

Editorial

Hospitals and Insurance Companies: Government-Protected and Favored Businesses

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As people increasingly suffer the financial and other adverse consequences of government intervention in medicine, cause and effect are under scrutiny as people seek relief. The inescapable conclusion is that government, through policy, regulation, and legislation, has been picking winners and losers, and the public and independent physicians are among the latter.

Government intervention in medicine has led to higher costs, shortages, and harmful anti-competitive conduct. Monopoly thrives, as does monopsony, in which a larger buyer controls the market and drives prices down. Simultaneously, freedom, choice, and any semblance of a free market are destroyed, all while socialistic government policies are equated with social justice.

McCarran-Ferguson Act

Passed in 1945, the McCarran-Ferguson Act granted monopoly power to health insurance companies by broadly exempting them from federal antitrust laws. Health insurers set their premiums based on the collective sharing of actuarial, rate, and cost data among competing insurers. With the exemption in place, monopolistic insurers have no incentive to lower premiums. Monopolies act to set prices above competitive levels. State insurance regulators have done little to constrain substantial increases in health insurance premiums.

Bills to repeal McCarran-Ferguson have passed twice with overwhelming support in the House of Representatives. But, facing fierce opposition by insurers, bills to restore competition among health insurers have failed to pass in the Senate.

Meanwhile, insurers have engaged in a merger frenzy in recent years, which further increases their monopoly power.

Government-Sponsored Discriminatory Price Fixing

Government price fixing is never a good thing. It always results in government rationing, shortages, and stifling of innovation.

The Marxist-based Resource Based Relative Value Scale (RBRVS) first implemented in the Medicare program, whereby arrogant individuals believe that they can determine prices for all services better than millions of voluntary interactions in a free market, defies logic, basic economic principles, and history.

Government has made matters much worse in that it has implemented discriminatory price fixing, which enriches hospitals and harms independent physicians. It also harms patients who must bear the burden of higher co-pays for outpatient services provided in hospital-owned facilities. Although the cost of providing outpatient care in a hospital-owned facility is comparable to that in an independent physician-owned facility, government allows hospitals to charge a facility fee in addition to a professional fee. The combined professional and hospital facility fee is often double or more what a physician is allowed to charge for providing the very same service in a physician-owned office. This is driving independent physicians out of business and forcing many into hospital-employed positions. The leverage that hospitals have gained as a result of this discriminatory price fixing often coerces physicians to accept less than favorable

terms in hospital employment contracts. When patients lose access to care provided by independent physicians, because a physician has been put out of business by government or has had to accept a hospital-employed position, advocacy for the patient is weakened. In the case of hospital-employed positions, cost containment and profit enhancement goals often take precedence over optimal individualized patient care. The focus is on productivity: how many patients can be seen and treated per day.

Hospitals also enjoy favored status for treating indigent patients. Disproportionate Share Hospital Payments provide additional compensation to hospitals that treat indigent patients. Government does not provide similar compensation for independent physicians treating indigent patients either in the hospital or in their offices. Independent physicians are simply expected to accept financial loss for treating such patients. If an independent physician treats a large number of indigent or Medicaid patients, each one at a financial loss, the risk of going out of business is high. The RBRVS government price-fixed fees in the Medicare program may not cover, or may barely cover, the cost of providing care.

The flurry of hospital mergers in recent years, which government has allowed, has further concentrated market dominance for hospitals, leading to less competition and increased power and control over hospital-employed physicians. For those independent physicians who refuse to be assimilated as into *Star Trek's* collective-mind beings, The Borg ("Resistance is futile"), a nationwide purge is underway to eliminate independent physicians from the hospital and put them out of business.

Certificate of Need (CON) Laws

State Certificate of Need laws are another example of government intervention in medicine that has had a harmful anti-competitive effect. Like Canada, which limits the number of hospital beds and imaging equipment as a means of cost control, Certificate of Need laws likewise limit development of new facilities, expansion of existing facilities, long-term care facilities, rehabilitation facilities, and ambulatory surgery and imaging centers, including physician-owned facilities, for the same reason.

The Byzantine bureaucratic process of obtaining state approval to offer better access to care at a lower price, by constructing a new physician-owned ambulatory or imaging center, is subject to political influence and lobbying. Hospitals loathe competition and the downward pressure on its prices it would cause, and often fiercely oppose any new facility that would compete against them.

Like government price fixing, the decision on allowing increased competition depends on the ruling of a government agency. The notion that additional facilities or equipment might provide better access to care for a lower cost generally does not enter into the approval decision.

The CON process also strongly favors hospitals over physician-owned equipment and facilities. Hospitals are often highly successful in blocking the entry or expansion of physician competitors.

Health Care Quality Improvement Act (HCQIA)

The Health Care Quality Improvement Act is another example of government intervention favoring hospitals at the expense of due process for physicians in peer review. HCQIA presumes that a physician is "guilty as charged" (i.e. there is a reasonable belief that the hospital's action was warranted) and shifts the burden to the physician to prove otherwise by a preponderance of the evidence. HCQIA also sets forth requirements for notice and hearings in peer review actions, but provides that a hospital's failure to meet those requirements does not itself disqualify the hospital from obtaining immunity. It is government-provided favoritism of hospitals at its worst.

Safe Harbor

Government also protects insurers, hospitals, Group Purchasing Organizations (GPOs), and Pharmacy Benefit Managers (PBMs) from prosecution for engaging in kickback schemes that net billions of rebate dollars for insurers. These safe-harbor regulations result in massive cost inflation for patients treated in hospitals, and higher medication costs. Hospitals generally purchase medical products and supplies through a GPO. The GPO extracts huge sums from medical manufacturers in return for exclusive access to the hospital market. And member-driven GPOs "share back" with their members, who include hospital executives. Some hospital administrators thus benefit handsomely from this government-protected kickback scheme. Unfortunately, patients are the losers in this government-protected racket, which results in higher costs and shortages.

Insurers are also protected by government for engaging in kickback schemes with PBMs, whereby the PBM extracts significant rebates from drug manufacturers and passes some of

this kickback revenue on to insurance companies. This too has led to massive inflation of drug costs.

The PPACA or "ObamaCare"

And, last but not least, the politically named Patient Protection and Affordable Care Act (PPACA or ACA) strongly favored insurance companies by coercing the purchase of insurers' products, subsidizing the purchase of health insurance for some, and essentially indemnifying insurers against financial loss (ObamaCare's risk corridor program). No other private business ventures in our history have been granted such specific corporate advantages and welfare as have insurance companies.

Although ACA's individual purchase mandate was effectively eliminated in December 2017 by reducing the penalty to zero dollars, government subsidies and millions of dollars in payments not authorized by Congress to fund the ObamaCare risk corridor program have continued. Patients, who have been subjected to unconscionable increases in health insurance premiums and increased co-pays and deductibles, are the undisputed losers in this ill-conceived government intervention in medicine.

Conclusion

Our U.S. Constitution does not provide any role for the federal government in medicine, let alone for the specific welfare of hospitals, insurers, and their co-participants in government-protected kickback schemes. Government-sponsored price discrimination is costing patients more and is putting good physicians out of business. Federal law also should not provide nearly absolute immunity for hospitals in peer review actions. The provision of HCQIA, whereby accused physicians are presumed guilty unless they can prove their innocence, is abhorrent and contrary to our legal system that prioritizes due process and fundamental fairness. It is not the role of government to create monopolies, and pick winners and losers.

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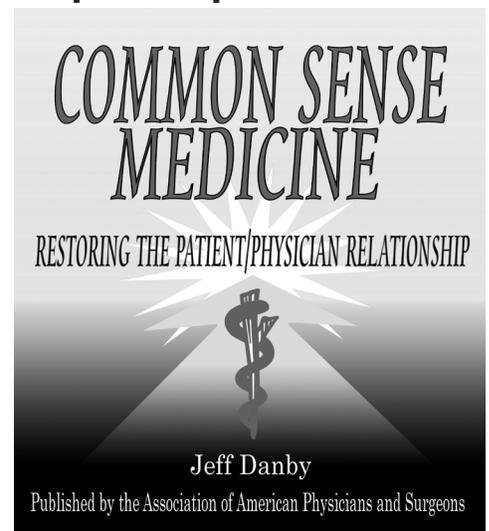
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