CHAPTER 1

Introduction

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A BRIEF RECAP OF THE HISTORY OF REFORM

As any student of history is taught, those who fail to learn from the past are doomed to repeat it. Thus, a brief review of the history of health insurance and its impact on the healthcare delivery system is in order to provide context to the discussion of what the 2010 reform legislation was designed to reform.

Early Reform Efforts

The 2010 reform legislation is but one late-stage episode in the history of the financing of healthcare in the United States, which dates back to the first Blue Cross plan established at Baylor University in 1929, when teachers paid $6 a year for up to 21 days of hospitalization. The financial pressures of the Great Depression caused expansion of Blue Cross plans by hospitals and ultimately led to the formation of Blue Shield plans by physicians. Private health insurance expanded dramatically during World War II when wage and price controls caused health benefits to be substituted for wages. This was also a period that saw the rapid expansion of Blue Cross plans, particularly in states north of the Mason Dixon line, in conjunction with labor unions. Shipping and steel magnate Henry Kaiser established the first staff model health maintenance organization (HMO) for wartime workers on the West Coast. In addition, the passage of the McCarran-Ferguson Act took place, which left the regulation of insurers to the states and provided insurers with the anti-trust exemption that accounts for one key element of the market structure we see today.

Tax Deductibility of Health Insurance

Congress sealed the deal with the passage of (now) Section 105 of the Internal Revenue Code in 1954, making health insurance premiums deductible by employers and nontaxable to employees.[1] The connection between obtaining healthcare and paying for it was severed for those fortunate enough to have employer-provided insurance, a second key element of today's market structure: tax-deductible health insurance premiums.

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The Great Society: Medicare and Medicaid

Fast-forward to the Johnson Administration's Great Society programs that inaugurated another rapid expansion of health benefits and government involvement and represent perhaps the most significant element of the modern healthcare market: Medicare and Medicaid, "insurance" covering the aged and poor, respectively. The influence of Medicare in particular is pervasive, defining what is and what is not covered by most health insurance plans through national coverage determinations. It is impossible, for all practical purposes, to bring a new technology or procedure to the market without Medicare approval for reimbursement. Medicare is the third key element in the structure of today's healthcare marketplace. Medicare adopted fee-for-service models for paying for hospital and physician services, the fourth key element. The increasing downward pressure from government budgetary constraints on Medicare fees to providers in the years since its adoption adds the corollary of "cost shifting,"[2] where those providers attempt to recover from private insurers and non-Medicare patients the discounts imposed by the government.

Medicaid is a program, shared between the federal and state governments, that covers the poor and, historically more significant, nursing home costs for lower-income seniors. Program spending slowed in 2006 due to the advent of the Medicare prescription drug benefit, and then resumed growth at a higher rate. The pattern in Figure 1.1, pre-reform, is also reflective of the aging population, slower economic growth after the 2008 recession, and immigration patterns.

Medicaid has two principal beneficiary classes pre-reform: 1) women with children and 2) the elderly who are unable to afford Medicare co-payments and co-insurance and, more importantly, nursing home coverage. Virtually everyone not otherwise eligible for insurance is covered post-reform and spending growth will accelerate dramatically as a result. It is the single largest budget item in virtually every state in the union and accounts for the sea of red ink that most states are awash in.[3] Medicaid, and its dramatic impact on state budgets and state income and sales-tax levels, is the fifth key element of the

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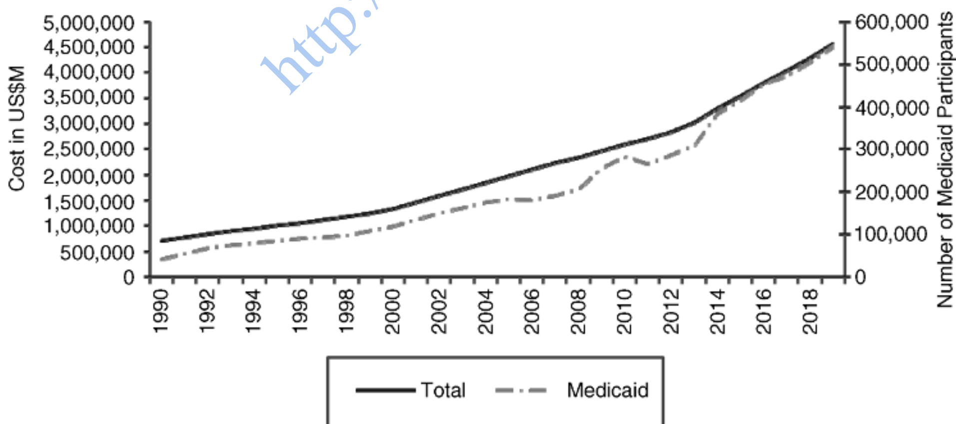

FIGURE 1.1 National Health Expenditures and the Medicaid Program
Source: www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp.

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healthcare system. The cost shifting to private insurers and patients from Medicaid is dramatically worse than for Medicare.

The 1970s: Medicare HMOs and ERISA

In 1972, the predecessor of the association of health insurers succeeded in getting congressional approval for payments to HMOs to provide Medicare beneficiaries with care. This legislation set the stage for the acquisition and consolidation rage of the 1990s, discussed later. Thus began the involvement of private health insurers in the Medicare program, the sixth key element of the current healthcare market and one target of the original reform legislation.

The late Senator Edward Kennedy made his first attempt at healthcare reform in the early 1970s, prompting then-President Nixon to respond with a plan of his own. Senator Kennedy's plan would have provided for a universal single-payer system financed through payroll taxes. The Nixon plan featured universal coverage and employer participation with a requirement that they contribute 65 percent of the premium.[4]

Driven in part by the Employee Retirement Income Security Act (ERISA) exclusions and the use of experience rating by health insurance companies to set premiums, it was also during the 1970s that self-insuring by larger business entities became popular. This was part of the demise of "true" insurance since more and more lower-risk populations were taken out of the insured risk pool in order that larger companies could save premium costs. Self-insurance is the seventh key element of the healthcare market.

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Regulation: The Anti-Kickback Statute

The passage of the Medicare and Medicaid Patient Protection Act of 1987, better known as the anti-kickback statute or AKS, was the second of a series of increasingly tough legislative and regulatory moves to control healthcare spending. The regulatory structure is the eighth key element of the healthcare market in the United States. Considerable detail is devoted to the present state of the regulatory environment later in the book.

Prospective Payment Systems

Attempts at healthcare reform stalled in the 1980s. The principal change from this period was replacing the charge-based system of paying for hospital services with the adoption of diagnosis-related groups (DRGs), the first prospective payment system, and the ninth key element.

The 1990s

At the start of the 1990s, the financial structure of the healthcare industry, to a large extent, looked as follows in Figure 1.2, although some markets had more advanced care models.

The 1990s brought to the forefront reform-minded think tanks, such as the Jackson Hole Group, and a focus on West Coast–style reimbursement mechanisms, principally capitation, as a means of reining in what even then were explosive levels of spending. The aborted attempt by the Clinton administration to implement national healthcare reform nonetheless

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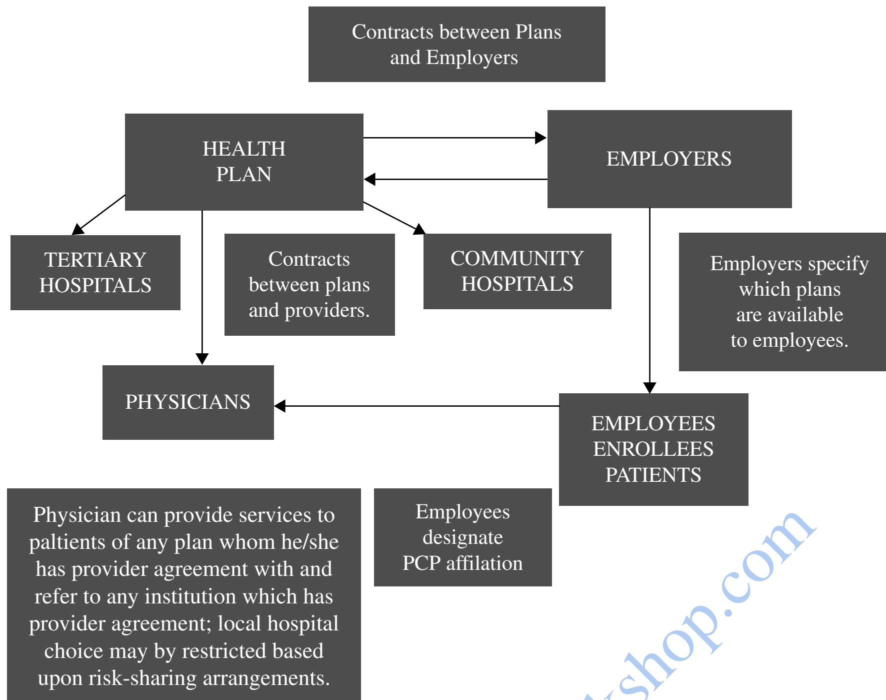

FIGURE 1.2 Market Structure at the Start of the 1990s
Source: Medical Practice Valuation Guidebook, 2001/2002, Mark O. Dietrich, CPA/ABV.

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sparked an unparalleled level of consolidation between both providers and, eventually, towards the end of the 1990s, insurers. With the stage set in 1972 for private insurer participation, California-based consultants spread the news about prepaid HMOs and Medicare risk contracts using capitation controlled by primary care physicians and hospital per diem payments in lieu of admission-based DRGs across the country. With capitation providing enormous financial incentives to physicians to reduce hospital admissions and length of stay, both admissions per 1000 population and average length of stay plummeted throughout the 1990s. Specialist utilization declined as well and the new era of primary care–driven healthcare was heralded. Capitation is the tenth key element in the healthcare market. See Figure 1.3.

Rise of Managed Care Managed care was now in full force, the failure of the Clinton reform notwithstanding. Many states with major urban markets, particularly those with high fee-for-service Medicare spending, including Florida and Massachusetts, were swept up in the wave. The Minneapolis–St. Paul collaboration among (dominant) employers, insurers, and providers was another model, as was Puget Sound Health in Seattle.

The Stark Law: Anti-Referral Statute The federal government saw expanded regulation as another means of controlling healthcare spending. Passed in 1989 and effective in 1992, the

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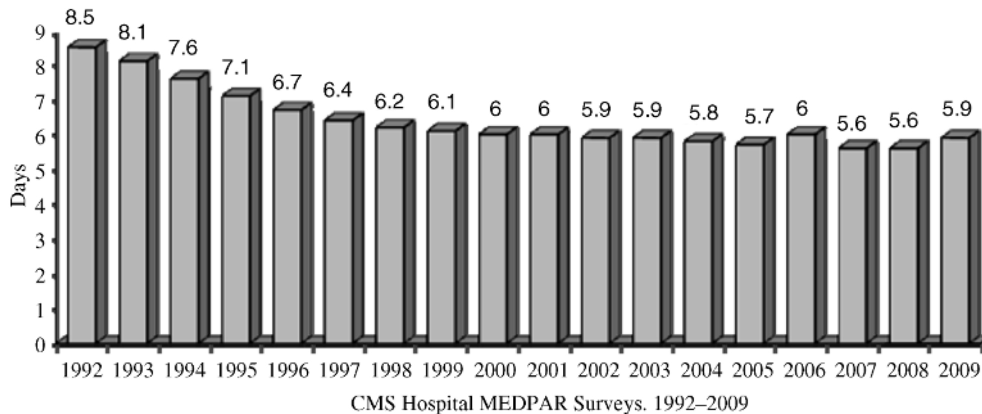

FIGURE 1.3 Average Length of Stay in Hospital for Medicare Beneficiaries
Source: www.cms.hhs.gov/MedicareFeeforSvcPartsAB/03_MEDPAR.asp#TopOfPage.

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first Stark Law[5] precluded physicians from referring to laboratories in which they had a financial interest. It was followed by Stark II, which expanded the prohibition to a number of designated health services (DHS). A variety of other changes not labeled reform also took place in this decade, including the Health Insurance Portability and Accountability Act (HIPAA), co-sponsored by Senator Kennedy[6] that now plays a key role in the delivery system.

Balanced Budget Act of 1997 The Medicare legislation known as the Balanced Budget Act of 1997 (BBA 97) made major revisions to Medicare, including the removal of preferred rates under Part B for surgical-services providers versus non-proceduralists, such as primary care physicians. It also introduced the Sustainable Growth Rate (SGR) formula as a means of updating the Medicare physician fee schedule (MPFS), one of the most complicating factors of the Medicare program today. The MPFS demands annual attention from Congress to defer the draconian cuts that would otherwise be made under the SGR.

The BBA also instituted major cutbacks in the Medicare risk contracts used to fund the provision of benefits to Medicare recipients enrolled in private HMOs, renamed Medicare+ Choice in the legislation. Prior to the BBA, Medicare risk contractors received 95 percent of the adjusted average per capita cost (AAPCC) of fee-for-service Medicare recipients in their county of operation. (This was supposed to save 5 percent for the government, but Medicare HMO enrollees tended to be healthier than those who stayed in the traditional Medicare program.) The effect of this formula was that payments increased at the same rate as spending in traditional Medicare, often resulting in substantial profits since Medicare risk contractors had much lower utilization rates than the fee-for-service Medicare system. Subsequent to the BBA, the payment was linked to a formula that generally resulted in contractors receiving an annual increase from the 1997 base year of only 2 percent, although legislation granted a special one-time increase of 3 percent in 2000. Severity of illness adjustments[7] were also made to the rates starting in 2000, a feature that continues to this day. (See Figure 1.4.)

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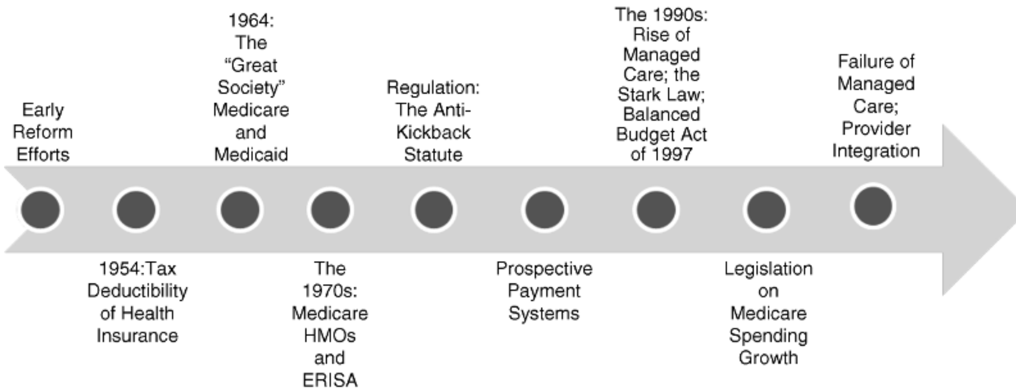

FIGURE 1.4 Timeline of Healthcare Reform in the United States

BALANCED BUDGET REVISION ACT AND BENEFITS IMPROVEMENT AND PROTECTION ACT

What were then seen as dramatic cuts in the payments to hospitals were also implemented and, for a time, succeeded in "bending the cost curve,"[8] as shown in Figure 1.5. These cuts were later mitigated by the Balanced Budget Revision Act of 1999 (BBRA) and the Benefits Improvement and Protection Act of 2000 (BIPA), and the cost trend resumed the march we see today. Readers may find a lesson there when considering the discussion of changes in hospital payments from the current reform legislation discussed later herein. The failure of Congress to hold the course on reduced Medicare spending was stage center as the country entered the new decade.

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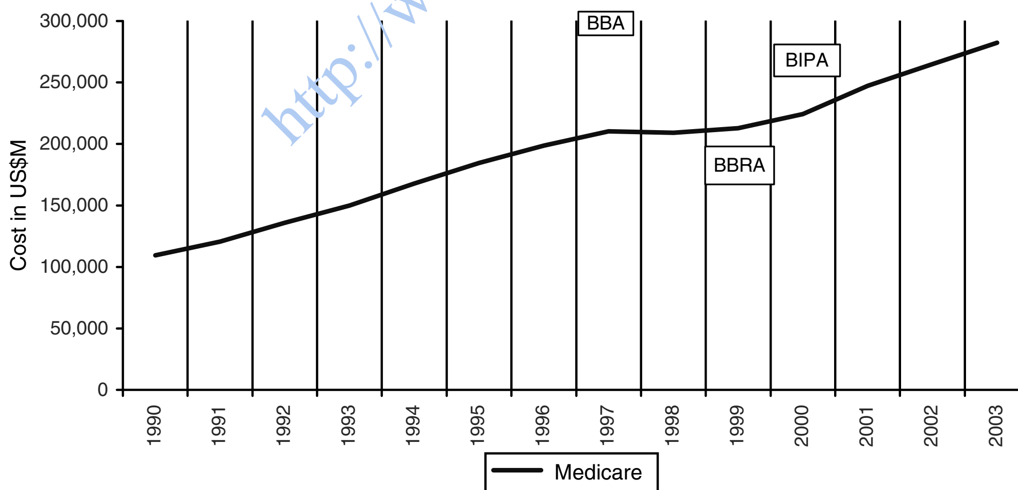

FIGURE 1.5 Effect of Legislation on Medicare Spending Growth
Source: www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp.

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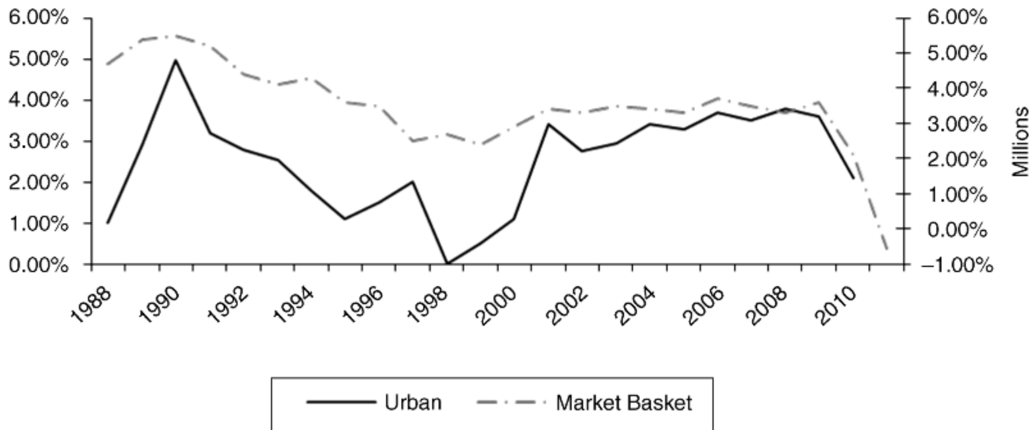

FIGURE 1.6 History of Market Update to Hospital Inpatient Payments
Source: CMS Annual Press Releases on Market Basket Update.

The history of the market basket updates to the inpatient prospective payment system (DRGs) is in Figure 1.6. Again, readers may find a lesson when considering the discussion of changes in hospital payments from the current reform.

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FAILURE OF MANAGED CARE

The 1990s also reemphasized the first key element, the McCarron-Ferguson antitrust exemption for insurers. As was the case with the deep declines in the average length of stay for the Medicare population, similar utilization declines occurred in the non-Medicare population and managed care was trumpeted as the solution to healthcare spending as insurers used their market power to reduce provider utilization and payments. The (failed) reform effort and the implementation, if temporary in many local healthcare markets,[9] of capitation and other risk-based models of provider payment, conspired to produce an actuarial environment in which covered lives were critically important to financial success. This, in turn, fed a frenzy of undercutting competitor's premiums to build market share and actuarial stability in a stock market valuation environment fed by the dot-com bubble. The natural inclination of executives of any company, particularly public companies, to acquire their weaker competitors[10] then took over as the underwriting cycle or natural business cycle of the health insurance industry led to declining profit margins and, ultimately, losses. By the time the bubble burst, the backlash against managed care was complete. The financial decline of the health insurers and the rebellion against managed care ended at the turn of the decade. (See Figure 1.7.)

PROVIDER INTEGRATION AND CONSOLIDATION

The acquisition model or affiliation model of physicians aligning with hospitals were the major legacies of the 1990s, and represent the eleventh key element of the current healthcare

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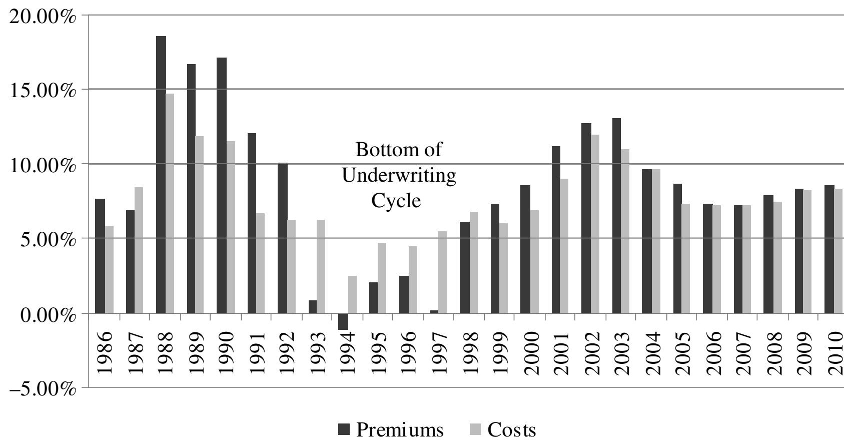

FIGURE 1.7 The Business Cycle in Health Insurance
Source: Data as reported in *Health Care-Managed Care*, January 7, 2010, Barclays Capital, in turn sourced from Milliman, CMS, and company documents; MCOL Managed Care Fact Sheet, 2011, www.mcareol.com.

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market, along with the reemphasis of the import of the antitrust exemption for insurers. Primarily a feature in urban markets with comparatively high healthcare spending and high population density, providers reorganized into delivery systems capable of undertaking joint negotiations with health insurers, the latter weakened by the bottom of the underwriting cycle. As the first recession of the new millennium took hold, integrated providers were poised to compete against larger health insurers in markets where negotiating leverage was the key to financial success, the twelfth key feature of the healthcare market. This completed the stage for the explosion in healthcare spending experienced in the new millennium. (See Figures 1.8 and 1.9.)

SUMMARY OF THE HEALTHCARE MARKET IN 2000

Key elements of healthcare delivery in, more or less, historical order of their appearance in the market:

1. Anti-trust exemption for insurers and insurer consolidation.
2. Tax deductibility of health insurance and the lack of consumer involvement in the cost of care.
3. Medicare and cost shifting to private insurers and patients.
4. Endorsement of fee-for-service models.
5. Medicaid and cost shifting to private insurers and patients.
6. Private insurer participation in Medicare.
7. Self-insurance by large employers.
8. Federal government regulation.
9. Prospective payment systems.

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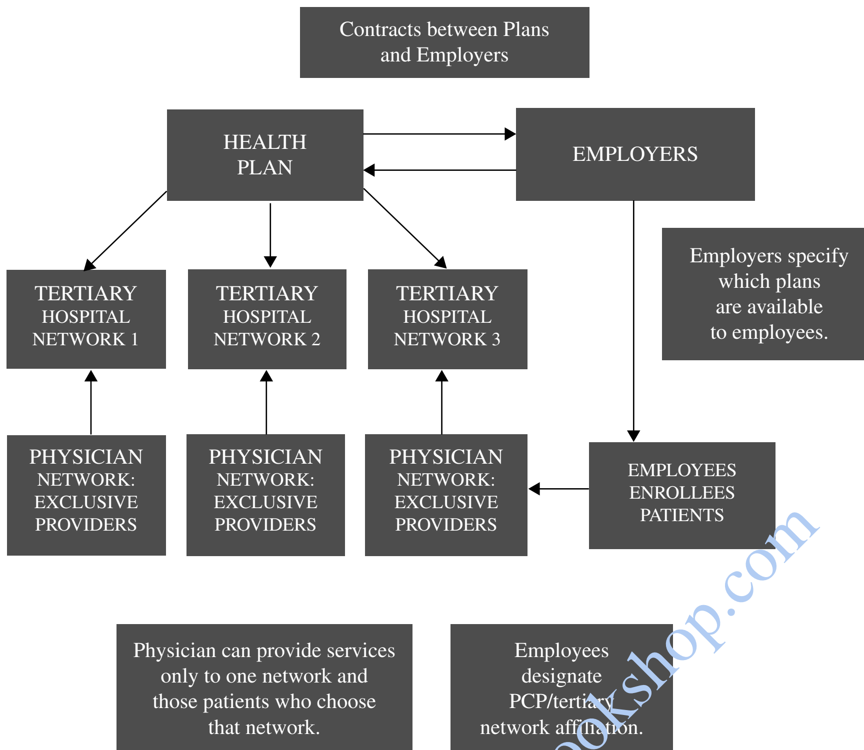

FIGURE 1.8 Integration of Providers, Teaching Hospital Dominated
Source: Medical Practice Valuation Guidebook, 2001/2002, Mark O. Dietrich, CPA/ABV

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10. Managed care and capitation.
11. Provider integration.
12. Import of negotiating leverage.

The New Century

The first decade of the new century saw healthcare reform without the label still front and center as expanding costs continued to consume ever-greater portions of GDP. The Medicare Modernization Act (MMA) of 2003, the signature healthcare provision of George W. Bush's first administration, saw the health insurance industry exercising its clout to expand its reach into the Medicare program again, one of the few growth opportunities for the insurance industry in the post-September 11 environment.

The legislation created a new prescription drug benefit, Medicare Part D. As described in the conference report:

> *. . . a new optional benefit will be established under a new Part D. Beneficiaries could purchase either "standard coverage" or alternative coverage with actuarially equivalent benefits. In 2006, "standard coverage" will have a $250 deductible, 25% coinsurance for costs between $251 and $2,250, and catastrophic coverage after out*

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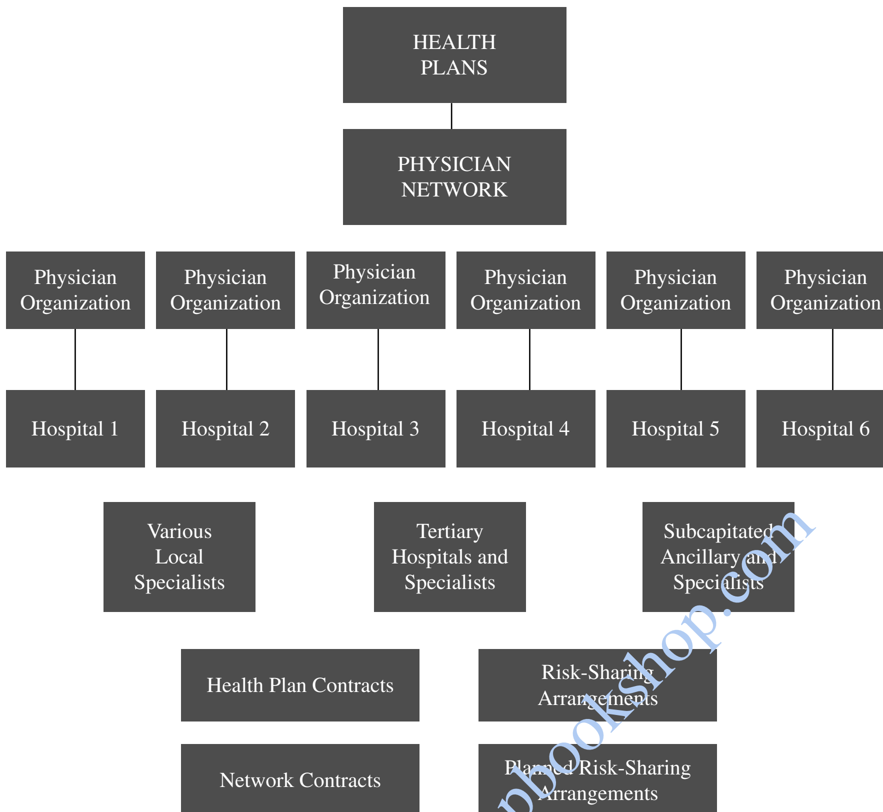

FIGURE 1.9 Integration of Providers, Integrated Physician Network Dominated
Source: Medical Practice Valuation Guidebook, 2001/2002, Mark O. Dietrich, CPA/ABV

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of pocket expenses of $3,600.[11] *Once the beneficiary reached the catastrophic limit, the program would pay all costs except for nominal cost sharing. Low-income subsidies would be provided for persons with incomes below 150% of poverty. Coverage would be provided through prescription drug plans or Medicare Advantage [formerly Medicare+Choice HMO plans] prescription drug (MA-PD) plans. The program will rely on private plans to provide coverage and to bear some of the financial risk for drug costs; federal subsidies will be provided to encourage participation. Plans will determine premiums through a bid process and will compete based on premiums and negotiated prices.*

Equally as important, from the standpoint of the later 2010 reform legislation, the health insurance industry succeeded in undoing many of the BBA 97 reductions in the Medicare+ Choice HMO program. Medicare HMOs had been declining steadily since the BBA. Enrollment fell from 6.2 million beneficiaries in 1998 to 4.6 million beneficiaries in November 2003 and the number of plans decreased from 346 to 155, according to the conference

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report.[12] As a result of the MMA, now renamed Medicare Advantage (private Medicare), plans were again paid at a rate at least as high as the rate for traditional fee-for-service Medicare, a change recommended by the Medicare Payment Advisory Commission (MedPAC), with the capitation rates then growing at the same rate as the increase in spending experienced by fee-for-service Medicare. However, in what was represented as an almost impossible provision in the law, the changes led to a system whereby, in 2006, some HMOs were receiving as much as 118 percent of the cost for a covered beneficiary in the standard Medicare program because they were able to add administrative costs and profit to the rate![13] This set up one of the most contentious debates in the 2010 reform effort.

In an attempt to reduce costs attributable to the rapid rise in both the volume and cost of hospital outpatient surgery and capitalize on the development of investor-owned freestanding ambulatory surgery centers (ASCs), the MMA established a new payment system (released by CMS in 2007) for ASCs and dramatically expanded the number and types of procedures that Medicare would pay for in an ASC setting. These rates were, in part, pegged to a percentage of the rates for hospital outpatient surgery, but annual increases were pegged to a generic consumer price index rather than a healthcare-specific market basket index.

Another dramatic change had to do with the abandonment of the Average Wholesale Price (AWP) methodology of determining what Medicare would pay for outpatient prescription drugs and biologicals. Under the AWP methodology, Medicare paid 95 percent of the reported AWP for a drug; however, those prices had little or nothing to do with what healthcare providers were actually paying for the drugs, resulting in many cases of enormous profits and, importantly, high out-of-pocket expenditures for Medicare beneficiaries due to the 20 percent co-insurance requirement of Medicare Part B. It was replaced by the Average Selling Price (ASP) method, which looked at what providers were actually paying for the drugs from the pharmaceutical companies and then paid 106 percent of that amount. Due to volume discounts to large users of these drugs, smaller users were forced out of this line of business since the 6 percent markup often did not even cover their cost, to say nothing of the inventory and carrying charges for drugs that can cost several thousand dollars per dose. Readers should take note that this change was in part the result of investigations by the Government Accountability Office (GAO), something that the 2010 reform legislation contemplates more of.

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As the country confronted reform in 2010, not much had changed since 2000 except that attempts made in 2003 to rein in healthcare spending had once again failed and the rate of increase was made even worse by the deep recession.

One Size Fits All? Geographic Disparities in the U.S. Healthcare System

There is one more element of the healthcare delivery system that needs to be added, creating a baker's dozen[14] of key elements: All healthcare is local. This seeming cliché, coined from Tip O'Neill's better-known phrase, "all politics is local," is perhaps the single least understood, and therefore least considered, aspect of reform. There are numerous and significant local elements to healthcare, including the presence of for-profit versus nonprofit hospitals and health insurance companies, different ethnic groups with different susceptibilities to different diseases, different ease of access to care, and different clinical practice patterns.

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Profit and Nonprofit Hospitals and Health Insurers

One of the authors conducted an extensive study of differences in several key healthcare markets in 2007. Significant portions of the following are based upon or taken from that research and paper.[15] The markets studied include Florida, Texas, California, Tennessee, New York, North Carolina, Massachusetts, and Michigan. The first four states were chosen based upon the significant presence of for-profit hospital systems while the latter four were chosen because they are dominated by nonprofit hospital systems. The key question posed: Why is it that for-profit hospital and other chains locate in some states and not others?

The most significant element to arise from this study was the historical presence of Blue Cross Blue Shield Plans[16] (Blue Cross or Blue Plans) in each of the states studied. The first key element, described earlier, was the anti-trust exemption for health insurers under the McCarron-Ferguson Act and the consolidation of health insurers. The more concentrated a market is in terms of health insurers, the less likely a healthcare services provider, such as a hospital, will be able to negotiate favorable contracts. A concentration of market control by an insurer leads to an expectation of lower profits by providers. For-profit companies cannot survive without profits and therefore would be expected to locate in markets where insurers were less concentrated.

For purposes of this analysis,[17] the market shares of each of the 50 states was divided into sub-groupings based upon:

1. Blue Cross plans.
2. United (the largest public health insurer).
3. Aetna, Cigna, Health Net, and Humana (the next four largest).
4. Local HMOs with strong market presence, for example, Harvard Pilgrim and Tufts in Massachusetts.[18]

This was done after eliminating states where for-profit insurers had small market share; where for-profit providers had little or no market presence; and rural states. 35 states were left in the sample.[19]

The remaining states were then ranked by the concentration of market power in the hands of those insurers as well as by the number of insurers[20] operating in each market. Concentration percentages were as high as 98 percent in Alaska where the Blue Cross plan had a 49 percent share and the named public companies collectively had a 49 percent share as well. Rhode Island's market consolidation ratio was 97 percent, with 58 percent in the Blue plan and 26 percent in United. The lowest concentrations were in Wisconsin and Kansas. The latter market is highly stratified by local geographic factors.

Figures 1.10 and 1.11 summarize the analysis for eight states, divided into those where public for-profit providers are principally present (Florida, Texas, California, and Tennessee) and those where they have little or no presence (New York, North Carolina, Massachusetts, and Michigan). Market concentration is defined here as the total market share of the Blue plans, public health insurers, and large local health insurers. The average is the market concentration divided by the number of insurers included in the market concentration total.

Figure 1.10 shows the four states where for-profit providers are prevalent. Although market concentration varies, these states generally have smaller Blue plans and a large market presence of for-profit health insurers (shown as United and Other Public). Tennessee is

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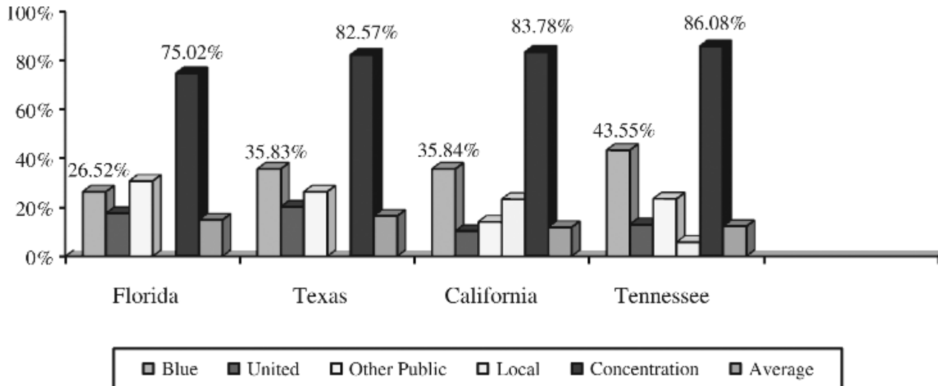

FIGURE 1.10 Insurance Market Concentration in States Where For-Profit Providers Are Prevalent

the only state in the top half of market concentration[21] where for-profit providers are prevalent—and it is the location of the headquarters of many of those companies.

Figure 1.11 shows the four states where for profit providers are *not* prevalent. Although market concentration again varies, these states generally have very large Blue plans (New York being an exception) and a small market presence of for-profit health insurers.

History of Blue Plans[22] How is it that Blue Cross plans played such a pivotal role in the way the health insurance market was structured? Blue Cross plans expanded rapidly during World War II's period of wage and price controls as unions sought enhanced benefits to supplement their members' limited incomes. At one point there were more than 100 Blue plans, the majority of which were located in the unionized, industrialized states primarily north of the Mason-Dixon line in what is sometimes called the Rust Belt. Some of these plans refused to contract with for-profit hospitals, thus serving as an effective barrier to market entry. Blue plans also enjoyed a tax-exempt status[23] for many years and protection from anti-trust action in many states.

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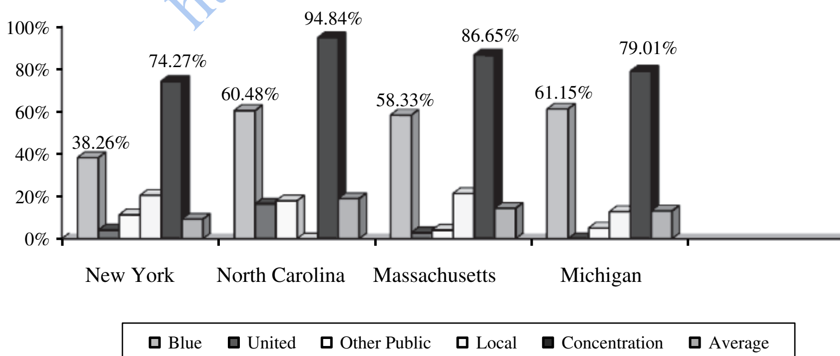

FIGURE 1.11 Insurance Market Concentration in States Where For-Profit Providers Are Not Prevalent

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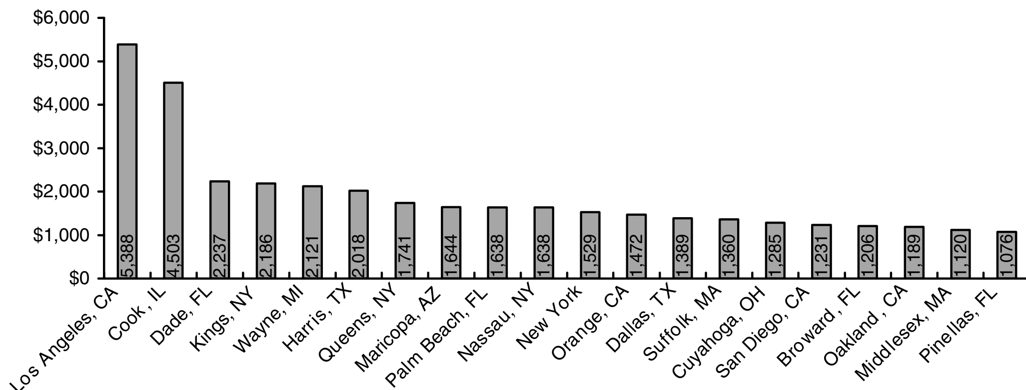

FIGURE 1.12 20 Largest Counties for 2005 Medicare Spending ($Billions)
Source: Centers for Medicare and Medicaid, 2005 data.

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The conclusion from this analysis is that the type of health insurance plans present in each state can vary radically from those in other states, even bordering states. This is one legacy of the first key element of the market, the anti-trust exemption, which allowed the individual states to regulate their health insurers and, in turn, helped create the type of insurer and insurance products available within their borders. Different plans have different relationships with the provider and employer communities. The federal reform attempts to treat all health insurers as if they were sprung from the same mold.

Medicare: The Other White Meat Besides avoiding states where Blue Cross plans have a large market share, for-profit healthcare companies go where the money is—like the Depression era's Willie Sutton[24]—and that is where Medicare spending is highest on a per capita basis.

Of the top 50 counties for Medicare Part A spending, there are 5 in Florida (which has 9 of the top 100), 4 in Texas (which has 15 of the top 100 and another 22 in the next 200) and 1 in California (which also has 9 of the top 100). Two of the top 10 counties (Miami-Dade and Okeechobee) are in Florida. Looking solely at the top 200 counties for Medicare Part B spending, 37 are in Texas(!), 9 are in Florida, 9 are in California, and 8 are in Tennessee. If you combine Medicare Part A and Part B spending, 25 of the top 200 are in Florida, 19 are in California, and 14 are in Texas. Money speaks louder than words.

By county, the top Medicare spending markets are as shown in Figure 1.12.

OTHER MARKET-BASED STUDIES

A key feature of this book is its citation of independent research in support of the analysis presented herein, typically from government or nonpartisan, nonprofit groups. Here are two other studies that look at geographic factors in the U.S. healthcare market.

Not surprisingly, *after* the research for the earlier paper was completed and the paper submitted for peer review, the Government Accountability Office or GAO released a report in September 2008: *Nonprofit Hospitals: Variation in Standards and Guidance Limits*

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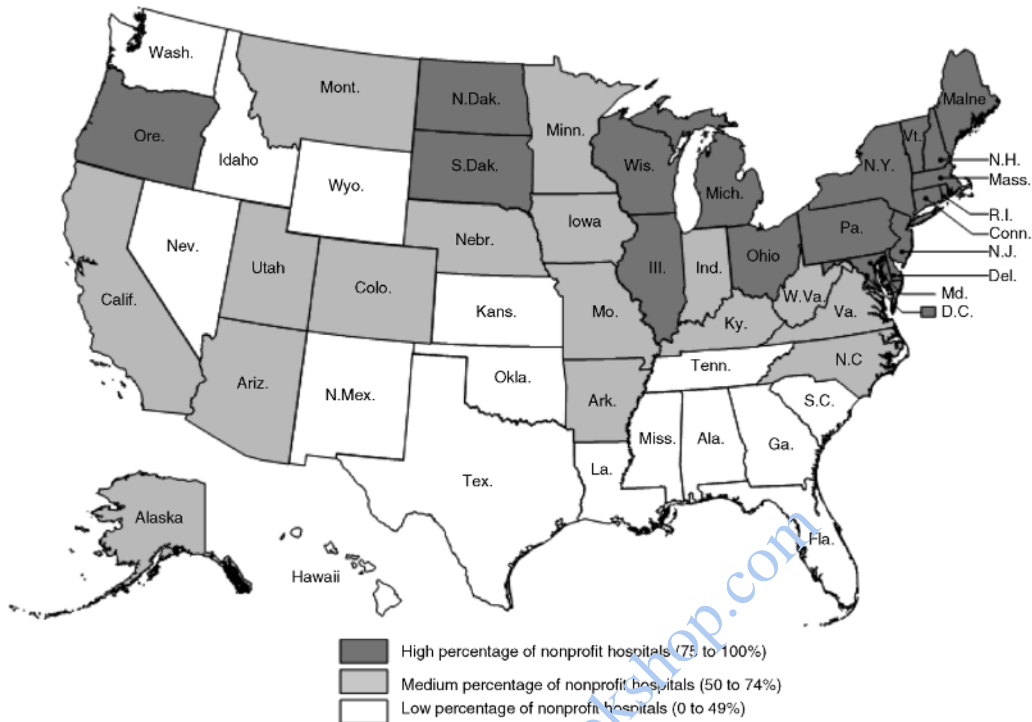

FIGURE 1.13 Geographic Distribution of Nonprofit Hospitals in 2006.
Note: Hospitals include nonfederal, acute care, and general hospitals.
Source: GAO analysis of 2006 CMS data.

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Comparison of How Hospitals Meet Community Benefit Requirements. Figure 1.13, taken from page nine of that report, shows the geographic distribution of nonprofit hospitals. Comparing this broader data to the previous discussion of Dietrich's research finds the expected concentration of nonprofit hospitals in the Northeast and Sun Belt where unions and Blue Cross plans historically dominated the market, whereas for-profit hospitals are concentrated in the South, where Blue Cross plans have less market share and state right-to-work laws have historically limited the spread of unions.

Geo-Clinical Differences

In April of 2011, the National Institute for Health Care Reform (NIHCR)[25] released a report entitled *Geographic Variation in Health Care: Changing Policy Directions*. This study was actually conducted by the Center for Studying Health System Change (HSC)[26] on behalf of NIHCR. The study cited 40 years of research identifying a wide geographic disparity in Medicare spending and utilization that came to the forefront during the federal reform debate when the CBO[27] suggested that Medicare spending could fall 30 percent if spending in higher cost areas of the country was reduced to that of the lowest cost areas, which include Iowa, Minnesota, Washington State, and Wisconsin. Notwithstanding the political

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momentum this CBO study generated for the modifications to the Medicare program that were ultimately trumpeted as paying for both the expansion of coverage and extending the solvency of the so-called Medicare Trust Fund, the available research does not support the expectation that cost can be reduced in this fashion. The HSC researchers cited MedPAC studies "that health status explained about 30 percent of the variation, and after accounting for price adjustments in Medicare payment methods, about 45 percent of spending variation across areas. While some portion of the unexplained variation may reflect inefficient practice patterns or inappropriate care, there is no sound way to attribute the remaining, unexplained variation to any particular cause."[28] Simply stated, no one has been able to identify in any meaningful fashion what accounts for the majority of the difference in regional spending.

As long-term students of healthcare data are aware, Washington State and Minnesota, to cite two examples, are notable anomalies in the cost of healthcare, both being early adapters of advanced (capitated) managed-care models including Medicare HMOs. Minneapolis, in particular, had large local employers collaborate with health insurers and providers to deliver care at a cost they were willing to pay for through insurance premiums. The practice patterns of healthcare providers typically reflect the influence and financial incentives of managed care regimens at a market penetration of 35 percent or so of patients. Looking back at capitation, the tenth key element described earlier, and Figure 1.3 showing the decline in hospital average length of stay for Medicare beneficiaries, one can readily see the impact of the 1990s managed-care era, even in fee-for-service Medicare. Individual state data is very different than the national data shown in that graph, with, as one would expect, Minnesota having one of the lowest rates of hospitalization in the country.

Reflecting back on his trip to London to lecture on the financial impact on physicians of U.S.-style managed care being introduced to control private health spending in the UK, coauthor Dietrich observed in August of 2009:

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It's about 650 miles from Paris, France, to Berlin, Germany. It's about that far from Boston to Charlottesville, Virginia, and from San Francisco to Portland, Oregon. And, it's about 3,000 miles from Portland to The Big Apple. Along the way from west to east, you pass over mountains, through deserts and vast hectares of farmland where very few people live. Point is, a lot of things change when you move far away from a given location. Lifestyle, food, environment, health, and—guess what—healthcare. There are a lot of rather silly comparisons between European-style healthcare systems for small countries that you can easily cross in half a day and the United States, one of the largest countries by square miles in the world and with an ethnically diverse population. These comparisons are similar in foolishness to the comparisons of public transit systems in countries the size of American states. The population of England is about 51 million in an area less than the state of Oregon, whose population is less than 4 million. England is 9 times more densely populated than the US: I'll betcha that makes public transit work better—if you can find a seat.

California has the sixth or seventh largest economy in the world—at least it did before the recession. The areas like San Francisco have very mature managed care market structures. If you go to Jackson, Mississippi, you are not going to find a managed care insurance system like San Francisco. And, given the lack of population size and density, you could never make one work. The greater Boston area has the

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highest concentration per capita of physicians in the country—and perhaps the world (find it here: www.cms.hhs.gov/MedicareMedicaidStatSupp/LT/list.asp#TopOfPage). That is not true of Millinocket, Maine, or the State of Montana. Because of the disparity in geographical distances and provider concentration (among other factors) the Medicare program has a special class of hospital called a critical access hospital to service rural areas, which are paid based upon their costs rather than the standard Medicare prospective payment system—Millinocket has one of these. Montana has less than 1 million people, but in size it is about the same square miles as Germany, which has 82 million residents. You have to travel a long way for healthcare in much of Montana, without public transit.

Although the analogies of geographic differences in healthcare spending to public transit are somewhat tongue-in-cheek, they are truer than their comedic intent would suggest, as the HSC study confirms. Using data from Centers for Medicare and Medicaid Services Chronic Conditions Warehouse, the HSC researchers found that the incidence of certain serious health conditions varied widely among Medicare beneficiaries in Miami, Indianapolis, and Seattle. For example, while the rate of heart attacks for the three cities was equal at 1 percent of beneficiaries, chronic obstructive pulmonary disease[29] was nearly two-thirds more prevalent in Miami as compared to Indianapolis and nearly three times as prevalent as Seattle. Ischemic heart disease[30] was similarly nearly two-thirds more prevalent in Miami as Indianapolis and twice as prevalent as Seattle. It is doubtful that the Patient Protection and Affordable Care Act of 2010 will change the economic circumstances, ethnicity, diet, and lifestyle of Americans in various parts of the country.

A return visit in May of 2011 to lecture on the same issues found managed care restrictions much more prevalent in the private insurance (non-NHS) segment of the UK health system as well as new opportunities from the prospective reform of the National Health Service. Not surprisingly, market forces at work are such that those who can afford it seek better care from those that profit from providing that care:

I returned from my lecture trip in London and Lincoln last week. Once again, I am fascinated by the similarities between the privately insured segment (about 10% or 6 million individuals) of the British population and what we see here in the States. A variety of American companies in the hospital and ambulatory surgery business are operating there. The National Health Service, famous here for being held up by the current head of CMS[31] as the example of how U.S. reform should be undertaken, is itself being reformed. There is an increasing trend to privatization of NHS services and if the current conservative/liberal coalition government has its way, a large scale reform will take place that passes financial control in large part to commissioning (purchasing) consortia controlled by the nation's GPs (primary care physicians) who already have vast control over referrals to consultants (specialists) and hospitals. The British tradition of primary care is distinctly different from our own—unless you are familiar with capitated managed care such as that in the Medicare Advantage Program. And the white paper (Equity and excellence: Liberating the NHS) put out by the British government proposes what looks like a very advanced version of full-scale, PCP-controlled capitation. There are considerably more GPs/PCPs per capita in the UK than in the States as well.

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The privatization of NHS functions is a very attractive opportunity for American-based companies operating in Britain and represents a growth area for revenue and profit.

SUMMARY

Here are the baker's dozen of key elements defining the United States healthcare market.

1. Anti-trust exemption for insurers and insurer consolidation.
2. Tax deductibility of health insurance and the lack of consumer involvement in the cost of care.
3. Medicare and cost shifting to private insurers and patients.
4. Endorsement of fee-for-service models.
5. Medicaid and cost shifting to private insurers and patients.
6. Private insurer participation in Medicare.
7. Self-insurance by large employers.
8. Federal government regulation.
9. Prospective payment systems.
10. Managed care and capitation.
11. Provider integration.
12. Import of negotiating leverage.
13. Broad geographic disparities.

It would seem that reforming healthcare and health insurance coverage in the United States would require legislation that addressed each of the 13 key elements—and numerous others that did not make the top of the list. In the next chapter we'll look at what was done in Massachusetts, since that was the model for the federal legislation, and get a sense of what the outcome of reform might be.

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NOTES

1. Interestingly, as Great Britain expands the use of private insurance to supplement the increasingly problematic National Health Service, premiums paid by employers on behalf of employees are taxed as compensation. Mr. Dietrich has lectured in England to private practice physicians on the subject of managed care insurance.
2. A detailed example of this phenomenon can be found in a Chapter 6 box.
3. Along with unfunded defined benefit pension plan obligations for state employees.
4. Based on the Kaiser Family Foundation's National Health Insurance report, *A Brief History of Reform Efforts in the U.S.*, March 2009.
5. Named after California Congressman Pete Stark who introduced the legislation.
6. Known better at the time as the Kennedy–Kassebaum legislation.
7. There is a detailed discussion of severity of illness adjustments in Chapter 4.
8. A familiar phrase in the 2010 debate as well.
9. And as Tip O'Neill said of politics, "All healthcare is local."

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10. Referred to as *management hubris* by leading financial valuation analysts such as Aswath Damodaran.
11. This spread between $2,250 and $3,600 became known as the "donut hole" and was "fixed" in the 2010 reform legislation.
12. Conference report, "Medicare Prescription Drug, Improvement, and Modernization Act."
13. Medicare Payment Advisory Commission. *A Data Book: Healthcare spending and the Medicare program*, June 2009.
14. That's 13 if you don't eat donuts or Danish.
15. Mark O. Dietrich. "Healthcare Market Structure and Its Implication for Valuation of Privately Held Provider Entities: An Empirical Analysis," *Business Valuation Review* 27 no. 2 (2008).
16. At one time, Blue Cross plans covered hospitalization while Blue Shield plans covered physician services, although that distinction has largely disappeared in today's world.
17. Using data from Lehman Brothers (now Barclays Capital) *2007 Managed Care Guidebook*.
18. Well-known because they are consistently rated in the top five HMOs in the entire country in various surveys.
19. Hawaii, Idaho, Iowa, Maine, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, South Dakota, Utah, Vermont, West Virginia.
20. For example, New York has multiple Blue Cross plans.
21. The median is 85 percent versus 86 percent for Tennessee.
22. We are indebted to health law attorney J. D. Epstein for his insight here, in particular, and with other aspects of the history discussed herein, in general.
23. Repealed in the Tax Reform Act of 1986.
24. The legendary bank robber.
25. A self-described 501(c)(3) nonprofit, nonpartisan organization established by the International Union, UAW; Chrysler Group LLC; Ford Motor Company; and General Motors.
26. HSC's research is cited throughout the book and includes a focus on differences in geographic healthcare markets.
27. www.cbo.gov/ftpdocs/99xx/doc9924/toc.shtml.
28. Medicare Payment Advisory Commission *Report to the Congress: Regional Variation in Medicare Service Use*, January 2011.
29. Typically a result of smoking cigarettes.
30. A condition reflecting fat deposits in the coronary arteries linked to diet and smoking among other factors.
31. Dr. Berwick at the time.

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