

CHAPTER 5

HEALTH POLICY: RATES, REGULATIONS, AND BODY PARTS

Because we have no goal or vision for our health care system, our health care policy, by default, is just rates, regulations, and body parts. Whatever changes we make are tinkers at the edges of a fatally flawed system. And, any tinkering we do in one part, only increases costs in the other parts.

When hospital payments changed from charges per day to flat fee per diagnosis, hospital costs went down. But, when hospital costs went down, outpatient costs went up. The problems of health care treatments did not disappear. What changed was where and how patients were treated and who got the money.

Like a giant amoeba, when we poke at a health care cost here, another health care cost pops out over there. We cannot fix what we have because we have no idea what it is supposed to do except not cost so much. We have conflicting agendas that cause cost-shifting from the private to the public which only serves to increase the costs of public programs. Then we complain about taxes and try to cut the public programs.

PUBLIC POLICY, PUBLIC PROGRAMS

Medicaid and Medicare were created in the early 1960s to care for the poor—largely women and children, the disabled and the elderly, and for all those who, for various reasons, could not fend for themselves.

Medicare was created to care for the elderly and covered those things that were of most concern to the seniors at that time—hospital costs. The government would pay for hospitals through Medicare Part A, with a trust fund that is financed by payroll taxes by current employers and employees.

Current workers pay for their parents' Medicare. The Boomers' kids will pay for the Boomers' Medicare.

Outpatient costs—Medicare Part B—is paid in part by the Medicare Trust Fund and by individual premiums.

When Medicare was created, the basic structure of the health care system was the fix-it, disease-oriented, fee-for-service system that simply paid pretty much what the hospital or physician charged. Like the commercial, private insurance system of that time, it did not cover preventive services, such as annual physicals or any early diagnoses or screenings. A patient went to the doctor, the doctor billed Medicare and billed the patient for the difference, if there was any.

When Medicare was created in the 1960s, the average age of death and eligibility for Medicare

were nearly the same—sixty-five years of age. Medicare got in trouble when people started living longer. No one expected our rapid jump in longevity. So, when people began living longer, and the new technologies converged, cost and access became an issue. In passing Medicare and Medicaid, Congress got into the business of employee benefits, because they defined what Medicare and Medicaid would pay for and what services or benefits, would be covered.

If something like mammograms is to be covered by Medicare, it literally requires an “Act of Congress” to add it to the Medicare benefit list. This means any new technology or procedure has to be added to Medicare, body part by body part. Commercial insurance follows the public approach because Medicaid and Medicare are such big payers. We now have Congress deciding about “drive-by deliveries,” or “mental health parity”—the same body part approach to health care. So health policy is reduced to cover this and cover that without a view for the health of the body as a whole, much less the health of a nation.

And commercial insurance just trots down that same path, because it requires less thought and less imagination.

An entire panel now exists within the Health Care Financing Administration—the Medicare Coverage Advisory Commission—to decide which procedures, biologics, medical equipment and medications will be covered by Medicare

rather than leaving the decision to the patient and provider. Those of us on the panel have had to file financial disclosures, be finger printed and have FBI clearances, all in the name of conflict of interest. But, many of the members and the expert participants, e.g., The Rand Corporation, EBRI, and Blue Cross/Blue Shield Association of America, get or give money to everyone or select the services their members receive. It is simply impossible not to have some kind of conflict of interest in this industry.

Now, with costs escalating, with an aging population that is living longer and using more services, and with Medicaid costs increasing as well, the only course Congress has taken to address health care has been to define benefits and control rates. They simply set the rates public programs will pay for the people who are providing care: doctors, hospitals, medical equipment vendors, and nursing home and home health care aides. Because they have no view of what a system of care should do, they set rates and define the range of benefits based on the latest lobbying effort, rather than setting standards.

One serious consequence to our rate, regulation, and body part approach is that many doctors refuse to participate in public programs or take patients on Medicare or Medicaid because they are not getting enough money to cover their costs. Consequently, many people who ostensibly have insurance really don't, because they can't find

doctors or, sometimes, hospitals who will take them. Especially now.

AND, NOW REGULATIONS

In addition to micromanaging by body parts in insurance coverage and trying to control costs simply by setting rates, we have regulated the health care industry to the point of insanity. Medicare coverage regulations exceed the IRS code in length, with nearly two hundred pages of what Medicare will and will not cover. The same is true for applications for public programs. In Washington State, the application to qualify for public assistance and Medicaid is twenty pages long—you would have to be totally desperate to answer so many, often humiliating questions to qualify. Many people who are eligible simply will not apply.

Then, in the rush to turn to managed care to save costs in the 1990s, an entire new fleet of workers was created in hospitals, health plans and physician offices. They spend their day reviewing contracts and faxing forms just to make sure the patients are actually eligible for services, that they are seeing the right doctor and going to the right hospital. One clinic in California, as an example, has twenty-five fulltime people who do nothing but verify eligibility, authorizations and referrals. The complexity of managed care network's rules, payment contracts, and contract requirements added cost to a system that was already beginning

to be gouged, added no value to patient care, drove up administrative costs and bled the system further.

We are suffocating in paperwork, rules, and regulations and are spending fortunes on lobbyists and body-part-of-the-month legislation. The focus is on Congress, because the private commercial insurance market won't cover anything unless it has to. But, if Congress says so, then they will follow suit. So everyone focuses on Congress, because as Congress goes, so goes the insurance industry. However, Congress is held hostage to the latest advocacy group and the latest lobbyist. Benefit changes are made to appease one group over here, then they cut costs over there, so their actions end up canceling each other out. We are all losers in this approach, because this is not a rational game.

As citizens and patients, we are buffeted on a sea of change, because we have no idea where we are going and what a system of care should do.