

From my perspective

In a recent column, I noted that the medical and surgical professions have gone out of their way to respond to government demands for increased accountability and transparency, whereas some health insurance companies have failed to compile and analyze reliable data to support their payment decisions.¹ The main point of that commentary was that if the government seriously intends to reduce costs, improve quality, and expand access, then insurers, physicians, and all other stakeholders should be held to the same standards.

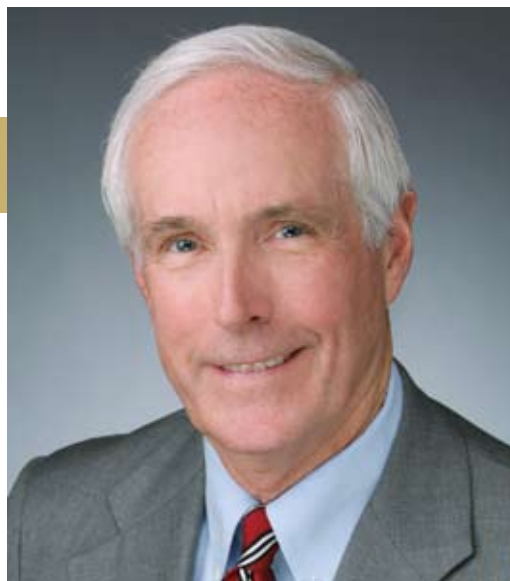
However, the evidence is mounting that physicians are bearing the brunt of efforts to reduce federal health care spending. Furthermore, it would appear that some policymakers expect health care professionals to accept greater financial sacrifices for the common good than they demand of health insurance companies.

Pay cuts

A recent example of legislators opting to protect the financial interests of insurance companies rather than those of physicians was notable in this past summer's Senate votes on the Medicare Improvements for Patients and Providers Act of 2008 (H.R. 6331). This legislation, which was enacted despite the objections of some prominent senators and the President, stops the 10.6 percent Medicare physician reimbursement cut that went into effect July 1 and replaces the 5.4 percent reduction scheduled for 2009 with a 1.1 percent hike.

During the initial round of voting on H.R. 6331, a total of 39 Republican senators opposed passage of the legislation. Like President Bush, they objected to the law because it trims \$13.6 billion from the Medicare Advantage program to offset the nominal physician reimbursement increase. In other words, when forced to choose between protecting physicians participating in Medicare from a steep pay cut and maintaining government funding for Medicare Advantage, these individuals sided with the large insurance companies that administer Medicare Advantage plans.

The senators and the President rationalized their decision by claiming that reductions in Medicare Advantage—a government-subsidized initiative that allows beneficiaries to purchase supplemental coverage from private insurers—



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would obstruct patient access to care. Either these legislators thought physicians would sit idly by and continue to treat Medicare beneficiaries for what would amount to a 16 percent pay cut over the course of 18 months, or they didn't contemplate the long-term access problem that would arise if tens of thousands of physicians dropped out of the Medicare program.

Fortunately, a significant number of physicians and patients made their voices heard throughout much of the two weeks following the initial vote, contacting their senators to express their deep concerns about the lawmakers' decision. Consequently, several senators reversed their positions on the bill, passing H.R. 6331 on July 9 in a 69 to 30 vote. The President proceeded to veto the law, maintaining his opposition to any legislation that would cut funding for Medicare Advantage, but Congress overrode his interdiction on July 15.

Money-making vehicle

Who stood to lose the most as the result of reduced Medicare Advantage funding? Mostly, it seems to be the insurance companies that administer the plans, especially in light of the fact that Medicare Advantage was paying them 12 percent more per patient than traditional Medicare reimbursement.² Oddly enough, though, many physicians report that Medicare Advantage plans reimburse them at a lower rate than traditional Medicare. If the money isn't being directed to the providers of the services the insurance companies cover, it stands to reason that the government funds are contributing to the insurance companies' bottom line.

Indeed, the federal government has become a significant revenue source for a number of major health care insurers. In fact, many insurance companies now view the administration of government-subsidized programs—including Medicare Advantage, as well as Medicare Part D (for prescription drugs), Tricare, and Medicaid—as a small but rapid-growth component of their business portfolios. As an example, in the third quarter of 2007, Humana brought in \$4.6 billion from its government-sponsored plans and just \$1.7 billion from its group and individual health insurance plans. Meanwhile, UnitedHealth Group's business has spiked since its purchase of Unison Health Plans, which in 2007 administered benefits for 370,000 Medicaid recipients to the tune of \$1 billion. Furthermore, insurance industry executives and analysts anticipate continued financial growth in earnings from government plans as the number of Medicare-eligible baby boomers balloons.³

Meanwhile, the system that many insurers use to process claims for non-Medicare patients continues to block physicians' ability to receive timely payment for the services they provide. According to the American Medical Association (AMA), physicians allocate up to 14 percent of their total collections to claims administration. The AMA maintains that eliminating, or at least reducing, inefficiencies in claims processing would save the health care system millions of dollars, which would yield lower insurance premiums and, thereby, expand access to affordable coverage. More manageable claims processing systems also would free up time for physicians to

devote to patient care and quality-improvement activities.⁴

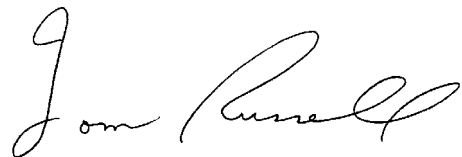
Equitable treatment

Unquestionably, insurance companies provide an important product for American consumers, so they should expect to reap some financial rewards. However, physicians also provide necessary services to patients, which ensure that they can continue to be productive members of our society. Therefore, it is unreasonable for the government to expect physicians to always be the ones who take a pay cut, who implement quality controls, and who strive for greater efficiency. The health care system is eroding not only because of issues that exist within the medical community, but also because many insurance companies are too focused on what is best for their bottom line and not for patients.

The key to overcoming the challenges in the U.S. health care system is to ensure that all stakeholders work together to cut costs, boost quality, and expand access to care. That means we must all make equal sacrifices and adjust our demands accordingly. Physicians cannot and should not be the only ones "walking the walk."

References

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Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.