciation, and amortization (EBIDTA) in five years? (If you need an EBIDTA reminder, you can find an excellent review at https://www.investopedia.com/terms/e/ebitda.asp.)

Hospitals say that the extra payments are needed to provide emergency departments and to cover the uninsured. The government makes them tax exempt in exchange for that charitable work, but there is no accountability on whether the amount of charitable care is worth the tax exemption.

Emergency departments, like fire departments and police, are essential to public safety. To cover those expenses, a Facility Fee Surcharge is added to every event that occurs in the hospital. Patients unfortunate enough to seek care in this venue pay for the community benefit of emergency departments. It is a tax on sick people to pay for a safety net.

A better option might be for emergency services to be paid out of the tax base. Communities could adjust the size of emergency departments to the size of the population and make arrangements to transport patients with complex needs to better equipped emergency departments. People hate paying taxes, but sooner or later, we will all need an emergency department, so we should pay for the privilege of having one available.

If everyone in the country had insurance that covered the costs of their care, hospitals would not need their tax-exempt status and would not have to increase the prices on one group of patients to pay the costs of treating a different group. For example, the Affordable Care Act was a small step in the right direction for solving the problem of hospitals and practices having to cost shift and raise rates to cover patients who can't pay. It makes perfect sense to subsidize insurance products so that patients can afford care without foregoing food and shelter. We currently all pay higher prices for the uninsured, with tax dollars, cost shifting and the loss of people from the workforce because their chronic diseases are not managed.

The insurance functions of hiring actuaries and using data systems to determine actual costs of care, set premiums and pay claims, are all that is really needed. Instead, there are for-profit commercial insurance companies

where even Medicare Advantage plans are managed at significant profits and minimal value to the country. Insurance companies claim that without cost containment tools, like prior authorization processes, doctors would provide endless services for endless fees.

But there are other ways to ensure that only the best care is delivered. Health care payments could be managed like banking if we only knew what optimal care really costs. Suppose we paid our academic institutions to convene panels for optimal care. In oncology we have the National Comprehensive Cancer Network (NCCN), where guidelines are published, constantly updated by physician scientists, and payors pay for care that is on guideline. Off guideline care requires peer review.

No winners or losers, just patient-centered health care

We can use data science to calculate the optimal payment for care. I developed the MASON (making accountable sustainable oncology networks) proposal and submitted it to the Center for Medicare & Medicaid Innovation (CMMI.) The proposal uses guidelines from NCCN, and a payment process designed to cover costs with a modest margin without the cost shifting and game playing that generates winners and losers. We would pay for drugs without a markup to cover all the costs of essential services. Data science can determine which costs are related to other conditions leaving the oncologist accountable only for cancer care. Data systems can pull data from EMRs to compare to guidelines and automate payments for care that meets standards. It would put a lot of administrators, the fastest growing segment of health care workers, out of work. The savings from not paying the administrative overhead would cut about 14 percent from the system.

The data science approach would cut into the profits of insurance companies and hospitals. But ideally, hospital payments should adequately cover the expensive services provided in intensive care units and operating rooms. Hospital systems are not capable of delivering efficient outpatient care. Hospitals would be paid the same margin as physician practices, and therefore would focus on those services that can be done only in a hospital setting.

We should pay for the most efficient site of service for chronic disease management, i.e., a physician practice embedded in a community convenient to where patients live. Imaging should cost the same in a free-standing imaging practice as in a hospital. Physician practices would thrive. Insurance profits would diminish because there would not be a need for many of their services.

Actuaries would be needed to determine the costs for fair coverage and a system to collect the premiums and pay claims. Perhaps a health care ATM?

We could eliminate copays and coinsurance as we know that those payments are barriers to good care, as well as bad care. Copays and coinsurances are highly regressive, hurting poor people and sick people more than the affluent.

Without having to hire people to manage insurance payments, practices could hire more clinicians. Of course, there would be a lot of consultants out of work.

Rethinking copays and coinsurance

We are told that copays and coinsurance are necessary to curb costs. Perhaps it is time to rethink that assumption, since it has not proven to improve the quality of care, and merely adds profit to insurance companies. If we truly had the knowledge of the actual costs of delivering optimal care, we could add copays and coinsurance when a patient knowingly chooses a higher cost site of service. As a self-insured practice, I removed all copays for my employees to see their primary care physicians. I want them to have controlled diabetes! My prices have not risen.

If I could, I would assign an account to everyone in my health plan and add money when they behave as I wish them to. Give credit for not smoking, for seeing one's primary care physician, for medication adherence, cancer screenings and for selecting the low-cost alternatives for lab or imaging. Remove credit for missing appointments or skipping prescriptions. At the end of the year, allow the patients to use their accounts for something that has value to them. If a patient wishes to try a therapy without value, like chemotherapy at the end of life, the copay should be very high. Now that would be value-based insurance design.

We can use scientific data to determine what care really costs in areas with different social determinants, and pay sufficiently, with a margin, for care in those areas. Perhaps we could even pay more to clinicians to encourage them to locate in underserved areas. Economic development for communities includes having a health care delivery system.

The high price of pharmaceuticals

Restructuring insurance payments should also address the high price of drugs. Consider the rationale for coinsurances for drugs: We would prefer that patients choose the low-cost generic rather than the brand name drug when an equivalent exists, so it makes sense to lower copays for generics. But when a patient with cancer must pay a 20 percent coinsurance for a drug with no generic options, that is a significant hardship that is designed to profit insurers.

Pharmacy benefit managers (PBMs) add more than 40 percent of the cost of drugs to the consumer. This counts as profit to the insurance companies and the PBMs, because discounts are not shared with the patients. Patients are forced to use the specialty mail-order pharmacies that are owned by the PBMs resulting in higher costs. Transparency of negotiations would lower prices rapidly, and are much easier to achieve than changing the patent laws to push drugs to generics earlier.

Rural health care and underserved areas

Rural communities are especially vulnerable to changes in the payment processes. The difficulties of providing care in rural and other underserved areas include the lack of employment opportunities for the partners of physicians, educational opportunities for the children of physicians, and cultural opportunities for the families, but the major impediment is financial. When a patient has fewer resources, the practice must provide more services. An affluent patient can forego a day of work and pay the fees to access care. Less affluent patients often miss their copay, leaving the physician with the option of sending them away (getting no revenue for that time slot, and having to reschedule); seeing the patient without collecting the copay (illegal, and creating a fee cut); or spending two-to-three times the value of the copay attempting to collect it. Yet, the CMS system of Geographic Price Cost Indicators pays doctors less in rural or less affluent communities than it does in the affluent ones. Since more people of color live in less affluent settings, health disparities worsen.

After seeing innumerable large hospital wings with a benefactor's name attached, it occurred to me that if those benefactors would endow small, three-to-five doctor offices in small towns or underserved areas, and lease them to physician practices for $1 per year, they would change health care. Eliminating a major practice expense would give those physicians the economic ability to practice with a reasonable income, and if after a few years the office was donated to the practice, it would grow roots in that area. Local practices are small businesses, hiring local people, paying local taxes, and becoming members of the community. This way the benefactor could name a lot of buildings!

Putting practices at risk

CMMI and CMS seem to have decided that the only way we will lower the cost of care is to put doctors and groups of doctors at risk for outcomes. The plan is to double down on risk, assuming that there will be significant enough risk that there will be years where the practice or the doctor loses money. So far, risk taking has benefited some plans where they can avoid high-risk expensive patients, but overall, CMMI programs that include putting clinicians at risk have not saved money for CMS.

The problem is apparent to any insurance commissioner. To allow an insurance company to take risk, the insurance commissioner requires actuarial data and reserves. The average practice, or ACO, or small hospital, has neither. If independent practices or small hospitals have two years of loss in a row, they may go out of business. We cannot risk the destruction of the infrastructure of care delivery. What we need is accountability.

It is clear from the projects that CMMI has funded that we do not have the answer to health care. The purpose of CMMI was to try a thousand ideas and keep the ones that work. I don't think they will be able to sit in Baltimore in their offices and solve this problem. Instead, they should fund those models that the Physician Facing Payment Model Technical Advisory Committee (PTAC) approved, and let people who are actually delivering the care develop a payment model that accurately reflects what they do.

Our patients are going broke because of health care. They need our help and our experience to get this fixed!

References

1. Health System Facts: Real Reporting Foundation, healthsystemsfacts.org, May 9,2022.
2. Kane CK. Policy Research Perspectives: Recent Changes in Physician Practice Arrangements: Private Practice dropped to Less than 50% in 2020. American Medical Association, 2021.
3. Rittenhouse D, Olszuk T, Gerteis JG, Genevro J, Hancock K, Li E, Carlasare L, Vargo C, Blake K. Supporting and Promoting High-Performing Physician-owned Private Practices: Voices from the Front Lines. Mathematica. American Medical Association. Oct. 22, 2021l 1 – 22.
4. Brock DW, Buchanan A. Ethical Issues in For-Profit Health Care. Institute of Medicine Committee on Implications of For-Profit Enterprise in Health Care; Gray BH, editor. National Academics Press (US); 1986.
5. Crowley R, Atiq O, Hilden D. Financial Profit in Medicine a Position Paper. Health and Public Policy Committee of the American College of Physicians. https://doi.org/10.7326/M21-1178.

The author's E-mail address is mcaneny@nmohc.com.