
The Problem with Health Care Reform

Nathan Kaufman

Providing more benefits to Medicare recipients and the uninsured may be politically beneficial and the foundation of the Presidential candidates' health care reform plans, but such a policy will only worsen the financial strain on providers—ultimately limiting their ability to care for patients.

Whenever the government attempts to fix the nation's health care crisis, the crisis deepens. This is clearly the case with most of the current proposals to reform health care.

For example, the government recently passed Medicare Part D to reimburse Medicare beneficiaries (voters) for pharmaceutical supplies. On the surface, this program makes sense. However, a deeper analysis shows that the cost burden created by this pharmaceutical coverage may ultimately result in reduced benefits for Medicare beneficiaries.

Together, Medicare and Medicaid comprise more than 25% of the federal budget. In addition, by 2013, over 45% of the Medicare program will be funded by general revenues (versus premiums and payroll deductions). On April 23, 2008, the secretary of Health & Human Services issued a Medicare funding warning that requires Congress to consider proposals to “reduce expenditures on an expedited basis.” At the current rate of spending, Medicare's Hospital Insurance Trust Fund is projected to be exhausted by 2019.

Pressure on Hospitals and Physicians

Providing insurance coverage for the uninsured is the primary focus of most current health care reform plans. However, once these individuals have government-sponsored health insurance, they will face another crisis: an absence of hospital beds and physicians to provide care.

Medicare and Medicaid represent more than 50% of most hospitals' revenues. The Medicare Payment Advisory Commission (MedPAC) reports that, on average, Medicare pays hospitals less than 97% of the cost of providing care to Medicare patients. The deficit generated by providing care to Medicaid patients is even greater. To make matters worse, hospitals are facing cost inflation due to employee shortages, ever-increasing unfunded regulatory mandates, and escalating costs of physician services. In addition, hospitals are losing high-margin services that subsidized the losses from Medicare and Medicaid to physician-owned enterprises.

Medicare's response to these financial pressures on hospitals is to reimburse hospitals at a rate that

will decrease the hospital Medicare margin by 1% to 2% per year. The hospital industry is already reeling from this policy. Several hospitals close every year. Currently, more than 1000 hospitals are operating at a deficit. Clearly, the undersupply of hospital beds is going to reach crisis proportions in many markets—if it hasn't already.

In addition, many physicians are seeing their compensation decline primarily because of shrinking reimbursement from Medicare and Medicaid. Medicare payments to physicians are projected to continue to decline in both real and inflation-adjusted dollars. If the current reimbursement methodology is not changed, MedPAC projects that by 2010, Medicare will reimburse for physician services at a rate below what they were paid in 1996! To deal with this underfunding, physicians are:

- Limiting the number of discounted patients they are willing to treat, especially those covered by Medicare and Medicaid
- Developing freestanding services to treat the patients who generate profitable revenue for hospitals (eg, those needing outpatient surgery)
- Demanding increasing payment from the hospital for services that they used to provide on a voluntary basis (eg, emergency calls)

So, who will care for the indigent and uninsured when they are covered by the new government-

sponsored Medicare/Medicaid-like health insurance plans—the hallmark of most politicians’ plans to reform health care? Hospitals that are obligated to provide care will not have sufficient capacity. And many physicians have already limited the number of government-funded patients they will treat. The crisis will shift from “no care because of no insurance” to “no care because of no providers.”

The belief exists that if patients (“consumers”) have more financial responsibility combined with more information on the cost and quality of care, then market forces will improve the health care system. But there is no empirical evidence that consumer-directed health care will have any positive impact on the healthcare system. The best value in health care is prevention, and yet the National Center for Health Statistics estimates that over 60% of the US population is overweight. In addition, research on how patients select their health care provider for all-cash health services (eg, LASIK surgery) indicates that the pundits are wrong. Consumers will not become rational shoppers of health care once they have more out-of-pocket responsibility (see *Health Affairs*, March/April 2007;26[2]:w217-w226).

Even if the pundits are correct, the supply and capacity of providers will be so limited that choice will not be an option when urgent care is needed.

Covering the Providers

Clearly, any proposal to reform the healthcare system must address the uninsured problem. However, it must also address several other issues currently not under considera-

PROVIDER ACTION

Impact to You

Providing more benefits to Medicare recipients and the uninsured may be politically beneficial and the foundation of the Presidential candidates’ health care reform plans, but it will only worsen the financial strain on providers—ultimately limiting their ability to care for patients.

What You Need to Know

Proposals to reform health care need to:

- Allow physicians and hospitals to align financial incentives
- Increase compensation for physician–patient encounters
- Provide financial incentives to expedite the use of EMRs.

What You Need to Do

You will need to deal with underfunding by:

- Limiting the number of discounted patients you treat
- Developing freestanding services to treat the patients who generate profitable revenue
- Demanding increased payments from the hospital for services you used to provide voluntarily

tion. Health care reform must:

- Allow physicians and hospitals to align financial incentives to improve quality and reduce the cost of care
- Increase compensation for physician–patient encounters, thus eliminating the need for physicians to subsidize their incomes by cannibalizing profitable hospital services
- Redistribute Medicare and Medicaid expenditures from profitable drug companies to underfunded physicians and hospitals by allowing government-sponsored plans to purchase pharmaceutical and other medical supplies at the same rate as that negotiated by Veterans Affairs.
- Tax health care providers who do not provide their fair share of care to the indigent and government-funded patients, and redistribute those funds to providers who have a disproportionately high share of such patients.
- Scrutinize commercial insurance payers (both nonprofit and investor-owned) under antitrust laws and regulations.
- Provide financial incentives to expedite the deployment of electronic medical records (EMRs).
- Continue reporting on quality and patient satisfaction and expand pay-for-performance.
- Provide antitrust relief for tax-exempt hospitals to enable coordination of care and reduce duplication of their expensive resources needed to remain competitive.
- Reform the malpractice litigation process.

The plan to reform the nation’s health care system can strengthen the system or it can hasten its demise. The reform plan must recognize the impending crisis in the provider community rather than merely take the politically expedient approach of providing more entitlements to patients while reducing reimbursement to financially strapped providers. **MPM**

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