Drivers of Health Care Costs

A Physicians Foundation White Paper - First of a Three-Part Series

For many years and in countless articles, physicians have been the scapegoat for rising health care costs in the United States. In fact, they have been blamed by many critics for the United States leading the world in health care expenditures.

A close examination of the data indicates that this blame is misplaced – that delving into key components in health care spending reveals something else. While there is general disagreement among the so-called experts as to the degree of impact of each component, almost everyone seems to agree that new technology – not physicians – is number one on the list of contributors to rising health care costs.

We have examined data on the leading key components and found that chronic disease conditions, life style – including obesity and addictions, administrative expenses, hospitals, pharmaceuticals, mandated insurance benefits, aging, end-of-life care, defensive medicine and health disparities have all had anywhere from a moderate to significant impact on rising overall health care costs.

In the final section, entitled "Interesting Statistics about U.S. Health Care System", we examine why infant mortality rates can be a poor indicator of the success or failure of a health care system. The same applies for life expectancy statistics. Issues such as medical innovation need also to be considered in the general discussion of a health care system's success or failure.

Following a settlement of a class action lawsuit brought by physicians against the managed care industry, The Physicians Foundation (PF) was created in late 2003. It is a nonprofit 501(c)(3) organization that seeks to advance the work of practicing physicians and help facilitate the delivery of quality health care to all Americans. It pursues its mission through a variety of activities, including grant-making, white papers, research, and policy impact studies. The PF focuses on the following core areas: health system reform, physician leadership programs, workforce needs and pilot projects. As the health care system in America continues to evolve, The Physicians Foundation is steadfast in its determination to foster the physician/ patient relationship and assist physicians in sustaining their practices during these challenging and turbulent times.

To this end, The PF commissioned comprehensive national physician surveys in 2008, 2010 and 2012 which revealed a deep sense of frustration, stress and anxiety. Navigating an increasingly hostile practice environment was causing widespread dissatisfaction and low morale. In the wake of burgeoning insurance and regulatory red tape, little or no negotiating power with insurers, increasing office operating costs with low margins, declining reimbursements and the ever present threat of a malpractice action--physicians were having serious problems in sustaining their medical practices.

And then along came The Affordable Care Act (ACA), passed by Congress on March 23, 2010. With its myriad of provisions affecting physician practices--not to mention its length and sheer comprehensiveness--physician angst only multiplied. And it doesn't appear that the recent action of the U.S. Supreme Court on June 28, 2012, has lessened that anguish.

Among the publications appearing on The PF website (www.physiciansfoundation.org) are several "Roadmaps" examining the provisions of the ACA and how they will impact physician practices. One of the goals of The Physicians Foundation is to bring these issues to the attention of the public, business, state legislators, members of Congress and policy-makers so they can better understand how these practice impediments are adversely affecting physicians in their efforts to deliver the best possible care to all Americans. The PF intends to continue its mission to remain in the forefront of those activities and projects to help physicians to better navigate through all of the practice uncertainties ahead.

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In light of the string of federal budget deficits, combined with a U.S. national debt approaching $17 trillion, the largest in the world – it is understandable that observers are scrutinizing health care costs which accounted for 17.9 percent of the nation's GDP in 2010, or almost $2.6 trillion. As the second highest component in national health expenditures at 20% (hospital care is 31 percent), physician/clinical services have captured everyone's attention.[1] Physician/Clinical services include health care services within the Department of Defense (higher costs in times of war), Indian Health Services, laboratory services, outpatient care centers and the portion of medical laboratory services and physician services in hospitals that are billed independently. Some critics have suggested that physicians' incomes and the fact that physicians direct most health care spending (80% is a frequently used number) are the real culprits in rising health care costs. But let us look at all of the relevant components that contribute to health care costs.

Physician / Clinical Services

Years ago the iconic Mike Royko, a Pulitzer Prize winning journalist who penned columns for the *Chicago Daily News*, the *Chicago Sun-Times* and the *Chicago Tribune*, received a poll about "doctors' earnings" which laid at their feet considerable responsibility for rising health care costs.[2] Royko, it should be noted, was revered for his style of not suffering fools or tolerating sacred cows. Considered so straight-forward and honest, he even criticized the new owner of the newspaper where he was employed – "No self-respecting fish would want to be wrapped in a ------ newspaper." In short, he told it like it is.

Here is how Royko responded in his column to the poll critical of physicians' incomes and their role in rising health care costs.

"*The poll tells us that the majority of Americans believe that doctors make too much money. The pollsters also asked what a fair income would be for physicians. Those polled said, 'oh, about $80,000 would be OK.'*

How generous. How sporting. How stupid.

You could conduct the same kind of poll about any group that earns $100,000 plus and get the same results. Since the majority of Americans don't make those bucks, they assume that those who do are stealing it from them.

It is also stupid because it didn't ask key questions, such as: 'Do you know how much education and training it takes to become a physician?'

If those polled said, no, they didn't know, then they should have been disqualified. If they gave the wrong answers, they should have been dropped. What good are their views on how much a doctor should earn if they don't know what it takes to become a doctor?

Or maybe a question should have been phrased this way: 'How much should a person earn if he or she must (a) get excellent grades and a fine educational foundation in high school in order to (b) be accepted by a good college and spend four years taking courses heavy in math, physics, chemistry and other lab work and maintain a 3.5 average or better, and (c) spend four more years of grinding study in medical school, with the 3rd and 4th years in clinical training, working 80-100 hours a week, and (d) spend another year as a low-pay, hard-work intern, and (e) put in another 3 to 10 years of post-graduate training, depending on your specialty and (f) maybe wind up $100,000 in debt after medical school and (g) then work an average of 60 hours a week, with many family doctors putting in 70 hours or more until they retire or fall over?'

As Mr. Royko went on to say, "*Based on what doctors contribute to society, they are far more useful than the power-happy, ego-tripping, program-spewing, social tinkerers.*

But propaganda works. And, as the stupid poll indicates, many Americans wrongly believe that profiteering doctors are the major cause of high medical costs.

Of course doctors are well-compensated. They should be. Americans now live longer than ever. But who is responsible for our longevity – lawyers, Congress, or the guy flipping burgers in a McDonald's?

Let us talk about medical care and one of the biggest problems we have. That problem is you, my fellow Americans.

Yes, you, eating too much and eating the wrong foods; many of you guzzling too much hooch; still puffing away at $2.50 a pack; getting your daily exercise by lumbering to the fridge to the microwave to the couch; doing dope and bringing crack babies into the world; filling the big-city emergency rooms with gunshot victims; engaging in unsafe sex and catching a deadly disease while blaming the world for not finding an instant cure. You and your habits, not the doctors, are the single biggest health problem in this country. If anything, it is amazing that the docs keep you alive as long as they do."

The fact that this all came from Mike Royko gives it extra credence, and makes his comments especially prescient.

Writing about the physicians' role in health care costs, in an article that recently appeared in *Health Affairs*, Mark Smith referred to the 80% of health care costs directed by physicians. He noted that: Physicians decide (that) "you're going to be hospitalized; you need an MRI; you're going to get a stent; you need a knee replacement." But despite the fact that they direct this spending, they are not necessarily the principal beneficiaries of it (especially now).

In addition, Smith noted, "Consider the economics of joint replacement. Medicare pays, on average in California, $18,000 for a total hip replacement ($16,336 to the hospital and $1,446 to the surgeon). A recent study asked 1,200 members of the public, 'How much do you think Medicare pays an orthopedic surgeon for a total hip replacement?' On average, patients thought that Medicare paid surgeons $11,000 for the procedure. (Interestingly, patients reported they thought that Medicare *should* pay $18,000 to the surgeon.) Cutting the surgeon's fee by 27 percent saves Medicare $390. While the numbers are higher in the commercial market, approximately the same ratio of payments exists; the bulk of the money goes to hospitals and device manufacturers."[3]

We can only imagine that some elected lawmakers (or their staffs) have the same misunderstanding of physicians' income as the general public. Or, as cognitive psychologist Amos Tversky famously said, "Whenever there is a simple error that most laymen fall for, there is always a slightly more sophisticated version of the same problem that experts fall for."

Smith also worries about physician burnout and a looming, if not already present, serious physician shortage. When writing about physician compensation, well-known Princeton medical writer and economist Uwe Reinhardt wrote: "One can think of several reasons why physician compensation in the United States is relatively more generous than elsewhere. First, physicians in most other nations face a powerful single buyer (monopsony) for health services. As the McKinsey Global Institute and Mark Pauly have shown, market power (or regulation) translates into relatively lower prices for health services, including the services of physicians. Second, U.S. physicians must make a larger financial investment in their education than their counterparts in many other countries do. They must recover the debt they incur as part of the educational process. Third, the incomes of highly skilled health care workers – notably physicians – are determined partly with reference to the incomes that equally able and skilled professionals can earn elsewhere in the economy. Because the U.S. distribution of earned income for all occupations is wider than it is in most other OECD countries, the relatively high incomes offered skilled professionals in the United States may well have served to pull up the incomes of American physicians relative to the incomes of their peers abroad."

With respect to physician training, Dr. Reinhardt weighs in on the subject this way: "Suppose that in country A physicians get free training through a taxpayer-financed educational system, while in country B physicians finance their own education and then, once trained, are paid higher fees. If country A classifies these training expenses as education rather than health care spending, which country would report higher health care costs? Is that difference in health care costs real or an artifact of labeling?"

Journalist Christopher Beam, who writes for *Slate*, had this to say about "American doctor salaries."

"They are high for several reasons. The first is the cost of education. In France and Great Britain, students go directly to medical school after high school, and their entire educations are free. In the United States, students must first get a bachelor's degree before attending medical school, and the average medical students' debt is $155,000 (editors' note: closer now to $200,000). Then come at least three years of residency, which usually pays less than $50,000 a year.[4] *Finally, there is the notion of opportunity costs.*

Presumably, many doctors could have opted for jobs on Wall Street or in management consulting instead of choosing to go to medical school. 'They sit in the Princeton eating clubs,' says health care economist Uwe Reinhardt, 'and one guy just got a starting job at Goldman for $150,000. Another guy says, 'I'm going to medical school to take on $35,000 a year in debt.'

But none of this really matters because doctors' salaries aren't a large enough chunk of health care spending in the United States to make a difference. According to Reinhardt, "doctors' net take-home pay (that is income minus expenses) amounts to only about 10% of overall health care spending. So if you cut that by 10 percent in the name of cost savings, you'd only save about $24 billion. That's a drop in the ocean compared with overhead for insurance companies, billing expenses for doctors' offices, and advertising for drug companies. The real savings in health care will come from these expenses."[5]

Complicating the entire issue for physicians (and certainly adding to practice costs, at least initially), particularly those in smaller private practices, is that there are 551 certified medical information software companies in the United States selling 1,137 software programs. According to Business Week (June 21, 2012), "Their products have one thing in common: They don't communicate with one another, and this is by design. EHR vendors which charge as much as $25,000 (and much more) per doctor for a system and

a monthly subscription fee on top of that, want to lock out competitors while locking in customers for life."6 This is just another reason why David Bronson, MD, President of the American College of Physicians, said that, "The burdens are worsening as physicians must contend with the costs and hassles of implementing new quality reporting standards and electronic health records. This is one of the reasons many of physicians are becoming employed; they just can't sustain their practices." He went on to say that high burnout rates are driving many physicians to move away from clinical practices and could deter some from entering the profession. For more on this important issue of burnout and morale, see The Physicians Foundation website at www.physiciansfoundation.org which includes our recent (September 2012) comprehensive survey of 630,000 physicians in the United States.

Earlier this year, a Colorado physician discussed the issue of medical practice sustainability with the *Wall Street Journal*. "His family practice uses electronic health records, calls up patients at home to check on their progress, and coordinates with other specialists and hospitals – all the things that policy makers and insurers say should improve patient care. But many of these enhancements aren't reimbursed under traditional insurance contracts that pay mostly for face-to-face visits with patients." It is not sustainable under the current payment system," he says. "There simply is just not enough money to go around to provide the services that we provide."[7] The upshot: Doctors fear a squeeze as they try to ramp up changes in tandem with evolving reimbursement schemes. "You're asking a practice that may be only marginally viable as a business to invest in significant infrastructure," says Glen Stream, President of the American Academy of Family Physicians, in the *Wall Street Journal* article.

Hospitals

Hospital costs during 2010 in the U.S. constituted $814 billion or 31.4% of all health care expenditures.

As mentioned in *Health Care News* in September 2012, *"At the heart of President Obama's signature health care law is a simple idea: bigger is better. His law incentivizes massive mergers of systems and providers into big players in the marketplace, binding them together to share costs. These new health care behemoths will be managed from Washington, with regulators wielding control from on high.*

That's just one problem. When it comes to health care, "bigger is better" isn't true. And consumers will pay a huge price for this mistake. The president's health care law contains rafts of new regulations, benchmarks, and taxes for providers to deal with. Since these limit profit margins and create new administrative costs, they make it very appealing for health care providers to merge into gigantic, sprawling systems of care.[8] A recent report in *The Washington Post* notes, '*The health care industry is increasingly turning to consolidation as a way to cope with smaller profit margins and higher compliance costs that many anticipate when the federal government's health care reforms under (Obama's law) take effect.' Across the health care industry, we're seeing the merger trend continue to rise.*[9]

These larger mergers don't actually translate to better care or to savings for patients. The Wall Street Journal recently reported on a patient from Nevada whose echocardiogram bill came to $373 before a merger and then $1,605 after a merger.[10]

The same treatment, in the same office, by the same cardiologist, separated by just six months – but with a price point far higher because the physicians had been purchased by a hospital system, allowing for a much higher price to be charged.

The larger a hospital system gets, the more monopolistic control it can exercise over a market, putting insurers at a disadvantage when it comes to negotiating rates. Obama's law accelerates the process, giving these large entities even more incentive to merge through the creation of accountable care organizations (ACOs). These large health care entities will destroy any hope for competition in a marketplace, driving out or buying out independent doctors and extracting as much money as possible from taxpayer-funded entitlements and the privately insured."

We have written previously about our strong belief that bigger is not better, and it appears that new studies confirm that assertion.

An August 2012 article in *The Wall Street Journal (WSJ)* discussed the overall issue. *"Major health insurers say a growing number of rate increases are tied to physician-practice acquisitions. The elevated prices also affect employers, many of which pay for their workers' coverage. A federal watchdog agency said doctor tie-ups* (Note: physician practices/hospital consolidations) m*ore likely resulting in higher Medicare spending as well, because the program pays more for some services performed in a hospital facility.*[11]

This year, nearly one-quarter of all specialty physicians who see patients at hospitals are actually employed by the hospitals, according to an estimate from the Advisory Board Co. That is more than four times as many as the 5% in 2000. The equivalent share of primary-care physicians has

doubled to about 40% in the same time frame. Traditionally, most doctors who see patients at hospitals are in independent practice.

The structural shift is being driven partly by declining reimbursements for physicians, particularly in certain specialties like cardiology. Doctors are also being pressed to make new investments, such as introducing electronic medical records, and some are attracted to the idea of more regular hours with fewer administrative headaches.

Medicare pays substantially more for certain services if they are performed at hospital facilities. A 15-minute doctor visit, for instance, cost the program about $70 last year at a free-standing practice, but the same visit ran about $124 if it was billed as hospital-outpatient, according to the Medicare Payment Advisory Commission. That difference can bump up reimbursements after an acquisition if a hospital system upgrades a clinic to become an outpatient facility, or moves services into a hospital site.

With private insurers, hospital systems with strong market heft can often negotiate higher rates for physician services than independent doctors get. The differential varies widely, anywhere from 5% or less to between 30% and 40%, industry officials say.

Other industry officials suggest the costs often mushroom even more. In a letter sent to some doctors in Nevada, Wellpoint, Inc. said the cost for a spine MRI, or magnetic resonance imaging, done at a free-standing center in the area ranged from $319 to $742, while the same test done by a hospital would run between $1,591 and $2,226."[12]

A letter to the editor of the *WSJ* on September 4, 2012 is instructional: *"It would behoove Medicare and all other insurance carriers to provide private-practice physicians with incentives to stay independent. Increasing fees to these physicians will still be less costly than paying for the same services performed in a hospital out-patient setting."(Editors' note: Agree!)*[13]

A September 14, 2012 article, also in the *WSJ*, described the concern over consolidation felt in California. *"California's attorney general has launched a broad investigation into whether growing consolidation among hospitals and doctor groups is pushing up the price of medical care, reflecting increasing scrutiny by antitrust regulators of medical-provider deals.*

The probe, which has been under way for several months, is examining hospital systems' reimbursement from the insurers, according to people with knowledge of the matter. The regulator appears to be focusing on whether the systems' tie-ups with physicians, as well as ownership of hospitals, have given them the market power to boost prices in a way that violates antitrust law, these people said."[14]

As physicians find it increasingly difficult to sustain their practices during times of declining reimbursements, increased regulation, little negotiating power with insurers, growing practice costs, new EHR requirements, and combined with the always constant threat of a malpractice suit, who can blame physicians for looking to hospital systems for employment? But overall costs will continue to escalate.

One final footnote on the subject: It is interesting to note, as reported in the August 2012 media release of the Ambulatory Surgery Center Association, that, *"when asked whether they would prefer a doctor who is employed by a hospital or who owns his own office, 55 percent (of Americans /poll respondents) say they want a physician who owns and supervises his own practice."*[15]

Medical Malpractice / Defensive Medicine

One of the difficulties in recognizing the overall importance of the medical malpractice / defensive medicine issue as it relates to health care costs is that the physicians' cost of insurance premiums represents "only" about 1-2 percent of overall health care spending. But that 1-2% represents $27 - $54 billion dollars. Further complicating the issue is the Congressional Budget Office (CBO) estimate (mentioned in the Social Security Advisory Board Report in 2009) that "imposing limits on malpractice awards would only lower malpractice premiums by about 6 percent nationwide, resulting in a modest savings on total health care expenditures of less than 0.2 percent."[16]

The Robert Wood Johnson Foundation (RWJF) Report of 2008 gives short shrift to the premium cost issue, pointing out an article in Science and Technology by Sloan and Chepke, where it was estimated "that over a 30-year period (1970-2000), medical malpractice premiums increased from 5.5 percent to 7.5 percent of total physician practice expenses, so premiums cannot be an important cost driver. Research on whether defensive medicine affects spending is challenging because liability risk pushes physicians in the same direction as fee-for-service payment incentives – providing more services."[17] It should be noted, however, in reference to fee-for-service medicine (FFS), that the traditional FFS payment system doesn't really exist anymore. Medicare price controls, which insurers emulated, took care of that mechanism. As a physician

pointed out in the *Wall Street Journal* (*October 19, 2012*), "The only FFS practices remaining are cosmetic surgery and those physicians who accept cash only."[18]

But others point to the considerable cost of defensive medicine – ordering extra tests because of a fear of a lawsuit – which Phillip K. Howard (Chairman of Common Good) estimates at over $200 billion a year.[19]

Another problem with the malpractice lawsuit system is that 54 cents of the malpractice dollar goes to lawyers and administrative costs, according to a 2006 study in the *New England Journal of Medicine*.[20] Some critics of the current system also point to former Senator John Edwards, who, for example "made a fortune bringing in cases against hospitals for babies born with cerebral palsy. Each of those tragic cases was worth millions in settlement. But according to a 2008 study at the National Institutes of Health, in nine out of ten cases of cerebral palsy, nothing done by a doctor could have caused the condition."[21]

The U.S. Department of Health and Human Services reports that "Americans spend more per person on the cost of litigation than any other country." No surprise there. The report goes on to say that the U.S. had 50% more malpractice claims filed per 1000 population than the United Kingdom and Australia, and 350% more than Canada.[22] The fact that two-thirds were dropped, dismissed, or found in favor of the defendant certainly confirms that the present system simply is inefficient and does not work.

And, *American Medical News* (*September 2010*) adds that physicians prevail 90% of the time when a malpractice case does go to trial.[23]

According to the American College of Obstetricians and Gynecologists (ACOG), one in 10 obstetricians have stopped delivering babies, unable to pay malpractice premiums on the order of $1,000 per baby (probably a low estimate for today).

Those who like to lowball the costs of defensive medicine claim that it is difficult to separate it from the effects of other factors that lead to more intensive use of resources including the diffusion of new technology, the incentives of the fee-for-service form of reimbursement and the factors accounting for regional variation in spending. This is the rationale given in the Social Security Report previously mentioned for lower estimates of the costs of defensive medicine. An article on the subject in *Health Affairs* (*September 2010*) concludes that "defensive medicine practices exist and are widespread, but their impact on medical care costs is small."[24]

But Richard A. Epstein, a professor of law at the University of Chicago and a senior fellow at the Hoover Institute – while he estimates malpractice premiums constituting less than 1% of the total U.S. health care bill (*WSJ*, *June 30, 2009*) – does believe that defensive medicine adds as much as 10 percent to health care costs.[25] At a total health care cost of $2.7 trillion estimated in 2011 – the 10% estimate figures to be $270 billion! Author Marc Siegel, MD, puts it simply: "Fear of malpractice suits compel doctors to over treat when confronted with sick patients."

As mentioned in a recent *NEJM* article (*August 1, 2012*), its authors mention that "more than 75% of physicians – and virtually all physicians in high-risk specialties – face a malpractice claim over the course of their career. Regardless of whether a claim results in liability, the risk of being sued may cause physicians to practice a type of defensive medicine that increases costs without improving the quality of care."[26]

But lost in almost all of the discussions of the impact of medical malpractice premiums and defensive medicine is the considerable agony and trauma suffered by those more than 75% of physicians and their families because of liability suits (or the threat of them).

The biennial surveys by The Physicians Foundation in 2008, 2010 and 2012 demonstrate how important the issue is to practicing physicians which impacts greatly on their sense of morale and optimism. This considerable (human) cost must be considered in examining efforts to change the present system, even if experts cannot agree on the financial costs.

As an article in *Health Affairs* (*September 2010*) points out, "Physicians can insure against malpractice awards, but they cannot insure against the psychological costs of being involved in litigation, including the stress and emotional toll."[27]

Parts two and three of this white paper will appear in future issues of *Missouri Medicine*. References can be found at www.physiciansfoundation.com.