SOCIETY OF ACTUARIES

Article from:

The Actuary

February 1996 – Volume 30, No. 2

OPINION

Avarice, adversarial relationships and bureaucracy: Major causes of our health care financing problem?

by Robert J. Myers

Conventional wisdom asserts that the causes of our apparently ever-continuing health care financing crisis are over-use of services, unnecessary services, inefficient providers, and excessive charges of providers. The influence of each of these elements varies, depending on the views of the beholder and critic.

In my view, the major causes of this elusive problem are avarice, adversarial relationships, and bureaucracy among the parties involved: insurers, providers of services, and patients. (The term "insurers" is used broadly to include the federal government in connection with the Medicare and Medicaid programs, commercial insurance companies, Blue Cross/Blue Shield plans, health maintenance and similar organizations, large employers with self-administered plans, and managed care plans.)

As an actuary, I like to have hard facts on which to base my views and conclusions and to "substitute facts for impressions." Unfortunately, in this area of health care reform, this is not possible.

Some aspects of the big picture

In the past, insurers have made unilateral attempts to contain health care costs. Notable among these was the change from a reasonable cost basis of reimbursement of hospitals under Medicare to the diagnosis-related group method under 1983 legislation. On first glance, when only Medicare's financial operations are considered, this was outstandingly successful. However, the cost shifting by hospitals to other users of the services—mostly to other than Medicare insurers—largely (or perhaps even entirely) offset the gain.

Recently, the larger and more powerful of these other insurers have exerted pressure on the suppliers of services to lower their charges. This resulted, in part, in greater cost shifting to the remaining small insurers and the relatively few individual payers. In some cases, large insurers have forced the suppliers of services, being less powerful and organized, to provide services at less than their costs. If suppliers had not done so, the insurer would have diverted the business elsewhere, and so the provider, by operating at low capacity, would have had an even greater loss. Under the circumstances, the unfortunate provider had the choice of the lesser of two evils, with ultimate bankruptcy whether it lowered charges or lost the business.

Further, the resulting conflict between the insurer and the provider of services can cause the latter to cut corners on the services and not deliver the high-quality, adequate-quantity services called for. Some suppliers might even justify intentional cheating and fraud on the dubious grounds that they are just protecting themselves, and that "everybody else is doing the same thing."

Also, when the insurer builds the panel of "acceptable" physicians, the best ones (however that can be determined) tend not to participate, because the reimbursement rates have been bargained down to a much lower level than their usual and customary ones. On the other hand, the less capable and qualified physicians with less business are naturally eager to sign up.

So, the patient loses out in the end, by having fewer suppliers available and receiving inadequate, lower-quality service, possibly with long waiting times, less comfort, and inhumane treatment.

A law of physics states that for every action, there is an opposite and equal reaction. Recently, some service providers have banded together to defend themselves against the power of the larger insurers. This movement has taken the form of such entities as independent physician associations and physician-hospital organizations. The result is more adversarial reactions and an unsatisfactory health care atmosphere.

Inept, slow-moving bureaucracies can result in health care which, although low in cost, is not of high quality nor humane. High-technology procedures will not be "allowed" or will be reimbursed at the low amounts applicable to primitive procedures, and the insurers will, naturally, not protest. At the same time, the patient will be unaware of the situation of the physician or surgeon being more interested in the bottom line than in the patient.

Two micro examples

Two actual situations with regard to the operations of an ambulatory surgery center (ASC) in the Midwest are good examples of how some of these conflicts work out in actual practice with managed care plans and Medicare.

Most such plans have adopted the use of the eight Medicare outpatient ASC groupings as the basis for their contracts, usually based on the Medicare rates plus a percentage. As technology has improved, several new procedures can now be done on an outpatient basis by an ASC that are not approved by Medicare. These new

(continued on page 5)

Health care financing problems
(continued from page 3)

procedures are usually a bone of contention with managed care plans.

Following are two examples of the difficulties encountered.

Laparoscopic hernia repair. Adult hernia repair can be done either as an open procedure or by a laparoscope. The open procedure requires a large incision by the surgeon, which results in a much longer recuperation period. The ASC charge for this method is approximately $1,000, and the Medicare-approved reimbursement is $570. "Lap" hernia repair is done through two small incisions, with a recovery time of three days or less. Medicare has approved the procedure but allows for only the same reimbursement as an open procedure. The equipment required to do the procedure laparoscopically costs more than $80,000, and the disposable supplies cost more than $500 per case. Because money is lost on Medicare cases, surgeons are urged to do Medicare cases as an open procedure. A base charge of $2,400 has been established for a lap hernia repair for all other insurance carriers. Managed care plans are given the option of accepting that price or having only the open procedure for their subscribers. This is unacceptable. It allows a managed care plan to dictate the type of procedure over the surgeon's knowledge of what is best for the patient. The issue has not been resolved with some managed care plans, because they will only reimburse at whatever rate is established in the contract, normally a group 4 rate or roughly $600. In those cases, the surgeons are told to schedule their cases elsewhere.

Laparoscopic cholecystectomy. A "lap choly" permits the removal of the gall bladder using a laparoscope through two small incisions. The same equipment is used for this procedure as for the lap hernia repair, but the disposable supplies are more expensive. Because Medicare does not approve this procedure, the same problems have been encountered with managed care plans. A base charge of $2,500 has been established by the ASC for all plans. Medicare patients are refused. Again, several managed care plans have wanted to reimburse at the unlisted procedure fee (roughly, $600). This would not even cover the cost of the supplies. Patients from these plans have not been accepted. The last surgery refused on this basis was done at a hospital, and the charges were more than $7,000.

It may be naivete and wishful thinking on my part, but a new start and reconciliation among insurers, providers of services, and patients is long overdue. All parties involved should cooperate with each other, neither seeking excessive gains for themselves nor demanding a "pound of flesh" from their colleagues, clients, and suppliers. Within the recesses of my actuarial heart and mind, I devoutly hope that this can be accomplished.

Robert J. Myers was chief actuary at the Social Security Administration during 1947-1970 and deputy commissioner during 1981-1982. During 1982-1983, he served as executive director of the National Commission on Social Security Reform. Since 1993, he has been a member of the Prospective Payment Assessment Commission. He is a past president of the Society of Actuaries and lives in Silver Spring, Maryland.

AERF establishes Wooddy Scholarships

Four scholarships worth $2,000 each will be awarded for the first time in July 1996 from the new John Culver Wooddy Scholarship Fund. Administered by the Actuarial Education and Research Fund (AERF), this fund was established when Wooddy, who died in 1987, left nearly one-third of his estate to AERF to provide "scholarship aid for worthy students pursuing an actuarial education." Wooddy was active in the profession, serving two terms on the SOA Board of Governors and founding the Reinsurance Section in 1982.

Eligible undergraduate students are those who will be seniors in the semester after receiving the scholarship, are ranked in the top quartile of their class, have successfully completed at least one actuarial exam, and are nominated by a professor at their schools.

Applications are limited to one a school, and financial need is not a factor in selection. Students may obtain applications from their professors or from Paulette Haberstroh at the Society of Actuaries, 708/706-3584. Deadline for application submissions is March 31, 1996.

Editorial
(continued from page 2)

Canada has solved the generational problem by providing the same coverage for every citizen, regardless of age. Their workers today do not have to bear the burden of demands for more care by the retired population. Maybe Canada's system would work in the United States. Or, maybe Americans will be driven to it through cost increases that cannot be controlled because of the demands of the generation that votes.