INSIDE: The Doctor as a Patient, Transportable Data, Disparities and the Disadvantaged

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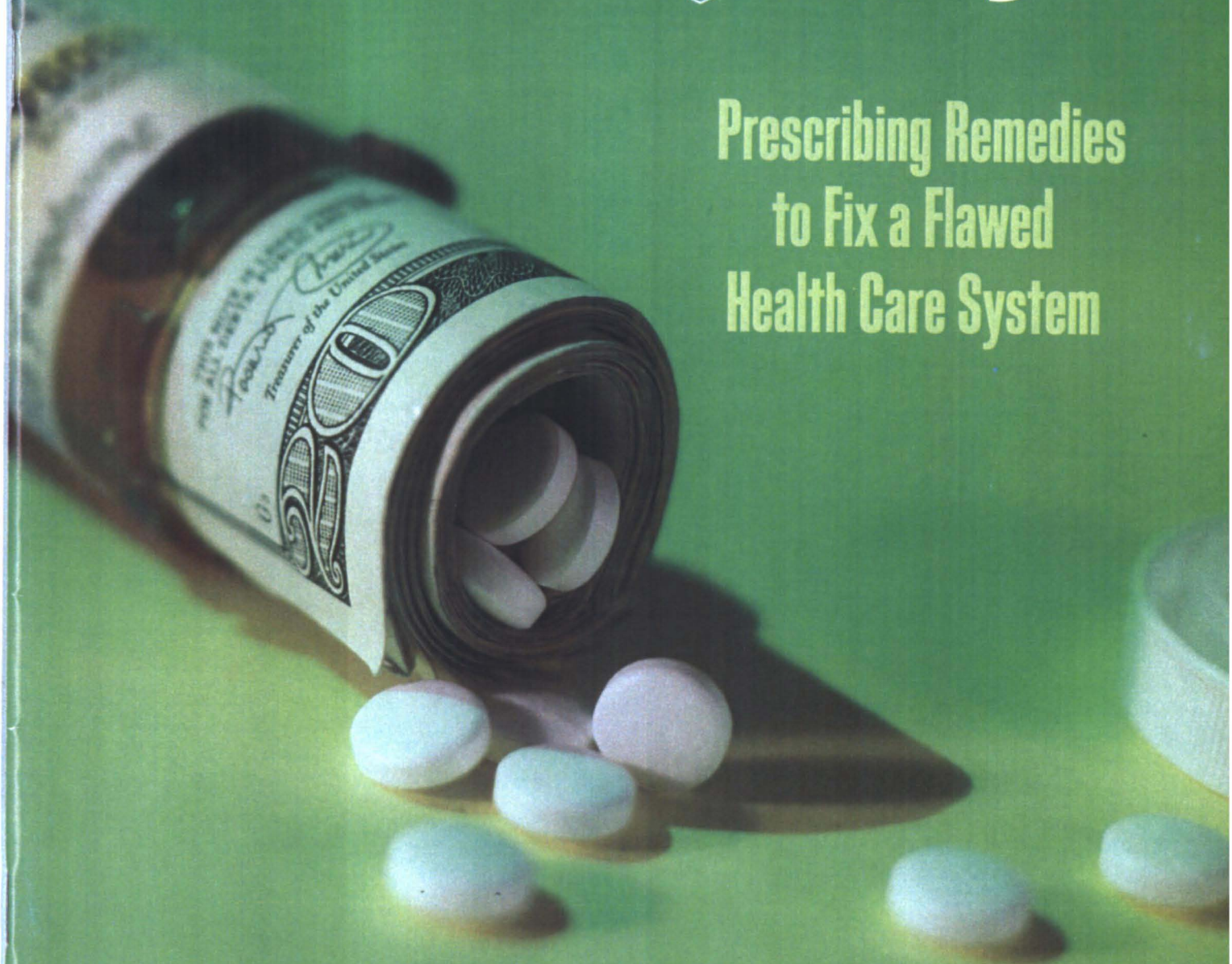

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EDITORS' NOTE

Teresa A. Cheek
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Science and technology are making possible cure or amelioration of illness in ways unimaginable only a few years ago. Yet, economic pressures and political inertia prevent increasing numbers of Americans from gaining access to basic health care, let alone those breathtaking advances. The current structure of health care finance, remodeled intermittently and haphazardly over the past half century, pleases almost no one.

This year's changes in federal and state leadership present a chance for change. A confluence of increasing cost and inconvenience involving society's most important institutions has the potential to provoke cooperation among natural antagonists who share dissatisfaction with the status quo.

Delaware Lawyer presents five important viewpoints on these issues. Widener law professor Andy Fichter suggests what might happen if there are no changes in health care policy. Neurologist Dr. Alan Fink describes in vivid detail the experience of a physician who became a patient. Johns Hopkins health finance expert Gerry Anderson explains how it came to be that uninsured patients are charged more than those with the good fortune to be insured. Paul Kaplan, chief medical officer of Blue Cross, describes the health care industry's need for an information network. Lolita Lopez, Sarah Noonan, Terri Cheek and Dr. Christine Donahue-Henry explain how community health centers deliver primary health care services without regard to ability to pay in a creative, effective way.

Many choices face us. The worst possible outcome would be for us to look back from 2028 and rue the missed opportunities of this era.

Delaware Lawyer also notes with sadness the passing of Hal Schmittinger, a titan of the Kent County Bar who, as a leader of the Delaware Bar Foundation and president of the Delaware State Bar Association, helped launch this magazine 26 years ago.

Teresa A. Cheek

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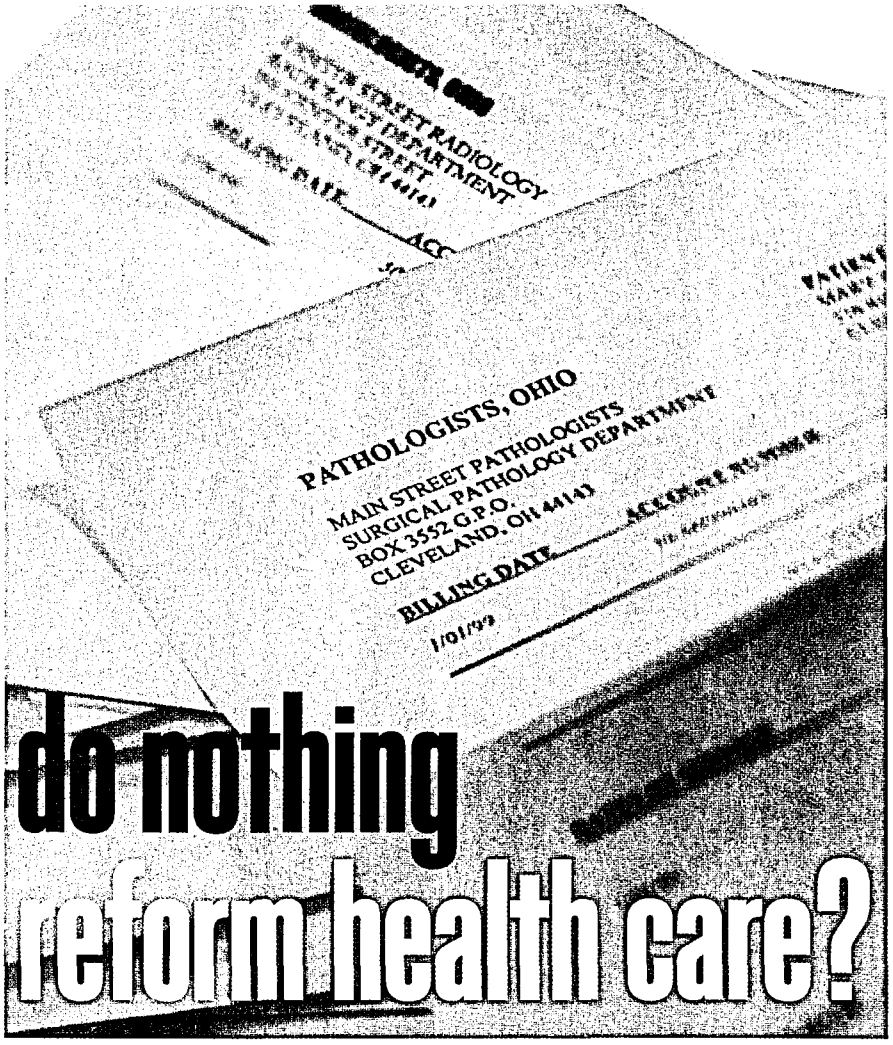
FEATURE

Andrew J. Fichter



What if we do nothing to reform health care?

More than half the public believes the American health care system is functioning poorly and requires fundamental changes.

If the answer to the title of this article were based on recent surveys of public attitudes, inaction would seem unlikely, and this would be a very short article. More than half the public believes the American health care system is functioning "badly"[1] and requires fundamental changes. The portion of the public that believes the system needs complete overhaul has increased for two decades.[2]

Yet, we have been here before[3]; each time broad reform has seemed likely, it has been derailed by entrenched interests.[4] So we need to consider the consequences if the past outcome repeats itself.

Cost

We can expect continued increases in the amount we spend, in the rate of increase [5] and the percentage of our economy represented by health care.[6]

Access

The number of uninsured will continue to rise, those with insurance will pay more out of pocket for health care and employers will reduce the coverage they offer.[7]

Quality

There are encouraging developments worthy of note,[8] but as yet no evidence that morbidity and mortality rates are falling.[9]

That trends may continue does not mean that things would remain the same. Some trends lead to disaster. In a survey of persons planning to attend a recent World Health Care Congress,[10] most believed that employer-based health insurance coverage will erode further. This would constitute a fun-

damental change in our health care coverage system. Medicare's trustees project that if spending increases at the current rate, Medicare's hospital trust fund (Part A) spending would begin exceeding federal tax receipts this year, and the fund would be out of money by 2019.[11] If these projections have merit, doing nothing will assure that something new — and probably unwelcome — will happen.

But before we contemplate how forces already at work may distort the picture of our health care system, let's look at that picture in its current form.

Cost

Americans spent $1.9 trillion on health care in 2005, or $6,697 per person, nearly twice the rate in France, Canada and Germany and two and a half times that in the United Kingdom, Italy and Japan.[12] Health care expenditures have increased from less than 5 percent of gross domestic product in 1960 to nearly 15 percent in 2005. The Congressional Budget Office has projected that, without changes in law, health care will constitute 25 percent of gross domestic product by 2025 and 49 percent in 2082.[13] By another estimate, if we do nothing, by 2040 there would be no money left in the federal budget for anything other than Medicare, Social Security and interest on the national debt.[14]

What is driving the cost increases? The answer is, a list of some things we may want to change and some things we may want to leave alone. Technological and clinical advances have historically contributed the most.[15] This factor accounts for between 38 and 65 percent of the long-term growth in health care expenditures, depending on whom you ask.[16] Obviously we would want to think twice before taking action to restrain this trend. The next most significant factor is inflation — increases in the cost of medical goods and services — which may account for close to a quarter of long-term growth in health care spending. Inflation in health care outstrips that in the general economy.[17] While there may be opportunities to reduce cost here by reducing over-utilization of health care services, such measures have never achieved much popular or political support. Inevitable demographic changes — the fact that our population is aging — may account for between 2 and 7 percent of spending growth.[18]

The good news is that we may be able to do something about such other factors as changes in third-party payment arrangements, administrative costs and fraud control. Managed care, as it turns out, was a significant development in the struggle for cost control (while it lasted). [19]

The bad news is that the things we can do something about are not always the biggest cost factors.[20] It may discourage lawyers and lawmakers who devote significant energies to fraud and abuse issues to learn that that fraud, for instance, is probably a negligible factor. (On the other hand, lawyers may be encouraged by data to the effect that they do not contribute as much to cost increases as some insurers and policy pundits suggest: malpractice premiums account for less than 1 percent of health care costs.[21]) I stray from my premise, however, in speaking of what might happen if we do something about health care costs.

Access

Health care policy makers do not think of the issue of cost in isolation, but rather in relation to two other policy concerns, access to care and quality of care. The relationship is dynamic. Put simply, increases in cost can be expected to correspond to increases in quality, but will be reflected in decreases in access (the number of people served drops as care becomes more expensive). Conversely, if we want to increase access to health care goods and services, we can expect a corresponding drop in quality and an increase in cost. Push on any component of the triad and the effect is felt by the other two. (This insight helps organize any health care essay, including this one.)

The most notorious access statistic is 47 million, the number of uninsured persons in America today. The best-informed view is that this number will increase, not only as an absolute number but as a percentage of the total population.[22] However grim this prediction may be, it does not tell the whole access story. Several other trends deserve mention, two of which will receive it here.

First is the trend toward more out-of-pocket payment by everyone, even those with insurance.[23] Leading health care economists also believe that out-of-pocket spending will increase from 17 to 25 percent of all health care costs. Think of co-pays and deductibles, and think of them on steroids in some cases, because there are powerful policy-making forces behind this trend. A major component of President George W. Bush's health care policy, as announced in successive State of the Union addresses, involves enlisting market forces to control costs by making individuals more sensitive to costs.

One manifestation of this approach with roots going back to the administration of President Bill Clinton was the introduction of health savings accounts, which leave it to individuals to pay certain health care costs out of funds accumulated on a tax-advantaged basis if they agree to participate in high-deductible insurance plans. Another manifestation is medical tourism, the growing practice of seeking health care goods and services in foreign countries because they are unavailable at favorable prices in the United States. All such trends point to an increasingly tiered health care coverage arrangement in which people from different economic strata have widely differentiated coverage schemes. Those who can afford high-deductible plans will have one set of alternatives; those who cannot afford coverage will receive health care, if at all, through publicly

funded programs such as Medicaid.

The second trend is the predicted erosion of employer-based coverage.[24] Employers have begun to argue that they cannot be competitive in global markets with companies in countries with national health insurance because, depending on how you look at it, foreign products are effectively subsidized by this arrangement, or American products are burdened by a price premium in the form of the allocable cost of employee health benefits.[25]

In addition to motive, employers may soon have increased opportunity to shed health care costs, if certain aspects of President Bush's policy gain legs in future administrations. President Bush proposed in his 2007 State of the Union address that health insurance premiums should be tax-deductible. Implicit in this proposal is the prospect that many employees who now receive health care benefits on a pretax basis through their employers could purchase their own coverage directly from health plans with tax-advantaged dollars. Under such circumstances, employers might take the opportunity to stop offering health insurance as an employee benefit. This would be a historic change, as Americans (other than those eligible for Medicare) have by and large received health care coverage through employers for the past century. If that picture changes, something else will need to change as well if we are to avoid aggravating access problems like tiering and increasing the numbers of uninsured and underinsured. Even with no reform, employers may look for the exits. And if this happens, and nothing is done about reform, some believe the costs of insurance premiums and administrative costs will increase accordingly, on the theory that individuals cannot bargain as effectively as employers and insurers will need to incur the additional expense of more direct marketing to consumers.

Quality

If cost increases and we experience erosion where access is concerned, the triadic theory of health care policy tells us to expect gains in the quality of health care. Presumably, we would have to be experiencing increases in real, not just inflationary spending for this to hold true, but fortunately (depending on your point of view), that seems to be the case.[26] Indeed, those whose opinions presumably matter see quality improvement as the brightest spot in the health care picture, with advances in technology — especially information technology — leading the way.[27]

While we spend more than other nations on health care, we do not live longer and we are not healthier.

Electronic health records (EHR) accessible at all points of the delivery system (hospitals, doctor's offices, nursing homes, pharmacies, operating and recovery rooms, patient bedsides, residences) have the potential to reduce medical errors. To be sure, there is much to be done with respect to quality. While we spend more than other nations on health care, we do not live longer and we are not healthier.[28]

The Agency for Healthcare Research and Quality estimates that hospitals will report an average of one adverse patient safety event per bed per month, or 11,239,832 reports per year.[29] We currently kill as many as 98,000 people per year by avoidable error in hospitals alone by an estimate reported by the Institute of Medicine.[30] But it seems fair to say that quality is one area in which the picture could improve, even if we do nothing to reform our health care system. This is not to say things would not improve more quickly with EHR-enabling legislation, patient safety legislation, quality-targeted expenditures, mandated quality improvements and other reforms, but again I drift from my premise.

What if we do nothing? Things will change anyway, but without direction from public policy. Why not allow that to happen? After all, *laissez faire* advocates contend, a free market could do as well as or better than regulators at distributing health care goods and services. Your position on that issue probably turns on whether you ultimately believe health care is best categorized as a commodity or as a right or entitlement. If you believe receiving adequate health care is a basic human right, you will not be satisfied to leave it to market forces to distribute health care, as you would if health care were just another service.

Resolving that issue is beyond my scope. I can, however, contribute a few observations to the discussion. I am not an economist (although I sometimes play one in the classroom), but I am relatively confident that I could find economists to support the proposition that we do not now have, and possibly never can have, a truly free market in health care services. For one thing, the principles of supply and demand are artificially constrained in the health care marketplace. We have legal barriers to entry on the supply side of the market. Practitioners need to be licensed, and then to practice within prescribed areas, goods and services are heavily regulated and so forth. And because demand

consistently exceeds supply it would be extremely unlikely, if not impossible, for a free market to deliver the same quality of health care goods and services to everyone. Lower income people will have to accept lower quality or less access to health care. A free market, then, will ration health care, and rationing is one of the most enduring shibboleths of the health care policy debate. No policy maker is comfortable supporting this result, or even acknowledging its inevitability.

Economists have said that free market principles fail in health care for another reason. Commercial markets are ultimately efficient because consumers can be counted on to find the proper balance of price and value in the long run. As the notable economist Kenneth Arrow and others have observed, however, this principle may not obtain in health care, where information is distributed asymmetrically.[31]

Consumers are never fully adequate to the task of finding optimal value in health care, not only because they do not know enough medical science, but also because in many instances they must depend on their medical professionals to direct selection (doctor's orders, referrals) and then to assess outcome ("yours was a [good/bad] result; it was all you could have hoped for"). Health care consumers, moreover, are notoriously insensitive to price issues, whether because an insurance company or other third party is often paying the bill, or because health matters (which can include life and death) are often non-negotiable.

Some tweaking aside, we may thus already have nearly as free a market as we are likely to get in health care, and we may therefore already be looking at the market outcome: more underinsured and uninsured, inflation and tiering on all fronts, with a chance of better quality through technological advances. Thus even if we interpret "doing nothing" as "letting the market do its thing," that approach is unlikely to solve the problems we now confront. ◆

FOOTNOTES

1. Harris Interactive, *Majorities in the United States and Three of Five Largest European Countries Believe Healthcare is Doing Badly in Their Countries,* Feb. 12, 2008, *available at* http://www.harrisinteractive.com/news/newsletters/healthnews/HI_HealthCareNews2008Vol8_Iss3.pdf (last visited March 25, 2008).

2. Robert J. Blendon, *One Academic's Perspective on the Role of Health Affairs,* 26 Health Affairs 1531 (2007), at 1532.

3. Colin Gordon, Dead On Arrival (2003) (identifying a number of periods in U.S. history where entrenched interests succeeded in defeating popular movements toward single-payor and universal health plans, including 1918, 1935, 1949, 1965, 1971 and 1994).

4. Victor R. Fuchs, *What Are the Prospects for Enduring Comprehensive Health Care Reform?*, 26 Health Affairs 1542 (2007).

5. Barry R. Furrow, et al., Health Law: Cases, Materials and Problems (5th edn. 2004) at 495-96.

6. *Growth in Health Care Costs*, statement of Peter R. Orszag, Director, Congressional Budget Office, before Senate Budget Committee, Jan. 31, 2008, http://www.cbo.gov/ftpdocs/89xx/doc8948/01-31-Testimony.shtml.

7. Furrow, *supra* note 5, at 495.

8. Institute of Medicine Report, *Key Capabilities of an Electronic Health Record System* (2003), *available at* http://www.iom.edu/?id=19374 (noting potential advances in patient safety with utilization of electronic medical records); also worthy of note are such quality improvement initiatives as Medicare's refusal to pay for medical errors. *Medicare Says It Won't Cover 'Preventable' Hospital Errors*, N.Y. Times, front page, Aug. 19, 2007.

9. Sharon Silow-Carroll, et al., *Hospital Quality Improvement: Strategies and Lessons From U.S. Hospitals* 54 Commonwealth Fund Publications (April 3, 2007), *available at* http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=471265 (last visited March 29, 2008). *See also* Institute of Medicine, *The Chasm in Quality: Select Indicators from Recent Reports, available at* http://www.iom.edu/?id=14991.

10. Harris Interactive, *supra* note 1.

11. 16 BNA'S Health Care Policy Report (March 31, 2008), at 424. *See also* Henry J. Aaron, *Budget Crisis, Entitlement Crisis, Health Care Financing Problem — Which Is it?*, 26 Health Affairs 1622 (2007).

12. Kaiser Family Foundation, *Health Care Costs: A Primer* (2007), at 2, *available at* http://www.kff.org/insurance/7670.cfm (last visited March 29, 2008). *See also*, CBO Testimony, *supra* note 6, at 3.

13. *Id.*

14. Scott Bittle and Jean Johnson, Where Does The Money Go? (HarperCollins 2008), at 9.

15. CBO Testimony, *supra* note 6, at 4-5.

16. *Id.*

17. *Id.*

18. *Id.* (indicating 2%); Furrow, *supra* note 5 (indicating 7% over the past 30 years), at 504.

19. Furrow, *supra* note 5, at 518.

20. *Id.* at 504.

21. *Id.* at 505.

22. Harris Interactive, *supra* note 1 (poll of attendees of World Health Care Congress indicates they believe the number of uninsured will increase to 18 percent).

23. Kaiser Family Foundation, supra note 12, at 10.

24. *Id.*

25. The employer-based system has its critics, including some strange bedfellows Andrew Stern, President of the Service Employees International Union, the country's fastest-growing union, and Lee Scott, CEO of Wal-Mart, the nation's largest employer. Both urge that we abandon the employer-based system. CNN, Feb. 7, 2007, *available at* http://money.cnn.com/2007/02/07/news/companies/walmart_healthcare/index.htm.

26. CBO Testimony, *supra* note 6, at 3.

27. Harris Interactive, *supra* note 1.

28. Dana P. Goldman and Elizabeth A. McGlynn, *U.S. Health Care: Facts About Cost, Access and Quality* (Rand Health, 2005), *available at* http://www.rand.org/pubs/corporate_pubs/2005/RAND_CP484.1.pdf (last visited March 29, 2008).

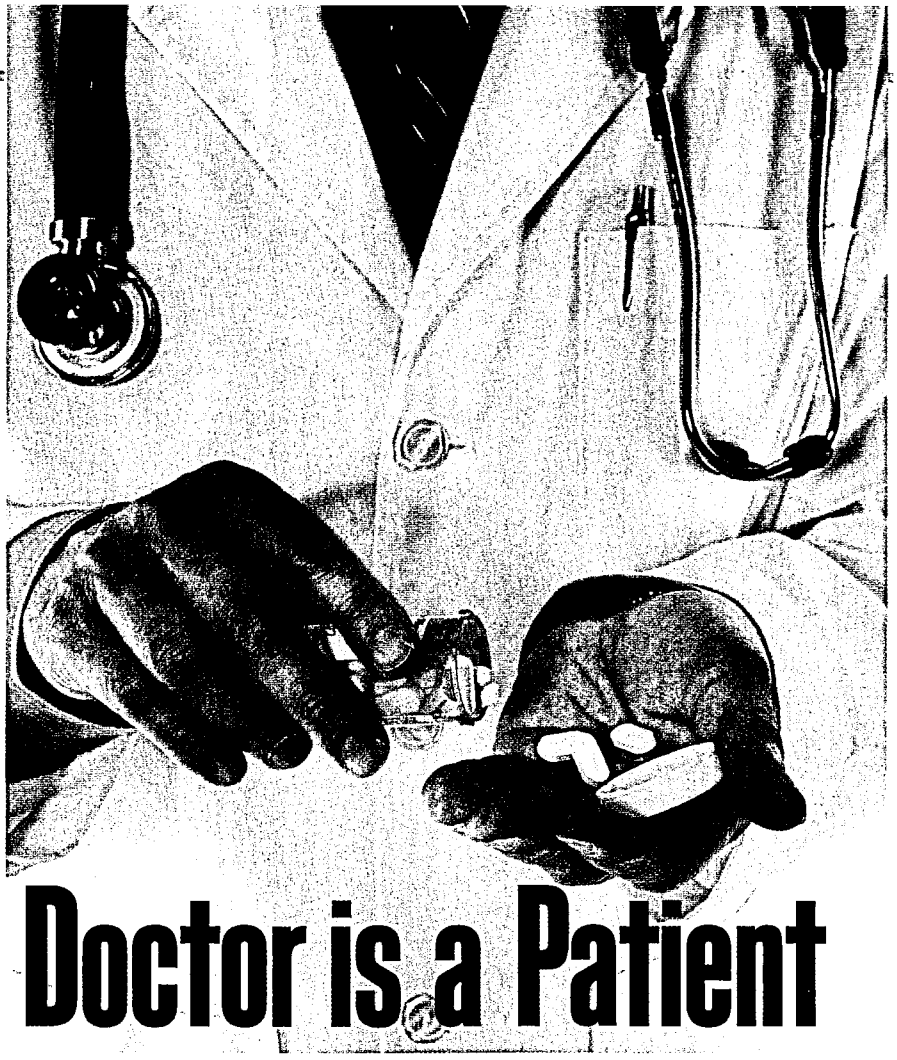
29. 16 BNA'S Health Care Policy Report (March 31, 2008), at 446.

30. Institute of Medicine, to Err is Human: Building a Safer Health System (2000), at 26.

31. Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 Am. Econ. Rev. 941, 951 (1963).

FEATURE

Dr. Alan J. Fink



When the Doctor is a Patient

Personal medical misfortune of family and friends determines how we see the American health care system.

If you are one of the lucky 20 percent whose life has not been marred by serious illness, who will suddenly pass away in your 80s without needing the services of the U.S. health care system, you may not need to continue reading this article. However, for the other 80 percent, this article is about what any of you might experience when you need the help of our health care system, and it is told by someone who had much experience as a health care provider in that system, but little experience — until recently — as a patient. I am a neurologist, and I am amazed by what I did not know about that system until I became a patient.

The largest expenses for health care in the United States are dependent on genetics, diet, risk-taking and environmental misfortune. Diabetes, a genetic disease spurred on by obesity, accounts for 25 percent of all U.S. health care costs. Smoking reduces the life span of an individual by 20 years. But examining American health care statistics does little to define one's view of our health care system. Personal medical misfortune of family and friends determines how we see the American health care system.

With the exception of several successful outpatient procedures (i.e., left shoulder rotator cuff repair, left Achilles tendon repair, and hair transplantation), I enjoyed perfect health, including running a marathon at 59. I had known since 1992 that my mitral valve was floppy, but I made yearly visits to an excellent Wilmington cardiologist who felt that the degree of mitral regurgita-

tion had been stable over the years.

I entered the maze of our $2 trillion-per-year health care system when, while at work on Oct. 4, 2006, I developed an intense burning sensation across my abdomen. Delayed by several excuses to myself regarding the source of the pain, I eventually arrived at the Christiana operating room approximately 12 hours after the onset of the unrelenting pain to be put to sleep so a surgeon, Dr. Wesley Clayton, could laparoscopically remove my appendix. Due to the lack of on-call anesthesiologists, Dr. Clayton had to wait an additional four hours to begin his surgery. For me, this resulted in an additional four hours of intravenous fluids.

In the recovery room after my appendectomy, my lungs filled with fluid — a symptom of congestive heart failure. The anesthesiologist was unable to remove the endotracheal tube that was supplying my lungs with oxygen. I am told that I responded rapidly to 10 milligrams of intravenous Lasix, a diuretic. Within several hours, my abdominal pain was relieved; I was eager to go home.

Before I left the hospital, the cardiac team ran a succession of diagnostic tests in an attempt to pinpoint a source of my congestive heart failure. These tests included a second intubation for a transesophageal echocardiogram, a procedure using ultrasound to assess the degree of rupture of the posterior leaflet of my mitral valve. When I awoke, the technician who performed the echocardiogram excitedly told me that I would need a surgeon to repair my severely damaged mitral valve. This was the same valve that had been diagnosed 14 years earlier and had served me without crisis since that diagnosis.

The technician wrote down the name of a Washington, D.C., cardiothoracic surgeon. My Wilmington cardiac team, including my own cardiologist, confirmed the technician's impression, also believing I would need immediate surgery. One on-call cardiologist told me that I should not leave town, even to get another opinion, due to the severity of the mitral valve weakness. If I did not have surgery, my degree of valvular impairment would lead to an irregular heart beat, placement on the anticoagulant Coumadin, heart failure, and kaput, death.

In a matter of hours, my happy and seemingly healthy life had been transformed into an unexpected medical crisis. It's an experience repeated many times a day for thousands of patients, but one that you cannot truly appreciate until your blissful ignorance has been rudely interrupted by the prospect of mortality.

Thirty-six hours after my appendectomy, with two episodes under my belt of anesthetically induced coma, I met with the cardiothoracic surgical team, which patiently answered my questions, agreeing that I was at some risk for major consequences if surgery were not done within the next several weeks. My fear of being placed on Coumadin worsened when a member of the surgical team explained that if they could not repair the valve, there was a likelihood I would end up with a mechanical valve, requiring a lifelong commitment to Coumadin.

When my wife asked the local cardiac team about obtaining a second opinion from a cardiothoracic surgeon at a major teaching hospital who had repaired a friend's valve, one of the physicians disparaged the university surgeon's operating skills. We thanked the team for protecting us from this incompetent surgeon. (Our friend, by the way, recovered perfectly from his heart valve repair.) "Is there any problem doing two major surgeries so close together?" my wife asked the team. Their reply was that we should not worry, that surgery could be done as soon as the next week, if need be. My own cardiologist advised me to wait at least four weeks following my appendectomy to have my heart surgery. The cardiac team's recommendation to have the surgery so soon flew in the face of a dictum I impart to my own patients: "If possible, you should separate major surgeries by at least six weeks."

I returned to work pain-free 72 hours after my appendectomy. Over the next two weeks, I heard from many of my medical colleagues who vouched for a new cardiothoracic surgeon in town who, as it eventually turned out, was able to repair my mitral valve perfectly.

Within a few weeks of my appendectomy, I developed symptoms of intermittent lightheadedness, fatigue, and numbness and tingling of my hands and feet. I made my cardiologist and my cardiothoracic surgeon aware that I could not wait a month for my surgery: "Please give me surgery as soon as possible." In my mind, having survived neurology night call for 36 years, I could survive anything. This panicked thinking may explain why Dr. Mehtmet Oz, the Wilmington cardiothoracic surgeon of Oprah Winfrey fame, preoperatively refers his heart patients to a psychiatrist.

I awoke from my mitral valve repair with a painfully split sternum, and, if my memory does not deceive me, I counted 15 lines attached to needles piercing my skin from my head to my toes. It took another eight hours for me to realize that my severe lower abdominal pain was not a natural consequence of my surgery. Several on-call physician assistants vetted my complaint, but I was not seen by an M.D. for another 14 hours, despite requests from my wife and me. We could not get a physician of any type to pay attention to my pain. The only people who would see me were physician assistants.

I was sent home a week following my cardiothoracic surgery, but I did not have the quick turnaround that my colleagues predicted. My chest and abdominal discomfort continued, with the added discomfort, two weeks fol-

lowing my cardiac surgery, of a constant burning in my throat. Three weeks following my cardiothoracic surgery, I was readmitted to the hospital, where specialists in infectious disease and gastroenterology thoroughly tested me to find the source of my complaints. My fatigue was so intense at one point that while I was lying in bed listening to healthy colleagues talk outside my hospital room, I imagined that there now existed a permanent wall that separated me from ever having the health necessary to join my colleagues again. I had been transformed from doctor to patient, and I feared my new identity might be permanent.

I did return to limited neurology practice two months after my cardiac surgery. However, I had to relinquish some of the more taxing aspects of practice, such as night call and weekend call. Six months after my cardiac surgery, I suddenly developed a painful feeling of bladder pressure that follows me through the day. Despite multiple tests and opinions from 20 different medical specialists, none have been able to diagnose the cause of my pain. Not one had any concrete suggestions as to how to resolve my three daily areas of pain: my throat, my gut and my bladder. Often it is difficult to remember pain, but my memory is prodded every day by pain, which erases any sense of well-being.

I now have to live each day with a plan as to how to control my pain by being judicious with different medications for irritable bowel and my painful bladder. My burning throat is alleviated by chewing gum. Over the last one and a half years, my irritable bowel has improved, but I still face daily inescapable bladder pain. There is a problem in explaining to consulting physicians what they cannot see by examination or testing. The irony is that as a neurologist, I have listened to and helped patients who suffer with alleged imaginary complaints, such as migraine headaches, facial pain and back pain that cannot be verified by physical examination or laboratory testing. After my own dust-off by the medical community, I feel my patients' pain even more so now.

Not only have I learned more about the emotional impact of illness and treatment over the past year and a half, but I also now appreciate their financial impact, as well. While I was recovering from cardiac surgery, my employer switched my expensive comprehensive health insurance to a cheaper, higher-deductible, less-inclusive health insurance. This change in insurers created a roadblock in trying to find a solution to my discomfort. Denial of payment for trials of medication, rejection of permission to obtain out-of-network consultations in New York and Philadelphia, and non-payment of specialists' recommended procedures created an administrative nightmare for my wife and me at a time when I was in severe pain.

Since my surgery, I have had to spend more than $20,000 per year on out-of-pocket expenses for care. A lifetime of paying premiums for care I never needed before seemed to evaporate in the heat of my new need. Even though I felt weak all the time, I had to work so that I could pay my additional medical expenses, as well as my health insurance premiums to protect myself from financial disaster from any future catastrophic illness.

I was surprised to learn that, if you do not have health insurance, hospitals actually charge you more than the "reasonable and customary charge." A patient of mine without hospital insurance received a bill from a Philadelphia hospital emergency room for $23,000 for four blood tests that, if he had been insured, would have cost approximately $700. Hospitals can charge an uninsured patient whatever they want. I needed an injection of Botox into my bladder to reduce bladder spasms. My medical insurance authorized the procedure, but after the procedure was performed, the insurance company refused to pay. The insurance company administrator explained that authorization does not guarantee payment — a distinction not made clear before I underwent this procedure. My insurer's resistance to paying my bills was as incomprehensible to me as my mysterious unrelenting symptoms.

Not only did my health insurer waffle on payments, but also my disability insurance, for which I had annually paid the premium the last 32 years, did everything possible to avoid making any disability payments. My policy stated that, if I were blind, quadriplegic or in a permanent coma, they would pay without question. Being disabled in some other way did not seem to suffice to obtain the protection I thought I had purchased. To add to my aggravation, the disability insurer demanded the production of reams of financial data to prove that I was truly financially limited, especially while working part time. I had to hire my accountant to explain to the insurance company that they had miscalculated their financial denial of my disability.

Before this experience, I had no knowledge of how economically fragile my chronically ill patients were. I surprised myself by not knowing the technical qualifications for payment in our health care system. I have since learned exactly what Medicare, Medicaid, Social Security Disability, Health Savings Accounts, Flexible Spending Accounts, COBRA and the Federal Employee Health Benefits Care actually mean to the patient.

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TRANSPORTATION AVAILABLE

a year, congressmen have available on a daily basis a staff of four full-time physicians and 14 nurses. This superior system of health care undermines the ability of legislators to empathize with the potential financial disaster that patients face.

I now fully understand why the lack of adequate health insurance is a major reason for personal bankruptcy in this country. Congress' patchwork attempts at solving the health care crisis have caused this country to fail to deliver adequate health care to its citizens. With the exception of treating breast cancer and reducing rates of cardiac disease, the United States is near the bottom in almost every measure of adequate health care.

The congressional inability to see the whole picture is exemplified by the enactment of the Federal Emergency Medical Treatment Act of 1986, which prevents hospitals from rejecting, transferring or refusing to treat patients who need emergency care but are unable to pay. Congress' failure to provide a compensation mechanism for these patients has meant that the hospitals shift the costs to employers and insurers, as well as patients without insurance. This cost shifting is one of the major problems behind the high cost of insurance premiums.

The lack of a thoughtful comprehensive approach to health care over the last 50 years impacts each of us when attempting to survive an acute or chronic illness. A landmark legal decision is necessary to wrest from the insurance companies control over patients' access to health care. But lawyers who could provide the necessary challenge are stifled by Congress's protection of insurance companies under Section 502 of ERISA. The Supreme Court decision of *Pegram v. Herdrich* reaffirmed the insurance companies' ability to evade medical malpractice liability, as well as most state regulations regarding health care, while they make critical decisions about the treatment received by their insured.

So, why should I whine about abstract federal law when it comes to my own health care problems? It is the preferential treatment provided to legislators that insulates Congress from its own inaction, including its failure to reduce the power of insurance companies in controlling health care? Regina Herzlinger, a Harvard professor of business administration, who has spent more than 30 years consulting to the government about health care, says she has no recollection of ever seeing a representative for consumers or patients at a health care bargaining table.

My own experience echoed additional problems others have noted in our health care system. For example, the ability of health care providers to obtain access to all of a patient's records and history is a chronic problem. Christiana Care has a first-rate computerized health care system and a mission of helping outlying physicians upgrade to a computerized health care network, but patients continue to face the problem of supplying their physicians with a complete set of medical records. Physicians can rarely acquire all of their patients' records. Despite my physician's concern over my post-appendectomy echocardiogram, I doubt that anyone compared that echocardiogram with previous studies performed over the last 10 years. If my complete record of echocardiograms had been reviewed, my cardiac surgery might have been delayed or even avoided, possibly delaying or avoiding my current agony. I tell my patients that whenever they have an interaction with our health care system — a pharmacy visit, a doctor's consultation, tests, and labs — to collect their own private set of medical records.

Another chronic problem is a lack of information about treatment options. Even though I am a physician, I obtained much of my current knowledge about valvular cardiac surgery only after my surgery. I know now that New York University surgeons perform mitral valve repair by not splitting the sternum of the chest, but by removing a portion of the ribs to get to the leaky valve.

Medical treatment is an inexact science, at best, and quality varies from provider to provider and from day to day. The challenges that face doctors and patients are formidable under the best of circumstances. Difficult problems often are made worse by the very institutions created to ameliorate them. As for my personal experiences, there is not a day that passes without my second-guessing, not only the timing of my surgery, but also the decision to have cardiac surgery at all. Many patients with essentially normal cardiac function have defective mitral valves that are never repaired. Perhaps my current complaints of bladder and bowel pain were caused by the performance of two surgeries so close in time.

I survived my medical journey due to the support of my partners in Neurology Associates who covered my patients for me; my family, including two strong sons whose joyous spirit carried me on their shoulders; friends who never stopped calling while I was recovering; my loyal secretary, Diane Shaw; and Casey, a soft-coated Irish Wheaton terrier, who snuggled close to my chest when I could not get out of bed. If not for my wife, this piece would have been published posthumously.

And yet, through all my disappointment in this health care system, I want to remain working in this most difficult environment, one that too often abandons patients when they need help the most. I hope that I will be a better doctor to my patients now that I have been and will continue to be a patient myself. Each of us needs to understand these problems and force our political and health care system to make difficult improvements before the ambulance arrives at our door. By then it may be too late. ◆

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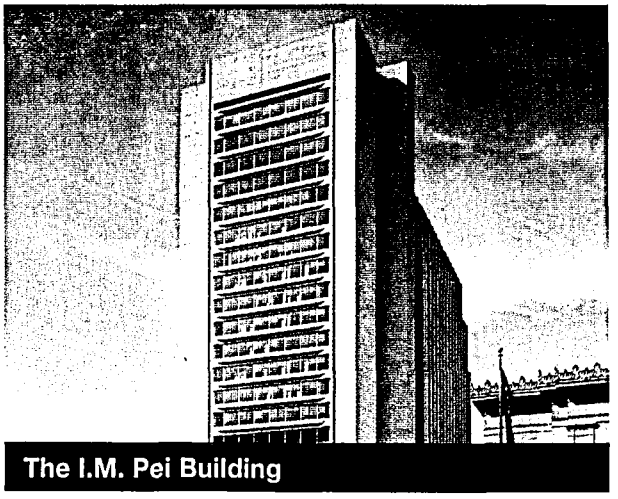
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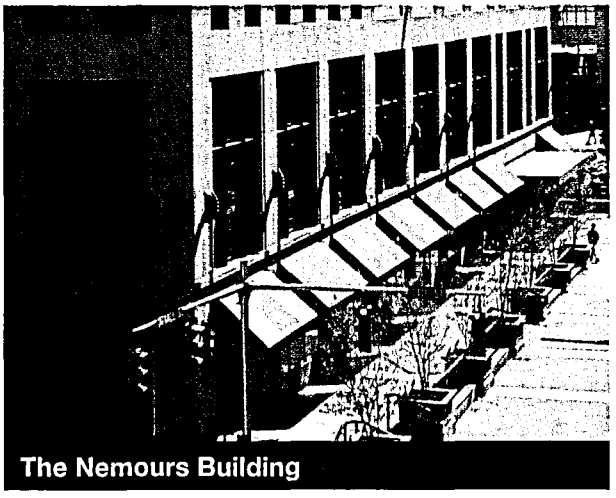
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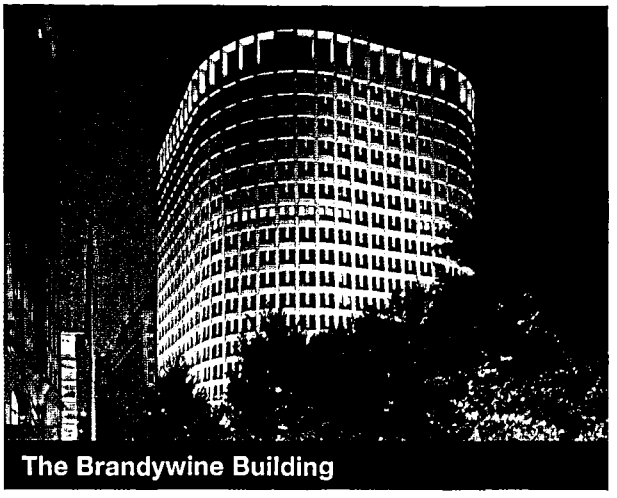
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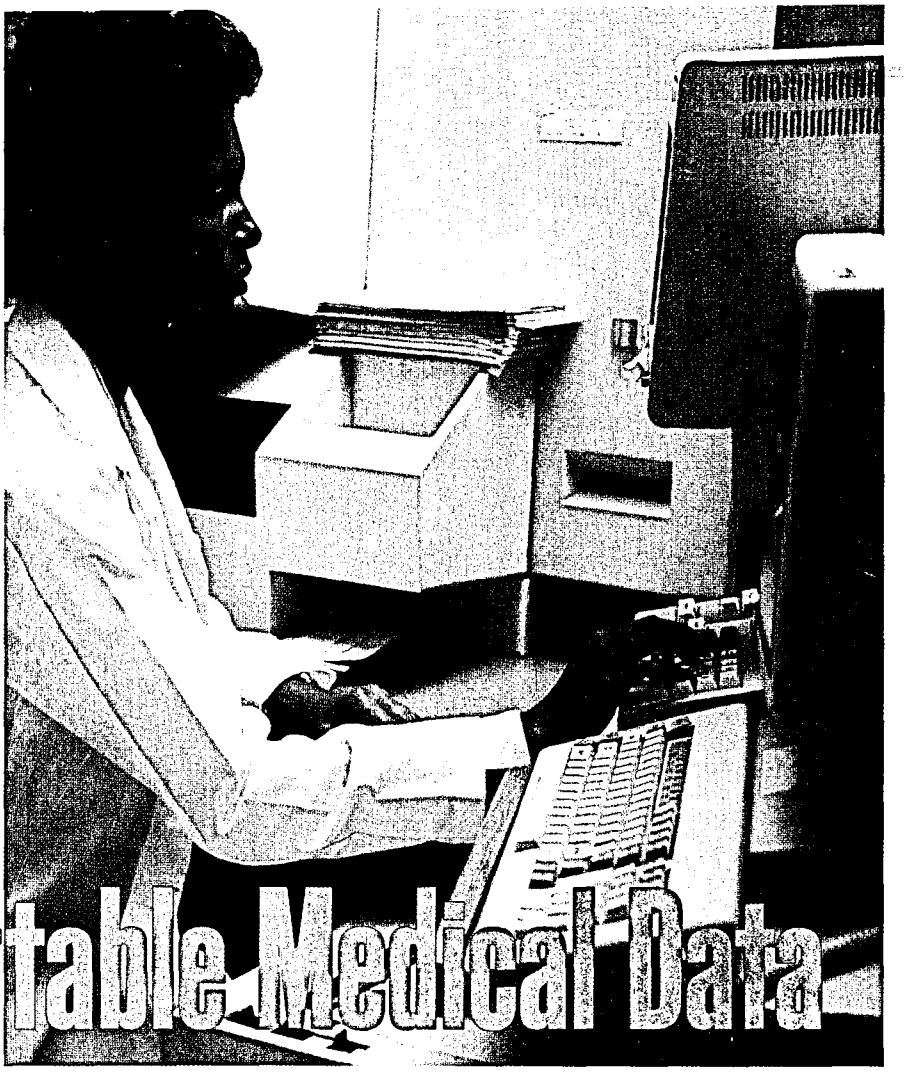

The Value of Transportable Medical Data

It is time for the medical industry to modernize and embrace technology to better serve its patients.

Organized medicine has been slow to embrace the technological advances that would assist in the day-to-day operations inherent in running a medical practice. Almost every medical practice now uses a computer to bill insurance companies and patients for incurred care; however, there are still providers that send their claims to insurance companies printed on paper as opposed to taking the easier route and submitting these electronically.

Have you ever thought about the fact that vets have worked out a way to notify you when it is time for your pet to get its immunizations updated, yet many doctors have no way to do the same? If banks are able to communicate instantaneously with each other enabling a person to use their ATM card that was issued in Delaware to obtain money in the local currency in England, why can't doctors communicate with each other in the same way? The same concern related to accuracy of data and privacy was overcome by the banking industry. It is time for the medical industry to modernize and embrace technology to better serve its patients.

An ideal world

Ideally, doctors would be able to store medical records electronically and other physicians who may need to treat the same patients would have access to these records after receiving consent from the patient. The results of all medical tests would be stored in this system and would be immediately accessible. Doctors would be able to mine their data to identify the popula-

tion of people that were late for various tests or who failed to have tests performed despite the fact that they had been ordered. By creating a universal system, providers would be able to track their patients at all times.

Barriers to adoption of electronic systems

Organized medicine is slowly embracing the value of computerizing medical records for patients. Barriers to acceptance by the majority of providers remain and include:

- Cost
- Concerns about the safety of the data
- Concerns that the data may be inaccessible in the event of an outage
- The lack of a uniform standard for operating systems

While physicians are willing to explore the option of an electronic health system that can incorporate both billing and medical record storage, their primary concern is the cost of a system. Most are unwilling to commit to investing in a system that will cost them hundreds of thousands of dollars only to find that the majority of their colleagues, hospitals, laboratory vendors and radiology providers are using a system that is not compatible with their own.

The future of medicine

There are numerous forces that are shaping the way that doctors and patients will view the interactions with their health insurance providers in the future. Each of these factors requires that the health care system create a mechanism for patient health information to be transportable and immediately accessible. These factors include:

Consumer-directed health care/ high-deductible health plans

Employers are shifting greater amounts of the health care burden to their employees. This is occurring in the form of higher co-pays for care and high-deductible plans. Patients are paying more attention to the types of tests that are being ordered and requiring that their physicians justify the necessity for the medical procedure. They are doing more to ensure that there is less duplication of testing and requesting that their doctors do a better job of communicating with their colleagues about the results of tests rather than have a second doctor order a test, unaware that results are already available.

Regulatory oversight of health insurance companies and hospitals

The National Committee for Quality Assurance and the Joint Commission on Accreditation of Hospital Organizations have recognized for years that there is fragmentation in the health care environment and that this lack of communication has impacted on the quality of care provided to patients. Numerous industry standards exist to improve the communication between physicians, and between doctors and hospitals, to prevent unnecessary side effects and complications of medical care.

Fragmentation of the provision of the health care system

More physicians are giving up their hospital privileges and relying on hospitalists to admit patients on their behalf. A hospitalist is a physician that only sees patients in a hospital setting and accepts responsibility to care for a patient from the time of admission until the point of discharge. Once a patient is discharged, the hospitalist hands the patient back to their regular treating physician.

The risk with relying on hospitalists is that there is the potential for mistakes as severely ill patients are handed from doctor to doctor.

A new variable in the care of patients is the creation of physicians that only take care of patients while they are in their home (I will refer to these doctors as homeists). These doctors typically care for ill patients who are too fragile to travel to their regular doctors for office-based appointments. As you can imagine, these fragile patients could potentially end up in the hospital if their condition deteriorates. Without an adequate infrastructure for physicians to communicate effectively, there is the risk that all the providers caring for this patient could replicate testing or medications, amplifying the risk of a complication.

It has been recognized for a long time that patients that seek health care from behavioral health providers tend to neglect notifying their medical doctors that they are seeing a mental health provider. This creates problems when patients are prescribed psychotropic medications. One example of this is that patients prescribed a monoamine oxidase inhibitor (an antidepressant medication) should avoid various prescription and over-the-counter medications. The combination of these two types of medications could be fatal by causing a profound rise in blood pressure.

Patient-centered home

To counter the growing fragmentation in the health care system, the American Academy of Family Physicians, the American Academy of Pediatrics and the American College of Internal Medicine have collectively called on health insurance companies to modify their reimbursement model and increase reimbursement to the physician who declares that she will be the primary point of contact for all health care for a particular patient. In order for a doctor to adequately fulfill this role, they need to know everything about a patient in real-time. Failure to have access to data from all doctors that the patient is seeing defeats the purpose of having a "captain of the ship" monitoring a patient's care.

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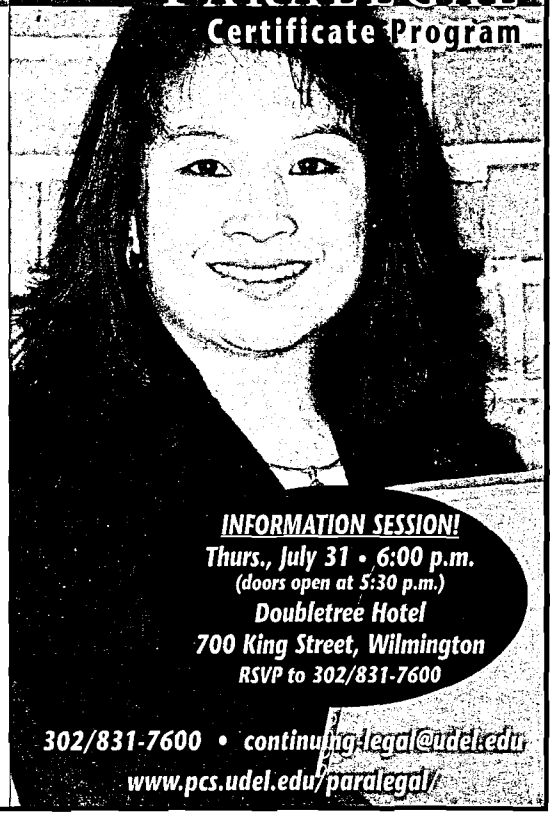

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Patients' desire to have more control over their medical records

Patients, aware of the financial cost of duplicative testing as well as the toll of complications from side effects from medication interactions, have begun to demand access to their medical records. Their goal is to make their health care information portable while preserving their privacy.

Two models are emerging to fulfill this need. One requires that patients save their personal health information on a Web site controlled by their health insurance company. Patients or their doctor can access this information when appropriate. The concern with this model is that the information could be accessed by the patient's health insurance company without patient permission. Another concern is that the cumulative medical record is lost if the patient elects to change health insurance providers.

The second model provides patients with a flash drive that they can either self-populate with clinical information, or they can rely on their physician and health insurer to provide information. The patient takes this flash drive to all physician appointments, emergency room visits and hospitalizations and makes the information on the flash drive available upon request.

Patient safety

Excessive exposure to radiation can be harmful. Preventing duplication of imaging studies can minimize the risk of radiation-sensitive cancers such as lung or thyroid.

Utilizing technology to enhance communication as a patient moves through the continuum of care will minimize errors or complications. In a study conducted between Blue Cross/Blue Shield of Delaware and a major hospital in Delaware, patients who were seen in the emergency department were asked to list all their medications.

This list was compared to the drugs that had been prescribed and paid for by Blue Cross/Blue Shield of Delaware. In 45 percent of the cases, there were differences between the two lists. The patient omissions in the drugs that they were taking could have been life-threatening or resulted in complications in the majority of these cases.

Employer activity to promote wellness

Employers are looking to wellness programs to improve the overall health of their employee population. The foundation of any wellness program is a health risk assessment. This is a questionnaire that is filled out by the patient and highlights their risk for various diseases. Interventions to minimize the risk of illness can be taken by the physician or insurer once the risks are identified. The concern expressed by employers is that many employees are worried that their employers will access information in the health risk assessment. In addition, if the employee fills out the health risk assessment, there is no mechanism for the employer to ensure that the information was made available to the employee's physician.

Privacy issues

Doctors are going to have to embrace the concept of sharing their clinical records with other treating providers. The health care system, along with lawmakers, is going to have to create a safe mechanism for patients to interact with their physicians and provide or deny access to their medical records.

Medical malpractice issues

In the future, the failure of physicians to access health information from multiple sources other than their own medical chart may be grounds for a malpractice action against them. Physicians are going to have to weigh the value of access to clinical information with the risk of not accessing this information. ◆

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Westside Family Healthcare and The Community Health Center Movement

Westside Family Healthcare has spent 20 years addressing health disparities and lack of access to primary healthcare among Delaware's disadvantaged populations.

According to preliminary 2005 data from the Centers for Disease Control (CDC), the three leading causes of death in Delaware in 2005 were heart disease, cancer and stroke. Delaware has for many years suffered from a higher-than-average ranking for cancer incidence and mortality. Although more recent data indicates that the incidence has improved to just 5 percent above the national average, Delawareans still die of cancer at a rate that is 9 percent above the national average.[1]

This data is alarming; closer examination also shows significant health disparities based on race and economic status, largely due to lack of access to care and insurance. A study of Delaware's cancer registry by Wilmington's *News Journal* concluded that "late diagnosis and lower surgery rates occurred more frequently among those who lived in poor areas."[2] Delawareans' life expectancies still show a significant link to race: life expectancies for people born in 2005 were 75.7 years for white males but 71.3 for black males, and 81.1 years for white females but 76.6 for black females.[3]

Diabetes is another critical health issue in Delaware, as it is the sixth-leading cause of death. According to the CDC, diabetes accounts for approximately 210 deaths in Delaware per year. Diabetes mortality was 2.7 times higher for African Americans than for whites.[4]

Many other indicators also demonstrate the magnitude of health disparities in Delaware. African Americans experience HIV infection/AIDS death at a rate that is 15.56 times higher than

whites. The African American homicide rate is 3.94 times higher than among whites, and African Americans are hospitalized for treatment of asthma 2.93 times more often than whites.[5] Delaware's infant mortality rate for the five-year period of 2001-2005 was 17.1 percent for African Americans, compared to 6.8 percent for whites.[6]

Available data on health disparities among Hispanics from the Delaware Health Statistics Center shows cancer and heart disease as leading causes of death, with cancer being slightly higher. AIDS is the fourth-leading cause of death for Hispanics in Delaware.[7] Although nationally the diabetes death rate for Hispanics is higher than white non-Hispanics, Delaware's diabetes death rate is slightly lower.[8] Inpatient hospitalization rate for diabetes is about 1.7 times higher than the national average for Delaware Hispanics.[9]

Westside Family Healthcare has spent the last 20 years addressing the issues of health disparities and lack of access to primary health care among Delaware's disadvantaged populations. Westside is a Community Health Center, or CHC, meaning that it provides care to underserved populations and areas regardless of the patients' ability to pay for treatment. Westside provides a "medical home" for patients who might otherwise go without preventive care and who would rely on hospital emergency rooms for treatment of both minor and chronic illnesses. Westside's three health centers in New Castle County served 15,672 users in 2007. That year, 89 percent of Westside's patients' incomes were at or below 200 percent of poverty, nearly 52 percent were uninsured and 34 percent received Medicaid benefits.

Westside offers a comprehensive array of services including family medical care for men, women and children of all ages; women's health services such as prenatal care and maternity care, family planning, gynecological care and preconceptual care; disease management and prevention for chronic diseases such as diabetes, cardiovascular disease and cancer; adolescent health services; full-service dental care; mental health care; podiatry care; diabetic ophthalmology care; 24-hour primary care with an obstetrics physician on call; and pediatric and adult preventative immunizations.

Support services include a low-cost prescription program; laboratory services; financial aid services including Medicaid, Medicare and sliding fee scale enrollment assistance and Community Health Access Program enrollment; bilingual services in English and Spanish with a language line interpreter service for other languages; certified diabetes education services; nutrition education; community outreach activities; and targeted health education classes. Westside collaborates with a number of community provider partners for additional specialty and support services.

Westside has grown dramatically since its beginnings 20 years ago in a small storefront location at the Adams Four Shopping Center.

Westside has grown dramatically since its beginnings 20 years ago in a small storefront location at the Adams Four Shopping Center on Fourth Street in Wilmington. Westside obtained full Federally Qualified Health Center (FQHC) status in 1994, and in 1998 completed its first major relocation and expansion project with its move from Adams Four to the first of its three current locations, 1802 W. Fourth St. In 2000, Westside obtained Joint Commission (JACHO) certification, and in 2002, it expanded its physical facilities again and began providing mental health and dental care services. Its patient population grew to 5,700. In 2003, with the assistance of its first Section 330 Expanded Medical Capacity grant, Westside opened its first satellite office, the Wilmington Hospital Annex site, at 1400 Washington St. In 2004, Westside opened its second satellite office in Brookside Plaza in Newark with the assistance of funding from the Delaware Health Care Commission and the Community Redevelopment Fund. Westside also received the National Health Service Corps Award for Excellence. By the end of 2004, Westside's patient base had grown to 11,805, and it had a staff of 62. In 2006, Westside completed a new facility in northeast Wilmington, and relocated the Annex Site to that location, 908-B E. 16th St.

The strong demand for affordable primary medical care in Westside's service area has led to its becoming the largest FQHC in the State of Delaware.[10] FQHCs are public and private non-profit health care providers that satisfy certain Medicare and Medicaid requirements and that receive funding under Section 330 of the federal Public Health Service Act. Section 330 grants, administered by the federal Health Resources and Services Administration, assist FQHCs with operating costs and also enable them to serve more patients by creating new health care access points, expanding their medical capacity, increasing the types of services they provide, planning for future growth and implementing health information technologies. FQHCs also rely on revenues from several other sources, including reimbursement for services from Medicaid, Medicare, the State Children's Health Insurance

Program and private medical insurance; self-payments by patients; state and local government grants; charitable foundation grants; donations from supporters; and their own fundraising and financing efforts. On average, only about 22 percent of FQHC revenue comes from Section 330 grants.[11]

Northeast Ribbon Cutting

CHCs were initially launched as part of the 1965 federal War on Poverty campaign in response to tremendous health disparities noted among migrants and impoverished African Americans in the Mississippi delta. CHC founders aligned their efforts with those of the civil rights movement and developed a unique model for health care, targeting poor communities and eliminating financial barriers to access. Their vision included comprehensive, high-quality medical care, patient-driven programs and culturally based patient education. The CHC movement's core principles included an emphasis on empowering the community where the CHC resided and encouraging community participation in decision-making for the CHC. This was accomplished by requiring that the majority of the CHC's board members be patients themselves. By establishing primary care medical practices in poor communities, speaking a variety of languages, understanding the culture and daily lives of the patients they serve and providing a sliding fee schedule that enables all people to access care, CHCs attempted (and attempt) to reduce racial and ethnic disparities in medical outcomes by providing affordable medical care to those who would otherwise go without.

The CHC program has grown steadily since its beginnings 40 years ago. The nation's CHCs are gradually realizing their goal of increasing access to care for our most vulnerable communities. CHCs currently serve more than 17 million patients nationwide, according to the National Association

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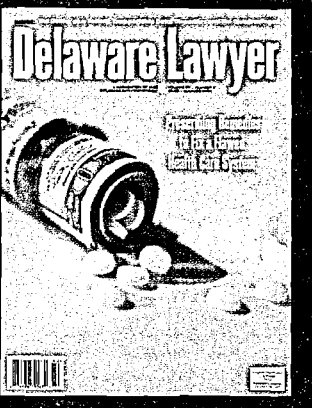

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of Community Heath Centers. The household income of more than 90 percent of these patients is at or below 200 percent of the federal poverty line and two-thirds are racial or ethnic minorities. On average, 40 percent are uninsured.[12]

Brookside Ribbon Cutting

Studies have shown that federal funding for CHCs is money well spent. The U.S. Office of Management and Budget has recognized the FQHC program as among the most effective and efficiently run federal government programs.[13] Several studies report that CHCs save the Medicaid program at least 30 percent in annual spending due to reduced specialty care expenditures and fewer hospital admissions.[15] In addition to being financially efficient, CHCs across the country are demonstrating better clinical outcomes and reductions in health disparities among the poor and minorities. According to a recent study, expanding the reach of CHCs will help eliminate primary care health disparities facing minority racial and ethnic groups.

In Delaware, CHC penetration has increased significantly over the past decade, due in part to the efforts of the Bush administration to expand the reach of health centers in areas of need, but also due to a local commitment to do the same in Delaware. Between 2000 and 2003, FQHCs in Delaware collectively reported an increase from 39,121 patient encounters and 10,894 patients to 57,116 encounters and 18,191 patients.[16] During this period, Westside, Delaware's largest CHC, posted the highest gains, increasing the number of center users by 107 percent and the number of encounters by 85 percent. Projections for 2008 indicate that Westside will serve 18,285 patients through 77,843 patient visits, which will constitute nearly a 30 percent increase in patient visits from 2007.

Westside has experienced a steady increase in its share of uninsured patients,

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reflecting current statewide trends. According to the U.S. Census, Delaware's Hispanic, African-American, Native American and recent immigrant populations are more likely to be uninsured, and according to an analysis released in December 2006 by the University of Delaware's Center for Applied Demography and Survey Research, the state's share of uninsured individuals grew to an annual average of 12.7 percent for the 2004-2006 period, up from 11.6 percent in the 2003-2005 period. An average of one in eight, or roughly 105,000 Delawareans, were uninsured during the three-year moving average period of 2004-2006, which is a substantial increase from the 95,000 uninsured from the previous three-year average.

In 2006, Westside served 5,324 uninsured patients (38 percent of the total patient population) through 17,018 patient visits. In 2007, Westside served 8,139 uninsured patients (approximately 52 percent of the total patient population) through 25,215 patient visits, which is a 53 percent increase in uninsured patients and 48 percent increase in encounters from 2006 to 2007. Westside's dramatic growth has been achieved through increased federal, state, corporate and individual support for expanded sites at two locations in Wilmington and one in Newark, as well as a commitment by Westside's board of directors to expand the agency's reach to other underserved communities in New Castle County. Westside's growth is also a strong indicator of our community's continued need for affordable quality health care services, especially among uninsured and underinsured residents.

Access is of foremost importance in providing medical care to underserved populations. Access is aided by locating CHC facilities in underserved communities, expanding hours into evenings and weekends to meet the needs of working patients, providing comprehensive "one-stop shopping" and "enabling" services, offering a sliding fee scale discount to the low-income uninsured and providing culturally competent and linguistically appropriate care.

CHC practices cannot, however, stand alone. Primary care health outcomes cannot be achieved without supportive and ancillary services. The most difficult challenge for CHCs is to identify partners who are willing to provide access to these services for both insured and uninsured patients in a culturally competent and compassionate manner. Westside has formed key partnerships with important health care and community allies. Such partners include the Delaware Division of Public Health and Christiana Care Health Services, and a number of caring specialists who have given their time and services freely to our patients. These collaborative partnerships must continue to expand and develop formally to ensure that the patients receive the necessary pharmacy, laboratory, radiology and specialty care services needed to complete their care.

Westside is also proud to be the first CHC in Delaware to enter into a Medical Legal Partnership with the Community Legal Aid Society, Inc. (CLASI). The partnership was born when CLASI and the Delaware Academy of Pediatrics approached Westside in summer 2007. The goal is to identify patients whose medical condition is either caused or exacerbated by factors that can be alleviated through legal action, such as substandard rental housing, disability discrimination or inappropriate restrictions to insurance access. Through this partnership, Westside physicians have begun to identify and refer patients for assistance. As a result of this novel initiative, many other physicians and health care organizations are joining in partnership with CLASI to implement similar efforts.

As Westside approaches its 20th anniversary, its work within the community will continue to expand. The number of uninsured individuals continues to rise and Westside will continue to work to meet their needs. As CHCs continue to expand their reach nationally, Westside will maintain its commitment to continue the proud legacy of CHCs. Please join Westside in "Celebrating 20 Years of Treating You Well!" To learn more about Westside Family Healthcare go to www.westsidehealth.org. ◆

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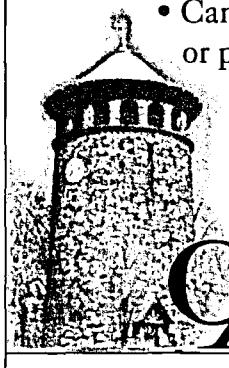

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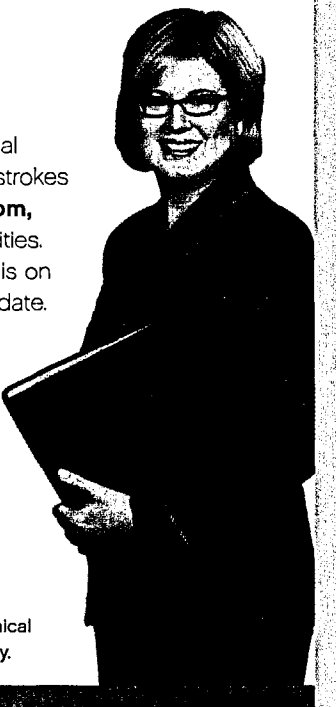

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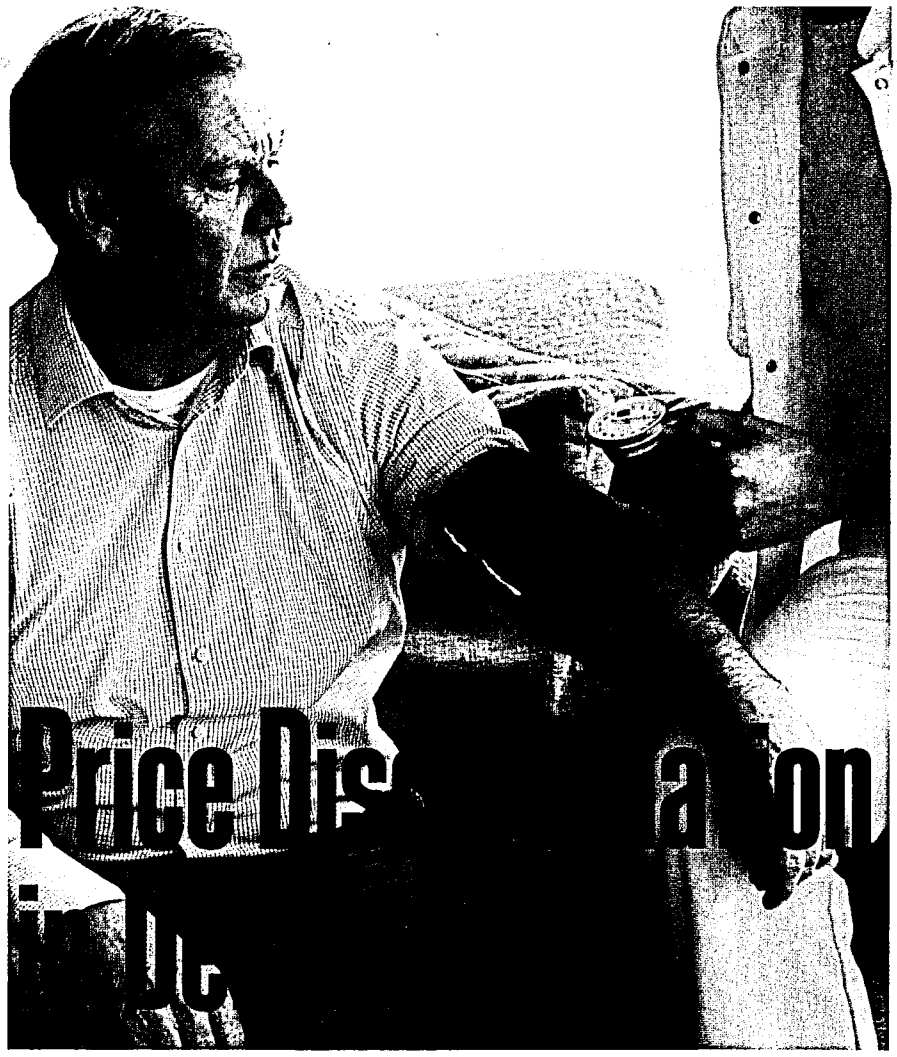
The Evolution of Hospital Price Discrimination



The pricing of hospital care for the uninsured has evolved to a degree unimagined by an earlier generation.

What happens when someone without health insurance goes to a hospital in Delaware? Unfortunately the answer is rather simple. First, they may have trouble getting admitted if it is not an emergency. However, if they are admitted, they are likely to get a very large hospital bill. In Delaware, the average charge for a hospital visit for an uninsured person is likely to be double what it cost the hospital to provide the care and approximately 80 percent higher than what the typical insurance company pays.[1] The pricing of hospital care for the uninsured has evolved to a degree unimagined by an earlier generation. This essay examines what can be done to assure that the uninsured pay a reasonable price when they enter a hospital in Delaware.

Fifty years ago, the poor and uninsured were generally charged the lowest prices for medical services. In 1968, a classic article on price discrimination in medical care explained why it was rational for health care providers to charge the highest prices to the wealthiest people and to discount the prices that the poor.[2] The article included this quote from a "highly respected surgeon" explaining his rationale for charging the rich the highest prices:

"I don't feel that I am robbing the rich because I charge them more when I know that they can well afford it; the sliding scale is just as democratic as the income tax. I operated today upon two people for the same surgical condition – one a widow whom I charged $50, the

other a banker whom I charged $250. I let the widow set her own fee. I charged the banker an amount which he probably carries around in his wallet to entertain his business friends."

Fifty years later, the situation is reversed and now the poor and uninsured patient is likely to be charged the highest price. This article focuses on the hospital industry, simply because there is better cross-sectional and longitudinal data on hospitals, and because most of the litigation and legislative discussion involves hospitals. However, it is also likely that the poor and uninsured are also being charged higher prices by physicians and other health care providers.

From soak the rich to soak the poor

In 1968, most hospitals used a charge master file to bill patients and most insurers paid based on the rates in the charge master file. The charge master file listed all of the services the hospital could possibly provide for the patient. The hospital's total charge was determined by multiplying the item's price according to this charge master file by the number of units received. For example, if the hospital charged $100 per day for room and board and the person remained in the hospital for four days, the room and board charge would be $400. The charge for two hours in the operating room might be $50. All the services that the patient received would be added to this bill to calculate a total charge.

In 1968, nearly all insurers paid full charges. However, the situation began to change as Medicare and Medicaid, and then the managed care plans and other insurers, started negotiating discounts. Soon the Medicare and Medicaid programs developed their own payment systems that were not based on the hospital's own charges and many private insurers also developed alternative ways to pay hospitals. Hospital chief financial officers were no longer able to raise their prices and have everyone pay the higher charges.

The only people that were expected to pay full charges were people without insurance because they did not have the government or private insurers negotiating price reductions on their behalf. As the public and private insurers negotiated increasingly big discounts, the hospitals began having financial problems and looked for a source of increased revenues. Many began raising prices on their charge master file. Between 1984 and 2004, charges increased at twice the rate that costs increased.[3]

> As the public and private insurers negotiated increasingly big discounts, the hospitals began having financial problems.

When hospital charges are not disclosed to patients

Hospitals in Delaware are not required to publish the rates in their charge master file. Markets work when prices are disclosed and the patient knows what items he or she is purchasing. This enables the buyer to make an informed decision. In the case of hospital services, the patient only learns the price after the service is delivered and the bill is presented.

In the case of hospital services, the situation is even stranger, because the doctor, not the patient, is generally the person selecting the items. Patients do not decide how long they will remain in the hospital, nor do they decide on what services they will receive. Market forces cannot operate when the relevant price information is not disclosed to the patient, and when the patient is not the person making the ultimate decisions.

Hospitals justify higher charges

Over the years, hospitals have attempted to justify the higher rates they charge to uninsured patients in several ways. One common justification is that the uninsured patient should have attempted to negotiate a discount from the hospital in advance. There are, however, several problems with this argument. First, price negotiation is not possible in emergency situations or during the hospital stay. Second, many uninsured patients have difficulty obtaining care from any hospital and trying to negotiate rate reductions simultaneously would be problematic.

A second response by hospitals is that many of the uninsured patients do not actually pay the bill and that the hospital has a charity care policy. In fact, nearly all hospitals have a charity care policy, and the collection rate from uninsured patients averages only 10 percent. However, there are a number of problems with this response. First, hospitals no longer have a federal obligation requiring them to publicize the fact that they offer free care. Second, many hospitals calculate the value of their free care at full charges, dramatically inflating the value of their charity care. Even with these over-inflated valuations of charity care, many hospitals are having difficulties meeting the charity care obligations that are

required under state law.[4] Finally, many uninsured patients are subject to aggressive attempts by hospitals and collection agencies, and as a result, medical expenditures are a major reason why people declare personal bankruptcy.[5]

A third response from hospitals is that they need the money in order to remain solvent. Most hospitals argue that they are being squeezed by Medicare, Medicaid, managed care and other insurers who are getting deep discounts. There are two problems with this argument. First, the need to earn a profit is not a justification for charging the uninsured and self-pay patients 80 percent more than what most public and private insurers are paying. Second, the medical care costs of treating an uninsured patient are nearly identical to the costs of treating an insured patient.

A fourth argument is that high charges are a good negotiating strategy with managed care plans. If the managed care plan does not have a contract with the hospital, then the managed care plan will have to pay full charges. The higher the charges, the greater the incentive the managed care plan has to sign a contract. However, this negotiating strategy ignores the fact that the uninsured patient is expected to pay these higher charges.

Another argument is that other hospitals in the same geographic area are charging similar rates. Often, the hospitals will argue that because other hospitals are charging similar rates, their own rates are justified. The problem with this argument is that hospital charges are not set by market forces. Because the charge master rates are never published and are not accessible to the public, it is impossible for the patient to do any comparison shopping – a key component of efficient markets.

Options to obtain lower rates

There are a number ways to lower the rates charged to uninsured patients. The most obvious is to provide health insurance to the uninsured persons in Delaware. This would dramatically reduce the bad debts of hospitals.

A second option is to have all insurers and uninsured patients pay a single rate. Countries such as Germany and Japan hold annual negotiations to set hospital rates. In these meetings, the insurers and hospitals sit on opposite sides of the table, with the government acting as the referee. However, current antitrust laws may prohibit this from occurring in the United States.

Hospitals will argue that because other hospitals are charging similar rates, their own rates are justified.

Another option is to allow the government to set the rate. In Maryland, hospital charges are set by the Health Services Cost Review Commission, a state regulatory body.[6] All insurers in Maryland pay a nearly identical rate, and the same rate is also charged to self-pay patients. Different hospitals in Maryland have different rates based on their case mix, labor costs and other factors. As a result of the rate-setting commission, hospitals in Maryland have the lowest charge-to-cost ratios and the lowest gross to net revenue ratios.

A third option is price transparency. Under this proposal, each hospital would be required to actually post charges. There is federal legislation to require price transparency, and President George W. Bush and Secretary of Health and Human Services Michael Leavitt have made this issue one of the administration's top health priorities.[7]

Unfortunately, there are numerous problems with price transparency in the hospital industry. First, a typical hospital bill contains 10 to 50 items, but the charge master file contains an average of 25,000 items. As a result, the patient will never use most of the items on the charge master file. Second, many of the items on the charge master file are written in code so that only the hospital administrators and a few other experts in the field can interpret their meanings. If the consumer is going to shop comparatively, these items will need to be described in layman's terms. Third, hospitals are currently allowed to change their prices at any time. A patient could comparatively shop for hospital services on Monday and enter the hospital on Tuesday to find that some of the prices have changed. Finally, posting prices is unlikely to improve the bargaining position of the uninsured person because uninsured persons are still unlikely to be able to negotiate discounts with hospitals even if they know the prices of nearby hospitals.

Instead of requiring hospitals to post charge master file rates, another possibility is to allow hospitals to charge a certain percentage above what Medicare or some other insurer pays. Hospitals could advertise that what they charge is 10 or 30 percent above the Medicare rate. This would satisfy the price transparency requirements because patients would only have to compare one price. It would, however, require hospitals to set rates for the uninsured using the Medicare payment system.[8]

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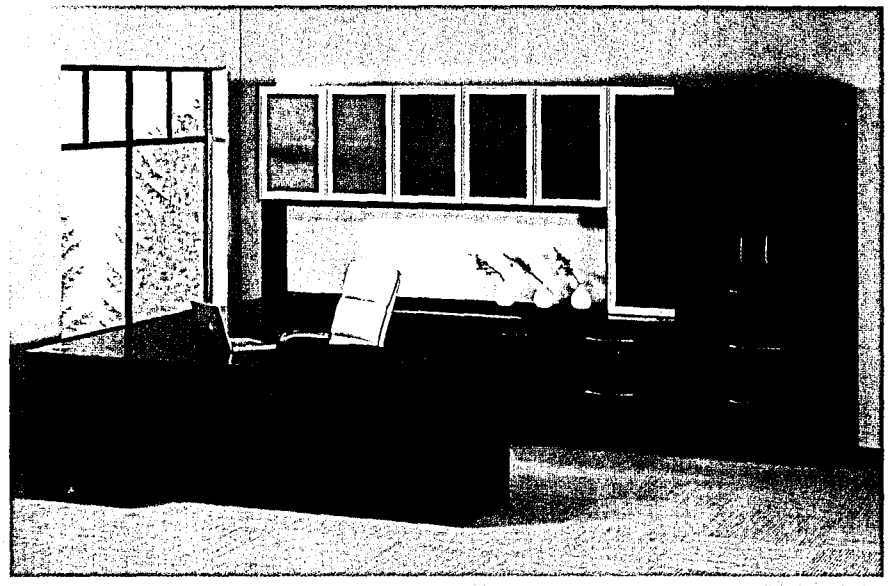

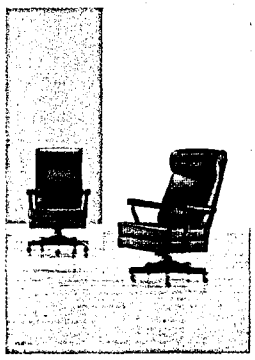

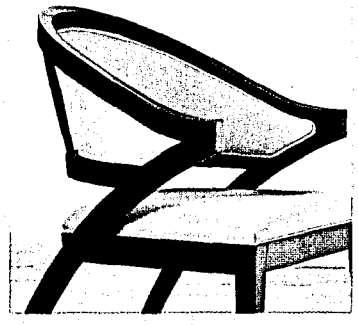

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A fourth option is to establish a maximum rate that can be charged to uninsured patients. There are a number of ways that this rate could be established. Three possible ways to set the rate are to have the hospital voluntarily set the rate; have the rate determined by the courts; or have the rate determined legislatively. Each of these options has advantages and disadvantages.

One option is to have hospitals voluntarily lower their charges to the uninsured and other self-pay patients. Until recently, many hospital lawyers advised the hospitals that giving discounts would violate Medicare rules. This was clarified by the inspector general of the U.S. Department of Health and Human Services and hospitals now can provide discounts to the uninsured. On April 29, 2006, the Board of Trustees of the American Hospital Association (AHA) approved a set of policies to lower the rates to poor uninsured people.[9]

Unfortunately, previous voluntary efforts by the hospital industry to control prices have not proven to be successful.[10] Also, more than 60 court cases challenging hospital rates paid by the uninsured are still ongoing, with some hospitals continuing to be unwilling to lower their rates to the uninsured in spite of the AHA guidelines.

Currently, this issue is being litigated. In one of the first cases, *Peggy Smallwood vs. Columbia HCA*[11], class certification was not granted, so the case did not proceed. Obtaining class certification turns out to be the major hurdle to overcome. It requires the class action lawyers for the uninsured to prove that indeed there is a class, and that the class has certain characteristics in common.[12] Recently, however, several courts have granted class certification and when class certification is granted, it is common for the hospitals to settle.[13] Hospital chief executive officers and boards of directors do not want to justify to the public why they are charging the uninsured much higher rates than the insured population.

A third possibility is for states to pass legislation determining a maximum rate that the hospital could charge. In 2004, I proposed in Congress that the maximum that a hospital could charge is the price that Medicare pays plus 25 percent.[14] The methodology is based on four principles. First, the payment rate should not interfere with the marketplace. Second, the payment rate should be above what most managed care plans and private insurers are paying hospitals. Third, the payment method should be transparent to the patient. Fourth, the system should be easy for the hospital to administer. The rate of Medicare plus 25 percent is derived by using the costs at a typical hospital and adding a 25 percent allowance for profit.

Conclusion

A three-step approach is recommended to lower the rates for the uninsured patients. First, hospitals should be encouraged to follow the American Hospital Association's guidelines. Some hospitals may not choose to follow the American Hospital Association guidelines for a variety of reasons. In this case, it is likely that lawsuits to force them to charge reasonable rates will continue. A third option is to have the states legislate a maximum amount that hospitals can charge. This may be an option if hospitals do not follow the voluntary guidelines and the court proceedings become too onerous. ◆

FOOTNOTES

1. Medicare cost reports from 1984, 1988, 1992, 1996, 2000 and 2004 were analyzed.

2. R.A. Kessel, "Price Discrimination in Medicine," *Journal of Law and Economics* No.1 (1968):20-53.

3. Medicare cost reports from 1984, 1988, 1992, 1996, 2000 and 2004 were analyzed.

4. J.R. Horowiz, "Making Profits and Providing Care: Comparing Non Profit, For Profit, and Government Hospitals," *Health Affairs*, 24(3):790-801; B.C. Guadagnino, Law Suits Indict Hospital Charity Case, Physician News Digest. http://www.physiciannews.com/cover/904.html.; www.cbs2chicago.com "Some Hospitals Not Providing Enough Low-Cost Care," May 30, 2006 http://www.topix.net content/cbs/384857070278146522257005734034303572524094.

5. D.U. Himmelstein, E. Warren, D. Thorne, and S. Woolhandler "Illness and Injury As Contributors to Bankruptcy," *Health Affairs*, Web Exclusive. Feb. 2, 2005.

6. G.F. Anderson, "All-payer Rate Setting: Down But Not Out," *Health Care Financing Review*, 1991, 35-41.

7. G.F. Anderson, "A Review of Hospital Billing and Collection Practices," Testimony before the Committee on Energy and Commerce (2004).

8. U.E. Reinhardt "The Pricing Of US Hospital Services: Chaos Behind A Veil Of Secrecy," *Health Affairs*, January/February 2006; 25(1): 57-69. M.E. Porter and E.O Teisberg "Redefining Competition in Healthcare," Harvard Business Review (June 2004): 1-14

9. American Hospital Association, "Billing, Collection, and Tax-Exempt Status," April 29, 2006.

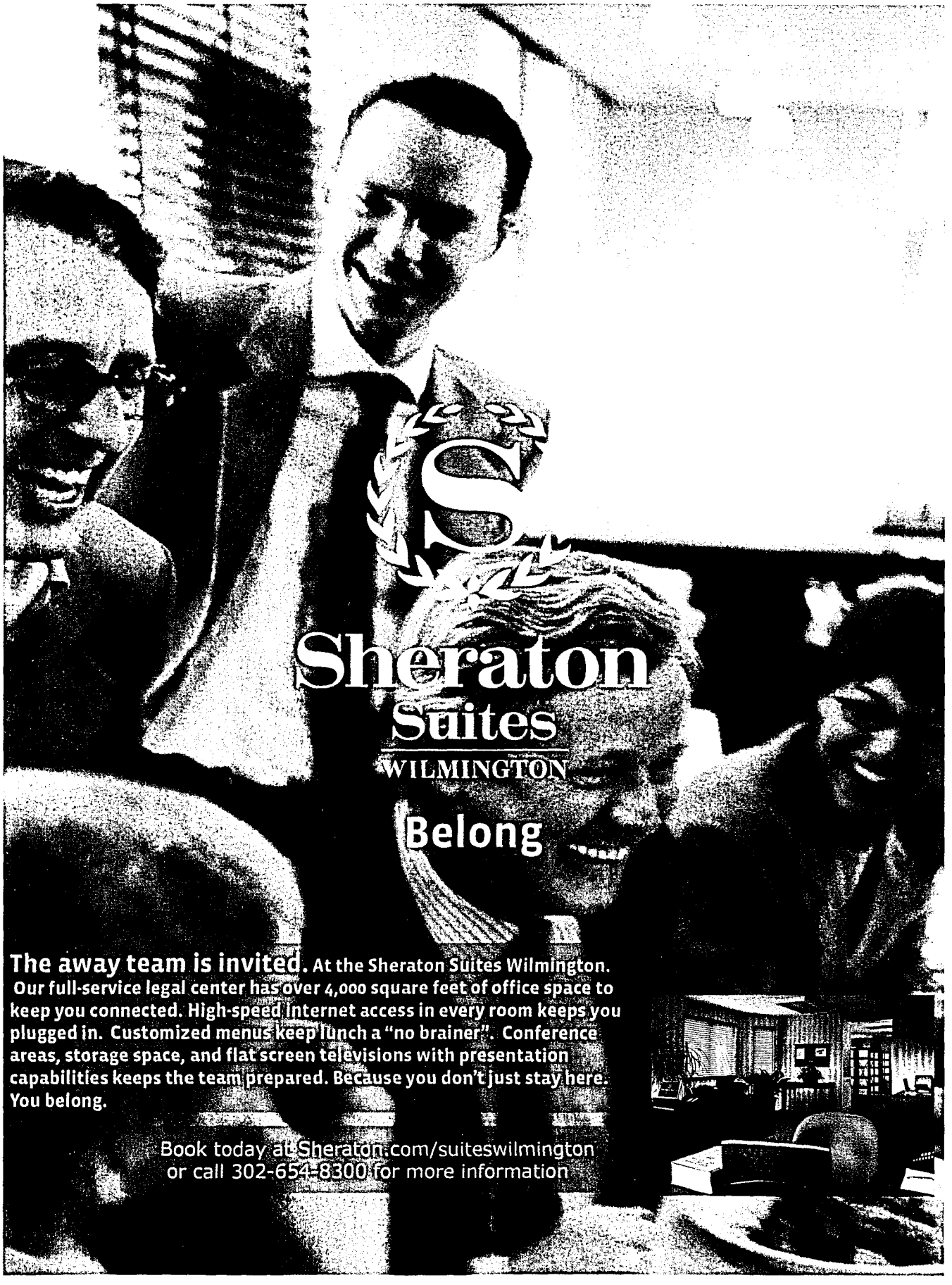
10. Karen Davis, Gerard Anderson, Diane Rowland, and Earl Steinberg. *Health Care Cost Containment.* The Johns Hopkins University Press, Baltimore, Maryland, 1990.

11. *Peggy Sue Smallwood v HCA Health Services of Tennessee Inc.*, Memorandum Decision, Case No. 92C-204, February 21, 2003 (M.D. Tenn.)

12. Defining the class is of critical importance because it identifies the persons (1) entitled to relief, (2) bound by the final judgment, and (3) entitled under Rule 23 (c)(2) to the best notice practicable in a Rule 23 (b)(3) action. Federal Judicial Center, Manual for Complex Litigation 21.222 (2004)

13. Cleveland Clinic In Ohio, Lakes Region General Hospital in New Hampshire, St. Elizabeth's Hospital in Illinois, Washington Regional Medical Center in Arkansas, Saint Mary's Hospital in Arkansas, Legacy Health System in Oregon, the Fairview and Allina Health Systems in Minnesota and Homestead Hospital in Florida

14. G.F. Anderson, "A Review of Hospital Billing and Collection Practices" Testimony before the Committee on Energy and Commerce (2004).



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