Saving America from the Four Horseman of Health Care

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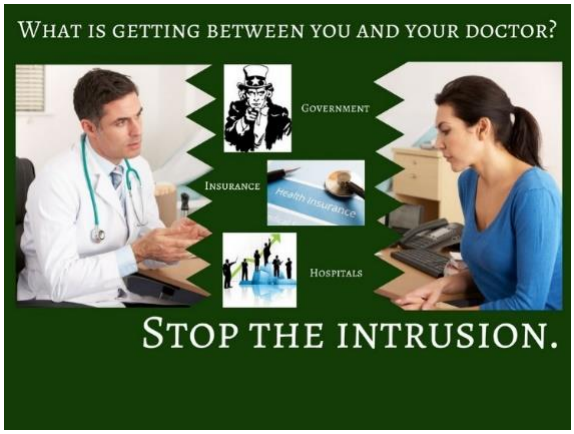
America's over-priced and unnecessarily complicated health-care system is destroying our economy, crippling our middle class, and driving out doctors. Special interest groups and other stakeholders are profiting handsomely and excessively on the backs of those who receive and provide the care.

Even though Americans spend more per capita on health care than any country in the world and their costs are rising, the average U.S. lifespan has been declining and is now shorter than 30 other countries, according to the World Health Organization.[1]

The path we're on is not only destructive and unhealthy, but it is also unsustainable. To reverse this devastating decline, Americans must work together to bring health-care costs down to healthy levels and remove intrusive factors that are compromising the patient-doctor relationship. Specifically, as we'll discuss in this paper, consumers and lawmakers need to act apart from special interests to provide price transparency, to eliminate wasteful spending where no value exists, to stop health-care consolidations, to reduce burdensome regulations, and to ultimately give consumers more value for and control of their health-care dollars.



Here we take a closer look at the various entities that contribute to our over-priced, over-burdened system to create an understanding of the root causes, and, most important, to offer solutions.

Introduction:
All Americans share the desire to have access to good quality health care at an affordable price. Yet, despite spending $3.3 trillion a year – a cost projected to reach $5.7 trillion by 2026 – our health-care system is getting worse, and costing Americans more. Already, health-care consumes 18% of our nation's gross domestic product,[2] and almost one fifth of the average family's household income.

Driving these rising costs are lack of price transparency, top-heavy hospital administrations, over-reaching insurance providers, excessive regulation, too much consolidation, and an antiquated tax policy. The status quo is big, strong and has no incentive to change the system.

Just four sectors of the industry collectively account for $100s of billions, and potentially $1 trillion of wasted annual spending: hospital systems, insurance

companies, the pharmaceutical suppliers and government-mandated health information technology.

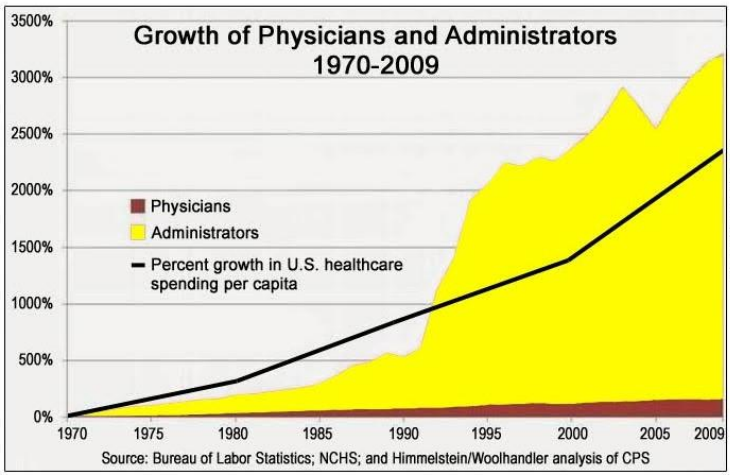
Let's look at how each one contributes.

HOSPITAL SYSTEMS

Though our nation needs and has outstanding hospitals, their top-heavy administrations, monopolistic tendencies, bargaining power and lobbying strength are costing our system far more than is reasonable or affordable.

- **Administrative Burden:**

Between 1970-2010, the number of health-care administrators grew more than 3000% according to the Bureau of Labor Statistics. During the same time, the growth of physicians was only 200%. Concurrently, spending on U.S. health care rose 2300%. From 2010-2014, over a million more health-care administrative jobs were created, largely to manage the additional regulations that resulted following the passage of the Affordable Care Act.[3]



* 2300% increase in U.S. healthcare spending per capita between 1970-2009 (Source: Health Care Costs: A Primer, The Henry J. Kaiser Family Foundation)

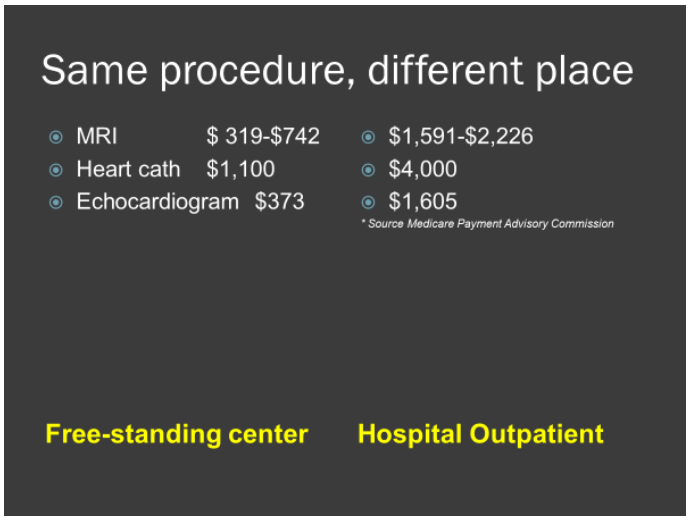
Studies indicate that administrative costs account for 20% to 30% of the U.S. health-care spending. That is far higher than spending for that category in any other country. This administrative glut leads to hospitals filled with an excess of executives and managers who provide no patient care yet take a generous portion of the health-care dollar.[4,5]

- **The price of consolidation:**

Health care consolidation is a cancer on the system. Over the past decade, hospitals have been rapidly merging with other hospitals, acquiring independent medical practices and freestanding outpatient facilities, such as imaging centers and surgery centers. This has led to a tremendous increase in health-care expenditures.[6]

Hospitals buy independent medical groups and centers so they can capture market share, and charge facility fees. These are fees that the law allows hospitals to charge that add no value. Hospitals argue that they need to charge these fees to maintain their higher overhead.

As a result, the same service that cost $500 in an independent practice or center, after an acquisition now costs three, five, even 10 times more. Because of the way the law is written, hospital-owned centers get paid a lot more for the same services as independent doctors and centers. This markup benefits hospitals at the expense of the patient and taxpayer.



In its reports to Congress, the Medicare Payment Advisory Commission has long recommended site-neutral payments between hospital outpatient departments and private physician offices. MedPAC has reported that paying the same amount for the same services regardless of where those services are performed would dramatically reduce health-care spending.[7]

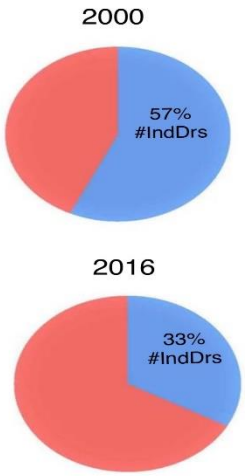
In a 2013 MedPAC report, analysts concluded that if Medicare equalized payment rates in 66 common categories, and paid hospital outpatient departments the same as private doctors or only slightly more, net health-care spending would go down $900 million a year.[8]

Currently, the law allows Medicare payments to flow differently depending on whether payments go to a hospital outpatient setting (Outpatient Prospective Payment System -- OPPS) or to a private physician (Physician Fee Schedule -- PFS). Thus, it allows hospitals to get paid more, often several times more, despite the consequences to the patients. Because this pricing disparity is written into the law, only Congress can change it.

The change would make a significant impact. A study out from the Physicians Advocacy Institute reported that hospitals buying up doctors was the leading driver in soaring Medicare costs. Between 2012 and 2015 Medicare costs rose $3.1 billion due primarily to the 49% increase in hospital-employed doctors that occurred over the same period, the report said. And here's the clincher: The study only looked at four procedures. If the tally included all procedures, the total would be far higher.[9]

Site neutrality would also help keep America's doctors independent, which would help preserve and restore the sanctity of the patient-doctor relationship. If independent doctors received the same reimbursements as hospital-employed doctors for the same services, hospitals would not be incented to buy medical groups, and doctors would be less inclined to become hospital employed. Currently, because of the uneven reimbursements, hospitals can afford to pay doctors more than these doctors can make in independent practice. A level playing field would eliminate this significant driver behind our nation's

rising health-care costs.



As the following graphic illustrates, in 2000 well over half of our nation's doctors were independent. Today that number is one in three.

Hospitals operate as businesses with no incentive to keep costs down. In fact, they encourage emergency room visits, and train their primary care doctors on ways to internally refer to in-system specialists, surgical centers and rehabilitation facilities. They train billing officers to up code where possible when generating bills to generate higher reimbursements. In areas where one health system has a monopoly, patients have little to no choice, and prices can be ten times higher than costs for the same care at independent centers.[10]

Source: Accenture

Studies show that surgeries performed in physician-owned hospitals or smaller independent surgery centers cost on average 30% less than those performed in a hospital-owned facility. Taking these surgeries out of the hospital setting would result in a savings of $500 billion per year. The independent physician-owned Oklahoma Surgery Center dramatically lowers fees by operating on a cash basis, transparently publishing fees. Yet, the Affordable Care Act stifles growth of independent surgery centers.[11]

In addition to getting additional revenues, another reason hospitals buy medical groups and merge with other hospitals, is to gain market share and eliminate competition, which increases their bargaining power with insurers. (These payers, we'll see in the next section, also have no incentive to keep costs down.)

Regardless of what merging parties will tell you about streamlining care, cost reductions and greater efficiencies, when health-care entities merge, costs only go one way, up, way up. No legitimate study shows otherwise. The only parties who benefit are the executives at the top.

This is why consumers need price transparency. Cash pricing for all services needs to be the standard. The fact that 90% of all health-care payments go through a third party keeps both patients and doctors alike in the dark about what health care costs.

For consumers to be good stewards of their health-care dollars, and for doctors to be allowed to make prudent decisions, pricing must be clear. Representatives from both sides of the aisle have introduced HR 4808 a pricing transparency bill to that effect.[12]

- **Tax-exempt abuse**

In America, 62% or 3,900 of our hospitals and health systems are "non-profit." In other

words, they are tax exempt. These institutions pay no property tax, no state or federal income tax, no tangible personal property tax and no sales tax. Yet, many of the executives at these hospitals receive seven-figure salaries, enjoy skyboxes and luxury retreats, and host extravagant galas to fundraise.

Exempting certain charitable hospitals from taxes in exchange for taking care of the poor and elderly for free worked well in the 1950s, when these often religious organizations really did provide charitable care. But when Medicaid and Medicare came along in the mid-sixties, the old and poor had a safety net. Hospitals, however, did not want to give up their tax break, so they invented other ways of "giving back."

To justify their not paying billions of dollars in taxes, they claim on their 990 tax form the "free care" they provide to the poor and indigent. Only, as the chart below illustrates, they value this care using Charge Master prices, grossly inflated fees that are many, many times higher than any insurer would pay or Medicare would allow.[13]

Diagnosis	Avg. Charge Master Price	Total Medicare Allowable
Transient Ischemia	$30,192.00	$4,724.00
Simple Pneumonia and Pleurisy	$52,865.00	$9,380.76
Major Cardiovascular Procedures	$118,169.12	$21,269.39
Perm. Cardiac Pacemaker Implant	$86,717.42	$16,268.58
Chest Pain	$25,559.37	$3,626.24
Laparoscopic Cholecystectomy	$70,545.43	$10,699.04
Back and Neck Proc. Exc. Fusion	$51,584.65	$6,881.58
Infectious and Parasitic Diseases W O.R. Procedure	$180,708.87	$35,452.36

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Worsening the situation, every time a nonprofit hospital buys a for-profit medical group or freestanding center, the taxes that entity once paid into the community come off the tax rolls. Nonprofits are decimating their communities by eroding the tax base.

Uncompensated care in hospitals averages 6% a year and could be easily covered as a business expense.[14] For-profit hospitals do this all the time. Thankfully, the government has started looking more closely at what the nonprofit hospitals provide their communities in exchange for not paying any taxes, and a few – but not enough – have had the tax-exempt status revoked.[15]

Encouraging and rewarding physicians to treat our neediest patients in a truly charitable manner and receive a tax deduction in return could have a substantial cost-saving

impact while immediately increasing access for the poorest Americans. Bills to this effect are in the works and deserve serious consideration.

INSURANCE COMPANIES

Meanwhile, America's insurers account for another large slice of health-care spending. According to a study by the Commonwealth Fund, our nation's health insurance companies get two times more health-care dollars than the next leading developed country, and more than three times as much as many countries.[16,17] Inserting insurance companies into the health-care process hurts the system in several ways. First, because their contracts are confidential, they contribute to the lack of transparency in health-care costs. Second, the need for prior authorization (often from non-medical personnel) undermines doctors' authority to choose what's best for the patients.

The time medical personnel spend dealing with third-party payers is excessive and getting worse. In the United States, nurses and doctors spend nearly half their work week (21 hours) on insurance related issues, time that would be far better spent on patient care.[18]

- **Coverage is not care**

Insurance coverage gives Americans peace of mind because it is perceived as care, though it's not. However, our country's singular focus on providing coverage for all Americans is keeping costs hidden and high. Insurance companies and hospitals are the big winners. Of course, they want everyone covered – the insurance company gets to collect more premiums and the hospitals get guaranteed payment.

But this does nothing to reduce costs. In fact, our social experiment with mandated coverage has led to much higher deductibles, premiums and copays. Escalating premiums and deductibles are crushing our middle class, who are spending 20% of their household budget on health care, which they still cannot afford to access because they can't afford their deductible.[19]

As mandated coverage increased without transparency of cost, hospital systems and insurance companies have quietly profited with both hospital and insurance executives earning seven, and even eight-figure salaries.[20]

- **Incented to raise premiums**

Just as hospitals have no incentive to keep medical costs down, neither do insurance companies. One of the mandates in the Affordable Care Act, the Medical Loss Ratio provision, inadvertently rewards insurance companies for raising their prices. Requiring insurance companies to pay 80% of all premiums toward claims and retain only 20% for profits sounded good in theory, but insurance providers quickly figured out that the higher their premiums, the bigger their 20%. Predictably, insurance premiums have soared since the Affordable Care Act took effect.[21]

- **Networks ration care**

Insurance today has not only become increasingly expensive and confusing, but also more limiting. Insurance plans are limiting the number of doctors a patient can see by creating narrow networks, which ration care. This often results in a surprise bill for patients who may have multiple medical issues and who go to a hospital that accepts their insurance and gets treated by a doctor who is out of network.[22]

- **Health benefits or wages?**

Health care became about insurance in 1942 with the Standardization Act. After President Franklin Roosevelt froze wage increases, businesses looked for another way to compensate employees, and convinced the government to let them use pre-tax dollars to offer employees health insurance. Citizens purchasing individual insurance paid with post-tax dollars. Subsequently, businesses used insurance products to retain employees.

Today, the link between insurance and employment makes insurance non-portable, and limits American's employment mobility, especially as insurance costs have risen. Ultimately, the more employers are forced to pay in health benefits, the less they can afford to pay employees in wages. This is another way the current health system is crushing the middle class. As companies pay more for their employees' insurance (with pre-tax dollars) and less in wages, they pay less and less payroll taxes. This lost tax revenue was estimated at $250 billion in 2013.[23]

PHARMACEUTICAL SUPPLIERS

Alongside hospital systems and insurance providers, the pharmaceutical industry also contributes significantly to rising health-care costs. In 2017, the United States spent more than $360 billion on prescription medications – triple what was spent in 2000 -- and $31 billion for over-the-counter drugs.[24,25] The trend shows no signs of slowing.[26]

- **GPOs, PBMs and deadly drug shortages**

At the center of these growing costs are Group Purchasing Organizations, which control the supply chain of medications and all hospital supplies to inpatient facilities, and Pharmacy Benefit Managers, which perform the same role for outpatient centers. GPOs and PBMs are middlemen disruptors that increase costs and create drug shortages. The shortages occur because the price to play in the system is simply too high, so drug manufacturers opt out.

Four GPOs dominate the inpatient market: Premier (publicly held), and Vizient, Healthtrust and Intalere (all hospital owned).

Similarly, three PBMs serve as middlemen for outpatient medications[27]: The companies are Express Scripts (publicly traded), OptumRx (a subsidiary of insurer UnitedHealth Group), and CVS Caremark (a subsidiary of CVS drugstores).

These intermediaries do no product development, do no research, and own no patents.

They do not produce any product. Yet they control nearly 90% of the pharmaceutical supply chain, for which they siphon off billions of dollars each year.

The three PBMs that dominate the field collect more than $200 billion a year to manage prescription services for insurance carriers covering 180 million Americans and government programs serving about 110 million more.[28]

The Safe Harbor Act of 1987 is to thank for allowing these organizations rise to this level of profitable power and control. The act allowed GPOs (and a few years later PBMs) to do what is illegal for hospital to do. They can take kickbacks from suppliers – the drug makers and medical device makers. These pharmaceutical and supply companies pay for access to buyers in a “pay to play” system, buying market share in return for contracts that give them access to exclusive contracts with GPO-member hospitals.

This safe harbor law rigs the whole supply chain. The kickbacks these suppliers pay the GPOs and PBMs for access to buyers can equal more than half of the suppliers' annual income for a single drug. A 2011 study found that the safe harbor inflated hospital costs by $30 billion dollars. Today, experts estimate 200 billion dollars.

Predictably, some suppliers have opted to simply stop producing drugs for which they have to pay such a high price to a middleman in order for their product to reach hospitals or outpatient centers. This refusal to pay for access has reduced the supply and therefore driven up the cost of vital drugs such as antibiotics, cancer drugs, anesthetics, and injectable solutions like bicarbonate and saline (simple baking soda and salt water).

Drug shortages force drug rationing, which raises ethical issues. The National Cancer Institute and Children’s Oncology Group have had to create protocols for cancer drug rationing due to shortages.

Due to this artificially controlled market, simple generics are now also expensive and in short supply. For example, epinephrine costs $1000 per prescription, intravenous nitroprusside costs $880 for 50mg, intravenous isoproterenol costs $1,790 per mg, and intravenous diltiazem is no longer available at any price. In crucial fields of anesthesia, surgery, emergency medicine and intensive care, shortages of Propofol, lidocaine, epinephrine and sodium bicarbonate contribute to the delay of medical or surgical treatments, prolonged awakening from surgery, and delayed hospital discharges.

Furthermore, the shortages have forced the U.S. to import cancer drugs from China, where manufacturing oversight is questionable.[29]

No path to affordable health care exists unless we address the pharmaceutical supply chain, and how it has been repurposed for profit.[30]

INFORMATION TECHNOLOGY

Electronic health records have become an increasing burden for health-care providers, costing billions of dollars and wasted hours. For every two hours a doctor or nurse spends on patient care, he or she spends three hours on a computer entering EHR data.

Researchers from Dartmouth-Hitchcock health system observed 57 doctors in four states and found that they spent 27 percent of their office day on direct clinical face time with patients and 49.2 percent on EHRs and other desk work.[31]

The burden of electronic medical records does not just cost doctors time away from patients, but also money. Further, it deprives patients of access to their over-burdened doctors, and indirectly drives up their costs. Independent doctors each spend on average $32,000 a year to own, operate and maintain the hardware and software required for EHR. Ironically, the “Quality Data” generated for CMS are neither being analyzed nor justified as to how or whether they improve or impact care, further proving that this data-gathering is burdensome busywork.

These high-tech medical reporting systems have so far failed to reduce the cost of billing. Furthermore, the White House’s 2018 economic report, released February 21, linked physicians' struggles to purchase and operate EHR systems to the increase in consolidation among hospitals. Reduced competition among hospitals is widely seen as a driver of healthcare costs.[32]

The Patient Quality Reporting System costs physicians $15.4 billion per year. The implementation of the Medicare Access and Chip Reauthorization Act/Merit Incentive Payment System (MACRA/MIPS) is expected to add $20 billion.

Practicing physicians know that the essence of the patient-physician relationship cannot be measured, quantified, regulated or controlled. Regulatory requirements for coding and claim processing are expensive burdens. Studies indicate that if coding and claims were streamlined, America would save $150 billion a year in health care costs.[33]

As the bureaucratic burden rises for physicians, they are opting to leave clinical medicine, retiring early and dissuading the best and brightest students from the profession,[34] all while we face an aging population that will need more not fewer doctors.[35]

THE PHYSICIAN WORKFORCE

Physicians account for only 8 cents of the health-care dollar, yet somehow, they get blamed for rising health-care costs. As costs escalate -- thanks to hospital consolidation, rising insurance costs, pharmaceutical cartels, and burdensome reporting requirements – the focus needs to shift to the other 92 cents.[36]

Physicians are the most highly trained professionals in our society for good reason:

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They are entrusted with nothing less than the nation's health. Yet our failing system is burning out this valuable resource by increasing their pressures, while decreasing their pay and autonomy.

Physicians are not the problem. But they are uniquely poised to be part of the solution.

SOLUTIONS

To reverse the negative effects these significant forces, and to save our health-care system $100s of billions while improving quality of care and access, we need to act unequivocally to accomplish the following in these four arenas:

Hospital systems

- **Make health-care pricing transparent.** Require hospitals to post cash prices. Pass HR 4808. Also require that all entities in the health-care revenue stream make the flow of money transparent (the sum of collected revenues, and who is receiving those revenues).
- **Require site neutrality**. And eliminate facility fees. This would help consumers shop, and reduce the incentive for hospitals to acquire doctors, which would slow consolidation, preserve independent doctors, and greatly reduce costs. (Again, the core principle here is that cost of care should not change based on where that care is provided.
- **Deter health-care consolidation.** Prohibit further hospital consolidations both vertical and horizontal
- **Stop the tax-exempt status abuse of nonprofit hospitals.** Either require them to provide true charitable care calculated at Medicare Allowable prices or pay taxes.
- **Remove barriers that prevent physicians from choosing independent practice**, and from owning hospitals and surgery centers.

Insurance companies

- Expand free market options for insurance. Remove the middlemen.
- Repeal legislation that prevents the growth of direct pay care, and remove barriers to establishing direct care
- Streamline the system so Medicare and Medicaid patients can opt for direct pay care
- Restructure Healthcare Savings Accounts law, so consumers may use HSA funds to pay premiums for private plans, direct primary care expenses, and health sharing programs. (Currently HSA funds can only be used to pay premiums for long-term care, COBRA, and Medicare parts A, B, C, and D.)
- Allow individuals the same tax advantages afforded to employers when purchasing insurance

Pharmaceutical Industry

- Repeal Safe Harbor Act for GPOs and PBMs

- Allow purchase of pharmaceuticals from online sources
- Allow international purchase of pharmaceuticals
- Allow the U.S. to be on a level playing field with other countries with respect to drug pricing competition in international markets
- Allow Medicare to negotiate drug prices
- Streamline and loosen rules on proven drugs from non-US sources

Information Technology:

- Streamline regulatory requirements, coding and claims
- Make EHR optional. Allow doctors to choose their preferred record keeping systems, either EHRs or paper charts.
- Make MACRA/MIPS voluntary, or repeal it

Physician Workforce

- Allow physicians the ability to see economically disadvantaged patients and deduct the charitable care given**.**

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