

## SUPPLY – DEMAND AND THE A.M.A.

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The August 24, 2009 edition of Modern Healthcare rates the 100 most powerful people in healthcare. The president of the American Medical Association rates 95<sup>th</sup> and its Executive Vice President 96<sup>th</sup>. No other representatives of the A.M.A. are listed. By contrast, Andy Stern, the president of the Service Employees International Union ranks 10<sup>th</sup> and Steve Burd, the president of Safeway stores, 17<sup>th</sup>.

How has organized medicine found its way to the bottom of the heap during the most significant effort to reform healthcare in decades? In the opinion of this writer, the AMA lost its influence years ago when it capitulated to government demands to remove the practice of medicine from the basic rules of the marketplace.

The practice of medicine was removed from market forces when the federal government, in conjunction with the A.M.A., created the current reimbursement system used by Medicare and most third party payors. The system created a reimbursement system which removes from consideration the quality of care rendered, the training and experience of the physician providing care, the efficiency of the care rendered, or the result of the care. As a result, the physician providing high quality, efficient and effective care is likely to receive far less compensation than the physician who provides less efficient and effective care.

The A.M.A. is financially wedded to the current reimbursement system. Its publication of the CPT codebooks, the primary reference for physician reimbursement, is responsible for a substantial portion of the A.M.A.'s annual revenues. Yet, to most practicing physicians, the CPT codebook is as confusing and counterproductive as the IRS code. Worse, the Resource Based Relative Value System (RBRVS) upon which it based not only discourages, but punishes, efficiency and fails to reward any efforts to reduce cost.

Does anyone believe that it is mere coincidence that many medical offices are less computerized than the corner gas station, or that it takes days or weeks for a patient to receive test results in an era of instant email communication? If there were a CPT code for emailing test results, with explanation, how many office visits would be eliminated in favor of this more efficient, and far less costly, method of communication. Yet, with medical offices struggling to survive with lower reimbursement rates, financial considerations drive offices to schedule patients for follow up appointments simply to receive information which could often be transmitted at far less cost, electronically. This is only one example.

There are also no incentives for physicians to consider costs of pharmaceuticals, costs of diagnostic tests, or alternative treatments in deciding upon a course of care. Yet, much of the cost of healthcare costs results from these decisions. How much money would be saved if physicians were provided with cost information and paid to evaluate the need for higher cost care before making these decisions?

Unfortunately, all current efforts by Congress and the President to reform healthcare, fail to address this foundational flaw in the healthcare system and, instead, are focused on ways to reduce the cost of physician care. Yet, efforts to reduce costs could be far more successful if physicians were brought into the process, rather than further removed from it.

Until market forces are returned to healthcare, costs will continue to increase, efficiencies will

continue to yield to the need to optimize reimbursements, and quality and access will continue to suffer.

The foundation of a market economy is supply and demand. Current reform efforts will dramatically increase demand by bringing more patients into the marketplace. Basic tenants of economic theory teach us that increased demand would lead to increased prices. Increased prices would then discourage demand and spur additional supply resulting in more people choosing to become physicians and healthcare workers. Similarly, those treating patients most efficiently would benefit by capitalizing by being able to care for more patients in less time. However, our current reimbursement system eliminates these basic economic forces because reimbursement rates are fixed, and the most effective way to increase profit is to perform more services on each patient, not to treat more patients more efficiently.

Without reforming the RBRVS based reimbursement system, adding more demand without addressing supply will only further exacerbate the myriad problems faced by our healthcare system. Absent more physician supply, the only way to deal with increased demand is to ration care or to substitute physician care with lesser educated physician extenders. Neither is likely to improve healthcare.

It is time to give physicians the flexibility to move to new economic models. Physicians should be free to charge depending upon supply, demand, efficiency and effectiveness. Alternative pricing could reward prevention, efficient and effective treatment of chronic conditions, and reduction in redundant or unnecessary testing and treatment. Making physicians stakeholders in the cost of pharmaceuticals could readily result in more careful selection of drugs, with appropriate consideration of price along with efficacy.

Unfortunately, the A.M.A.'s financial reliance on the CPT codes, and its historic tie to the present reimbursement system, makes the likelihood of meaningful reform far less likely. Its interest in reform, and the interests of the majority of the physician community, are not in alignment. Because reliance upon the current CPT code driven reimbursement system offers no room for innovation, real reform is unlikely. Yet, until these foundational issues are addressed, meaningful reform will fail.