A Physician’s Opinion Regarding Political Malpractice: The Origin of Medical Cost Inflation, HMO Rationing, and Obamacare Cartel Controls

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Abstract

Doctors cannot solve medical marketplace problems caused by political malpractice. These are government prescriptions that caused tax-subsidized demand inflation and that created futile managed care rationing-of-supply panaceas gone awry. Obamacare implements more of the same: a powerful cartel-utility version of managed care and another possible cost-control and quality failure.

A better way would be to decentralize medicine and to re-empower families with money to create a medical marketplace guided by real prices. It would take enormous effort to write a prescription for a new medical marketplace, where the consumer is king and where money (instead of politics) is used to distribute goods and services.

Chances are that a new prescription would make medical care and its catastrophic insurance coverage affordable for all Americans.

Background

U.S. cost-price inflation began abruptly after 1965 (for the first time in nearly 100 years\(^1\)) following passage of Medicare and Medicaid laws.\(^2\) This was a turning point: 85% of the populace (employed workers since 1942 plus the official old, poor, and disabled) suddenly had inexpensive tax-subsidized insurance—a piecemeal U.S. version of National Health Insurance (NHI).

The good intentions behind using tax subsidies to artificially decrease the price of insurance meant that untaxed insurance dollars were used to pre-pay even affordable and expected medical care. As care appeared “free”\(^3\) (“the boss pays for it”), unrelenting demand inflation followed.\(^4,5,6\)

Since repealing popular tax subsidies was considered political suicide, culprit economics was invoked. “Market failure” was allegedly due to profligate providers? practicing in an inefficient “cottage industry” doing “sick care” instead of “well care”. In 1973, the Health Maintenance Organization Act (HMO) was passed to control cost inflation through corporate efficiency profit-driven to maintain health.\(^7\)

After decades of government price fixing and HMO cost control panacea failures, these managed care partners needed an explanation. New culprits were found: a self-indulgent, smoking, and obese populace; greedy drug companies; and, once again, profligate irresponsible providers. Doctors are purported to be practicing poor quality care, because driven to profiteering avarice by the incentives of the fee-for service (FFS) system to do too much.\(^8\)

The lack of FFS driven inflation in any other industry is ignored.

In 2010 passage of the Patient Protection and Affordable Care Act (PPACA or Obamacare) was heralded as a cure for avarice driven cost inflation. Ironically, the PPACA cure for alleged profiteering provider behavior is to enlist this base motive as a “bonus opportunity” to incent ordering less care and increasing self-referrals. The managed care industry portrays this strategy, as payment reform to reward “value over volume” medical care.\(^8\)

What have been the effects on physicians of their demonization and the latest PPACA panacea controls? In a 2014 biannual survey of 20,088 physicians, 69% believed that their “clinical autonomy is sometimes or often limited and their decisions compromised”.\(^9\) Also, the recently passed Sustainable Growth Rate (SGR) “doc fix” legislation, threatens professional integrity by coercing physicians into being corporate bedside gatekeepers.\(^10,11\) The alternative is to be out of the money flow.

In the 2012 biannual survey of nearly 14,000 physicians, 84% agreed that the medical profession was in decline, and about 58% would not recommend medicine as a career to their children or other young people.\(^12\) Besides the enormous increase in paperwork and threatened autonomy, the role of gatekeeper rationing care for the benefit of corporation profit or some government agency, is perceived as a conflict of interest by clinicians.\(^13\) From 2012 to 2014 workforce morale has worsened;\(^9,12\) a challenge to the profession and the nation.

Why did past panaceas fail to control cost inflation and end-up threatening medical workforce morale and integrity? If previous managed care panaceas failed, will the PPACA panacea also fail?

Medical cost inflation caused by a sudden epidemic of culprit populace and provider behavior lacks credibility. Inflation ought to be explainable in ordinary economic terms of supply and demand.

Methods
Cost inflation, the attempts at its control, and its consequences are examined, as functions of ordinary economic principles of supply and demand.

Results

Two politically created transitions in the U.S. medical market place demonstrate the plausible role of political malpractice on the origin of cost inflation and on the futile managed care panaceas created to control it.

Transition I: From a Professional to a Commercial Medical Market Place (1973–2010)

From Good Intentions to Inflation
Today, it is still considered political suicide to repeal the well-intended and popular tax subsidies, which drive medical demand. Therefore, the political “necessity” is to ration access to supply instead. The response to sudden and unrelenting cost inflation after 1965 was managed care controls: price fixing and HMO barriers, as well as laws for Certificate of Need planning (defunct) and hospital Diagnostic Related Group fixed payments.

Commercial HMO Corporation Rationing (1973)
Managed Care Organizations (MCOs, the generic term for HMOs) were created in 1973 as gatekeepers in hope of controlling use of popular “free” care. The relatively weak U.S. HMOs became the corporate health service (CHS) versions of the more powerful, socialized National Health Service (NHS) MCO public cartels abroad. They were expected to perform the same rationing function. It was obvious that “not everyone could have everything they wanted.”

The HMO Act gave medical insurers the perverse legal power to control the use of the benefits they insured. HMO corporations thus had power to transfer insurance underwriting risk to clinics, typically through capitation fee payments or through their corollary, withheld fee-for-service pay to be earned back or rewarded for restricting use of corporation dollars spent on patient care.

Difference of a Professional from a Commercial Medical Market Place
From 1973 to 2010, we see accelerating transition from a professional medical marketplace, in which services were sold to patients, to a commercial marketplace in which patient populations (“covered lives”) of corporate and government agencies (the mega “payers”) were auctioned to providers for servicing. Providers bid a fee to perform services for patients and/or bid a capitation fee to service a specific population, such as for drug, clinic, or even for global costs. The auction prices for services have been fixed for public sector populations for many years and, theoretically, are negotiated for HMO corporate populations. State Medical Practice anti-fee splitting statutes still make it illegal to auction patients for servicing outside the umbrella of HMO and PPACA law.

Despite the intervening years of government price-fixing and blunt HMO industry barriers to care, uncontrolled demand inflation increased over 17-fold for all medical care between 1950 and 2000—nearly three times the rate of the rest of the economy. Meanwhile, management of much of the monetary flow in medicine had shifted from patients to HMO money managers increasing corporate bargaining power. These changes had a significant impact on the nation’s workforces.

Worker Turmoil
Workers were increasingly frustrated, as the inflationary effect of “free” health care fringe benefits ate away at take-home pay. They ended up in zero-sum budget games played by various HMOs attempting to balance fixed budgets. The famous (or infamous) dilemma of managed care became “Cost, Quality, Access—Pick Any Two”. Large employers could afford to circumvent HMO overhead and barriers by self-insuring worker care.

We will see later how HMO rationing of care access came to directly trouble the nation’s families in the 1990s.

Clinic Turmoil
Physicians paid a high price when government agencies and MCO payers systematically underfunded and over-regulated practices, killing clinics’ financial viability and ability to respond to increased patient demands arising from apparent free care. Prices for medical services have, by now, been nearly frozen for decades by federal and state public payer programs. These public program prices were then paralleled by corporate payers.

Physicians run too fast trying to keep up with ballooning patient demand and expanding medical knowledge. They have been demonized as the cause of inflation. They are told that their moral path to salvation is to be corporations’ bedside gatekeepers of patient access to care. Later, new managed care institutions were deemed necessary to provide quality care and financial accountability.
HMO/MCO Domination in the 1990s

Once HMOs came to dominate the U.S. medical landscape in the 1990s, they had the power and implicit backing of employer and government agency “buyers” to perform draconian rationing of access to medical care. It briefly controlled inflation in the early 1990s. However, corporate barriers, such as drive-by mastectomies and baby deliveries, proved unpopular. The HMO industry shrugged off complaints as mere anecdotes. This was belied in 1997; audiences around the nation watching the movie, As Good As It Gets, spontaneously leapt out their seats in angry sympathy, when a character vilified HMOs on the screen. Some states and Congress responded with patient bill-of-rights law. HMO managers found it easier to raise premiums than to continue wearing the black hat of overt rationing of care. Cost inflation resumed at double digit rates.

It is interesting that the HMO industry, despite public distrust, was able to parlay decades of failed cost control into unparalleled profits, and profits into political power.

Power and Merger Mania

As bargaining power shifted to HMOs, many independent practices merged to better negotiate prices and share the costs of increasing regulatory burdens. When mergers were not successful or possible, many practices sought what appeared to be a less risky business alternative: hospital employment.

Reacting to increasing payer power, hospitals also merged to increase their own negotiating power. Hospitals hoped that by buying clinic practices they could assure patient referrals and acquire a workforce to service large HMO Corporation and government populations. Time has brought this hope to fruition.

Transition II—From Commercial to Cartel Controls (after 2010)

Public cartels (as distinct from collusive private cartels) are established by governments to enforce rules relating to prices, output and other such matters most often rationalized as the means to a public good. Merger mania is one symptom that tells us that the second transition from a commercial to a cartel system of control is well underway. For physicians the result of enhanced mergers through implementation of Obamacare has become clear. The 2014 Physicians Foundation survey of some 20,000 U.S. doctors found that 35% described themselves as independent, down from 49% in 2012 and 62% in 2008.

In 2010, the HMO industry gained unfathomable power with enactment of Obamacare. PPACA creates a federally protected (and thus more powerful) utility-like version of the HMO corporate managed care industry. It is being implemented by Medicare and Medicaid Services (CMS). In effect, PPACA resembles a U.S. Public-Corporate Health Service cartel system analogous to the Parliamentary-NHS cartel systems seen abroad (more on this later). These health services are examples of public cartels.

Hospitals are busy forming Accountable Care Organizations (ACOs) favored by PPACA law. ACOs are mini-HMO-like insurance corporations of merged hospital and medical staff but without reserves other than future earnings. They are profit-driven by fixed capitation budgets to ration care or risk going broke. It is ironic that Patient Protection Act ACOs need to be legalized through waivers of patient protection laws. FTC waivers override anti-trust laws so as to allow collusive provider and ACO-HMO mergers. CMS waivers override anti-kick-back and Stark anti-self-referral laws so as to allow capitation fee-splitting (“gain sharing”) should bedside gatekeeping be profitable. Loss-sharing is not often mentioned. The result of the merger frenzy has been increased prices.

The model has changed from a favored commercial corporate system to a PPACA-protected corporate cartel system able to fix prices (for services and insurance) and to franchise delivery of care only to those entities underwriting insurance risk, such as ACOs. ACOs are further favored and empowered by the new law that repealed the old SGR “doc fix” law.

Selling ACOs

To explain previous U.S. corporate gatekeeper failure and to sell implementation of PPACA protected cartels and ACO payment reforms, I summarize here the three arguably evidence-free claims made by government and HMO industry payers: 1) medical inflation is due to “poor quality” care (too much, too little, too varied) and profligate provider behavior driven by an evil fee-for-service system; 2) costs will be contained by transfer of the corporate gatekeeping role to the culprit providers through capitation payments for servicing payer populations (payment reform); and 3) physician gatekeepers could gain redemption, when natural avarice is enlisted through “bonus opportunities” in the cause of conserving society’s scarce resources and, coincidently, payer treasure.

By successfully demonizing physicians, it became easy for the managed care industry to gain political assent for ACO bedside corporate gatekeepers, whose pay is contingent on restricting use of corporate money; a legalized financial conflict of interest troubling to doctors. This conflict of interest is often hidden by corporate promotion of pay-for-performance (P4P) for: value; or quality; or prevention; or outcomes; or coordination; or processes; or
“stewardship” of society’s resources—or whatever can best help sell profit-driven bedside gatekeeping to an unwary public.

**Quality P4P Fantasy or Sham?**

Population cost control through P4P of prevention and quality assurances may be a spurious hope at best. Some have thought it industry fantasy or even a sham.

It is fantasy to expect that medical practice will have an effect on population health equivalent to public health measures like clean water, good sewage disposal, well designed highways, food inspection, vaccination, basic research, and so forth.

One example is that, “Over the four decades since cost-effectiveness analysis was first applied to health and medicine, hundreds of studies have shown that prevention usually adds to medical costs instead of reducing them.”

Another example was the CMS quality Pay-for-Performance (P4P) incentive experiment using thirty-two ACO systems had, at best, variable cost control results, which disappointed many advocates. CMS reported that in 2012, 220 ACOs were started, 52 cut costs (with $700 million in savings/profits), and 115 had no savings. It is reported that 53 dropped out. At minimum, the CMS experiments had a 76% cost control failure rate. Despite failure, CMS announced ACO payment reform expansion. Some argued that experimental failure was due to a steep ACO learning curve, which made results too early to judge, or that utilization behavior penalties were not great enough to incent ACO gatekeeper cost control behavior, or measurements were inadequate.

Measuring population costs and quality become problematic, when subject to the vagaries of public policy, the business cycle, cultural status, and poverty, none of which medicine can control from the bedside. This makes dubious the use of P4P to fix the nation’s cost inflation problem, when driven by factors beyond clinic control. Studies in England and here, have shown that P4P has only a marginal effect, if any, on sustained quality or on costs. It may also be “toxic” to the performance of medical care typically complex tasks.

HMO-ACO corporate P4P payment reform aimed at prevention and quality of care for cost control may be typical of group-think fantasy. But is the P4P slogan “value over volume” a sham? Rarely mentioned is the corporate value of performance incentives (“bonus opportunities”) paid ACO gatekeepers able to increase the volume of physician self-referrals and to restrict the volume of patient referrals for care (measured by a “clinic cost of care index”). A local pundit once quipped that “what counts in corporate-cartel counting houses is what is countable: money.”

**A Big Box Medical Home Cartel System**

Centralized state power abroad can be harsh in rationing care for cost control. Long queues in many nations are testimony. In contrast, relatively weak U.S. HMO corporate managers were given an impossible job to ration care supply in 1973, since demand was the problem. As noted before, their 1990s attempts at draconian rationing were a political bust. After 2010 PPACA protected HMO/ACO public cartels would appear to have the potential power for more collusive rationing of care decisions and profiteering mischief. Might this be the ultimate profit-driven, low-utilization, federally protected, big box Medical Home cartel-utility system without independent oversight?

If there is no significant change, physicians and patients may find themselves in a centrally controlled PPACA landscape where they are seen as cost centers. The nation may also find that PPACA tax distortions affecting businesses and households could impair productivity (measured by Gross Domestic Product). A local Minnesota ACO vice-president predicts that in the next decade, after many mergers and acquisitions, only four giant HMO/ACO-government-backed health service utilities will control the entire nation’s medical sector.

**The International Story—From Socializing Medicine to Incessant Reforms**

The U.S. story has already played out abroad. After World War II, National Health Insurance programs (NHI) were developed in the United Kingdom (UK) in 1948, in Canada beginning in 1962 (expanded in 1966 and 1984), and in many other nations. NHI programs attempted to solve serious pre-war problems of access to medical care. Parliamentary-backed MCO (National Health Service) cartels were necessary to regulate use of apparent free care.

Authoritarian socialism (the mobilization of public and private sectors) had won World War II in 1945. This success served as a model for peacetime national economies in many nations; the memory of capitalism’s 1930s economic depression was still fresh. Western European nationalized industrial public cartel collectives created during and after World War II became a model for post-war NHS medical cartel collectives.

It was not understood that total mobilization to achieve a single wartime goal of national survival may not work in peacetime private sectors. In peacetime millions of people have millions of different goals for securing their personal survival and well-being.
In the UK industrial collectives were found inefficient and sometimes “a state within a state” prone to corruption. European industrial “mixed socialism” collapsed by 1980 and had to be deregulated. Indian industrial socialism collapsed in 1991 and was deregulated within a few weeks. By 1991 the tyrannical, less adaptable Eastern Bloc socialized nations suffered industrial as well as political collapse—supply and demand were simply irrelevant.

Despite incessant studies and periodic reforms, the medical MCO collectives of the UK and Canada developed symptoms similar to those seen when other industrial collectives fail: infrastructure erosion (plant, technology, and personnel), poor access (queues), distraught managers, and endless subsidies (high taxes) erected to prop up socialized industries. A Pay-for-performance (P4P) “incentive” reform in the UK troubled its work force and even corrupted some system management—a well-known hazard of politically incented P4P targets. The richer U.S. system has shown progressive, although milder, symptoms of limited access.

**National and Corporate Socialization of the Medical Market Place.**
The U.S. has socialized funding of medicine for relatively small selected populations: veterans, end stage renal disease patients, and the official old, disabled, and poor. We have arranged delivery of these services in a variety of ways not always with success. We have seen that serious problems arise when the medical market place for large or entire national populations is controlled by centrally directed MCO collectives. Why?

**Discussion**

In retrospect political malpractice began with good intentions; U.S. piecemeal NHI was realized in 1965, when 85% of the population had suddenly acquired tax-free insurance.

**The Moral Hazard of Insurance and Economic Mythology**
The artificial reduction in the price of insurance meant that tax-free insurance dollars reduced the apparent price of valuable good. When medical goods and services appeared relatively “free”, unrelenting demand inflation followed. This is the “moral hazard” of national health insurance—a predictable response from rational consumers to the reduction of a price.

The economic error of creating demand inflation was compounded by attempts to control it through rationing of care supply rationalized by culprit economics—providers caused cost inflation, not political motivations. This economic mythology led to political creation of centralized managed care cost control panaceas. They failed.

**The Fatal Error of Centralized Control of Microeconomic Sectors**
All MCOs, whether a NHS abroad or U.S. HMO/ACO corporation, are prone to socialism’s fatal error: no central authority, however brilliant the managers, can accomplish the functions of freely determined prices for the allocation of labor, capital, and human ingenuity. Neither management’s good-intentions nor the purity claims of not-for-profit insurance structures (nationalized or corporate) can fix the fatal error of a system with no real consumer prices to guide production and distribution of goods and services. Microeconomic systems including medicine, where millions of transactions take place daily between millions of people with millions of goals, have proved too complex to centrally plan and manage.

A dubious claim is that huge computerized data bases will beneficially affect demand inflation. It is worrisome that Big Data could be mischief’s new tool to ration patient access to medical supply with more precision.

Medical inflation is overt in the U.S and relatively hidden abroad. It will remain an unsolved policy maker problem of their own making until the problem of NHI excess “free” care demand is addressed. As long as the political command and control panacea mindset is unchanged, nations are stuck with MCO zero-sum rationing games played to balance fixed budgets through care of the many inexpensive well voters (“well care”) and queues for the few costly ill (“sick care”). The ill were once intended to be the primary object of medical care.

No one would recommend any state-run microeconomic sector after the failure of nationalized collectives around the world by 1991. Yet, once installed, socialized MCO public cartel systems (nationalized or corporate) have proven politically untouchable. They promise free care and cost control, even if these are a contradictory fantasy. After 2010, the PPACA U.S. cartel-utility version of healthcare is set to grow.

**The U.S. Cartel Leviathan.**
Despite the failure of its own ACO experiments, Obamacare’s corporate-state cartel-utility leviathan lumbers on, fueled by culprit economics, and promoted to prevent overuse of society’s scarce resources.

The reality is that ordinary economics can easily explain demand inflation, and the failure of managed care rationing of supply, when the problem is politically popular free-care demand. Culprit economics is mere sophistry.
There are three important concerns. The new protected U.S. corporate cartel system possesses power capable of profiteering from draconian rationing of care. The government regulator is in collusion with the corporations to curtail patient utilization of care. And the cartel system is capable of politically maintaining control over a big portion of our national budget. The real cost to the nation of cartel control of medicine has not been calculated and is yet to be paid.

**Are There Alternatives to Managed Care Cartels?**

Is there a way out of the fatal economic errors of political malpractice and the turmoil of centralized authoritarian managed care cost control panaceas that threaten patient-centered care, independent practices, the integrity of the profession, and the national budget?

The job of doctors is to take care of patients. Doctors from the bedside cannot solve the politically created problems of tax-subsidized demand inflation and rationing-of-supply cost control panaceas gone awry. If distribution of goods and services through politics instead of with money fails, what is the alternative?

**A Decentralized Medical Market Might Work**

A nascent decentralized U.S. private sector is growing. Health Savings Accounts have shown promise in controlling costs, as families are exposed to the real price of affordable expected expenses. If not derailed, this free market, in which families are empowered, can point the nation in a direction that might help achieve affordable health care and affordable catastrophic insurance coverage for all Americans. The poor could likewise be empowered through use of a state-controlled HSA-like debit card linked to state catastrophic insurance coverage.

**Conclusion**

It was political malpractice to ignore ordinary economic principles of supply and demand, when the U.S. government wrote prescriptions for the nation’s medical sector that caused the abrupt onset of tax-subsidized demand inflation after 1965 and created futile managed care rationing-of-supply panaceas to control it.

Resolving public-corporate cartel threats to patient care, clinic viability, and professional integrity would require political action to write a prescription for a new medical market place, where the consumer is king and where money (instead of politics) is used to distribute goods and services.

Chances are that this new prescription would make medical care and its catastrophic insurance coverage affordable for all Americans.

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