From the President

The Two Faces of Medicine

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As 2019 rolls in with all of its unknowns, the myth of Janus comes to mind. Janus was the ancient Roman god of beginnings and transitions, doorways, endings, and time. The Romans depicted Janus as having two faces: one looking backward to the past and one looking forward to the future. Janus was sometimes used to symbolize the progression of one vision to another and of one universe to another. Medicine is in one such transition.

The face of the patient-physician relationship is changing. One vision is the physician and patient discussing the patient's issues—strictly physical conditions as well as "social history." In this universe, physicians know about their patients' families and living situations. Their patients do not need a special palliative care specialist because their doctor knows how they want to be treated during a serious illness or at the end of life.

The other universe is the healthcare factory, where patients see a physician who sits behind a computer screen transmitting information to the Office of the National Coordinator for Health Information Technology.

Medicine must not leave the past behind in our quest for advancements to improve patient outcomes. Private medicine, reminiscent of the era when physicians were physicians, not "providers," is looked upon as ideal but impractical in today's hi-tech environment. Thirty-five years ago, 76 percent of physicians owned their own practice; by 2016, only 47 percent of physicians did so.[1,2]

What happened to the doctors? From July 2012 to July 2016, physicians left independent practice in droves to become employed by hospitals and health systems in every region of the country. According to a report from the Physicians Advocacy Institute, the number of physician practices acquired by hospitals and health systems increased by 86 percent between 2012 to 2015, with 32,000 additional physician practices acquired. By mid-2015, nearly 40 percent of physicians were employed by hospitals and health systems and 44 percent were employed by January 2018.[3] Between July 2015 and July 2016, hospitals acquired 5,000 more independent physician practices, and the number of physicians employed by hospitals grew by 14,000—an 11 percent increase.[4]

Why the fire sale? The regulatory burdens and costs of compliance were ratcheted up in 2009 with the Health Information Technology for Economic and Clinical Health (HITECH) Act that was tucked into the American Recovery and Reinvestment Act (the "Stimulus Act"). The "meaningful use" provisions initially gave financial incentives to physicians for using electronic health records—at an initial investment of more than $40,000. The incentives then became penalties for failure to use EHRs—in the form of civil penalties capped at $1.5 million and the threat of prosecution at the state level. Next, various "value-based programs" included in the Affordable Care Act (ACA) (2010), the Medicare Improvements for Patients and Providers Act (2013), the Protecting Access to Medicare Act (2014), and the Medicare Access and CHIP Reauthorization Act (MACRA) (2015) were foisted on practitioners. Under such programs physicians and hospitals are paid based on patient health outcomes. A physician's noncompliance means facing penalties of up to 8 percent payment reductions for choosing to spend their precious time with patients rather than with megabytes of paperwork with no proven medical value.

President Obama's health care advisers, including Ezekiel (Let Me Die at Age 75) Emanuel, admitted immediately after the ACA was signed into law, "Only hospitals or health plans can afford to make the necessary investments in information technology and management skills."[5]

To add insult to injury, hospitals are suffering from "merger mania." In 2017, there were 115 hospital/health system merger transactions, a 13 percent increase from 2016.[6] And this continuing trend toward consolidation and decreased competition results in the predictable side-effect of increased consumer costs.

A University of California at Berkeley School of Public Health study of consolidation of California insurance, hospital, and physician markets from 2010 to 2016 concluded that "highly concentrated markets are associated with higher prices for a number of hospital and physician services and Affordable Care Act (ACA) premiums."[7] The study found that prices for inpatient procedures were 79 percent higher and outpatient physician prices ranged from 35 percent to 63 percent higher (depending on the physician specialty) than in less concentrated markets. According to testimony at February 2018 congressional hearings on hospital consolidation, "Extensive research evidence shows that consolidation between close competitors leads to substantial price increases for hospitals, insurers, and physicians, without offsetting gains in improved quality or enhanced efficiency."[8]

In 2015, Medicare paid $1.6 billion more for basic visits at hospital outpatient clinics than for visits to private offices. Evaluation and management services cost $525 for an episode of care in the outpatient department compared with $406 in a physician office. And the patients—unbeknownst to them—paid $400 million more out of pocket and had their tax dollars wasted.[9]

Consumers stand to lose even more. The two largest insurers (Anthem and UnitedHealthcare) have 70 percent of the health insurance market. (Fortunately, in 2017 the Department of Justice stopped the Aetna-Humana and Anthem-Cigna proposed mergers because the merger would have left the country with only three large insurers.) But the real game-changers are 2018's "vertical mergers," in which one entity owns multiple functions in the commercial healthcare stream. Insurance companies have moved from reimbursing your physician to becoming your physician.

UnitedHealthcare is now busy buying up physician practices, building on its longstanding ownership of OptumRx, a pharmacy benefits manager (PBM). PBMs are the prescription drug gatekeepers who operate independently and, unfortunately, opaquely in price negotiations with drug manufacturers. In 2018, Cigna merged with Express Scripts. CVS (with one of the nation's largest PBMs) is on the cusp of merging with Aetna. The result: the three largest PBMs will be tied to insurance companies.

So, the foxes are guarding the henhouse. An insurer and a company that helps set the prices of the drugs that will be sold in CVS stores will be in charge of your medical care through its in-house drugstore clinics. People enrolled in Aetna health plans could be forced to seek care at CVS retail clinics. Anthem, which operates for-profit Blue Cross plans in several states, is developing its own in-house pharmacy operation. The only place competition will be found is in the dictionary between "collusion" and "conglomeration."

As *HealthLeaders* finance editor Jack O'Brien opined, "Any idea that this merger will translate to lower net costs to plan sponsors or employers doesn't make financial sense. Merging two large organizations to make a larger organization, with all of the integration that occurs within systems and departments, tends to benefit the merging companies, not the consumer."[10]

Scarier yet, Humana announced plans to become the nation's largest provider of hospice care. Couple that with Humana's "value-based" contracting program, the Hospital Incentive Program (HIP). HIP offers compensation based on quality improvement and performance. Palliative care is one of the three quality gauges.[11]

In the dystopian vision of medicine, independent physicians are devolving from trusted confidants to automatons. The patients are more often than not talking to the back of a computer or having hospitalists direct their medical care, often with no consultation with the primary care physician.

The ideal face of medicine reflects what patients want. Surveys consistently find that patients overwhelmingly want "personalized provider interactions"[12] with humane, personal, forthright, respectful, and empathetic doctors.[13] None of these attributes emanate from a computer screen full of metrics and centralized standards. Yet medical interns spend only 12 percent of their time examining and talking with patients, and more than 40 percent of their time glued to a computer.

Janus also was representative of the middle ground between backward and forward. The new face of medicine must have one voice taking the lessons and the best from the past and creating a bright future. Being an "old-fashioned" doctor does not mean ignoring scientific advances. It means seeing the patient as far more than a condition in an algorithm or a pre-authorization form. As physicians we must declare that we are not insurance company or government tools. As patients we tell our doctors and politicians that we are individuals, and deserve to be treated that way.

A few multi-billion-dollar conglomerates could soon dominate our medical services system. The options for patients are shrinking and it is becoming more and more difficult for a physician to maintain an independent practice or autonomous decision-making.

Undeterred, AAPS will continue to promote and provide tools to have a successful third-party-free practice and to fight the perils of vertical mergers at each opportunity. We have written letters of support of site-neutral payments, expanded Health Savings Accounts, favorable tax treatment for direct primary care (DPC) fees, and regulations that minimize physicians' administrative burdens.

AAPS will continue to support federal antitrust agency guidelines that protect and promote competition in the medical industry and carefully scrutinize mergers. We will support legislation that prohibits steering of patients by insurers or hospitals to their own providers, and gag clauses that prevent insurers from telling enrollees about other options, or from creating incentives to enrollees to go to less expensive providers.

Yes, maintaining an independent practice is becoming more challenging. But that is why we are here. AAPS has your back.

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