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What the heck is reference pricing?

One of our missions in Private Practice Doctors is to keep you informed. With the institution of the ACA (Obamacare) much of medicine has been turned inside out. In our continuing quest to make heads or tails out of this "extraordinary" law we have run into new information to share with your patients. The new buzzword you will hear in the coming days to come is **reference pricing.**

Evidently, the Obama administration has given the go ahead to put this new scheme into effect in the hopes of cutting the cost over-runs of the program. Here is how this strategy works. Insurers and employers put a dollar limit on what a health plan will pay for certain procedures…say CABG, hip replacements, etc. Then, anything above that flat rate limit is not covered by the insurers and would be considered as out of network. Let's put this in clear usage terms. Say a patient needs a $50K surgery, but the insurance company has referenced priced this at $30K. The consumer then needs to pay $20K out of his pocket, plus the deductible and also any other out-of-pocket expenses. This is true even if these procedures and the providers are in-network. What does this mean? Well, the patients could be surprised with big medical bills they must pay themselves, undercutting financial protections in the new health care law.

To make matters worse, this coverage will NOT count as an out-of-pocket expense. Why is this important? The answer is simple...under the health care law, most plans have to pick up the entire cost of care after an annual out-of-pocket limit, which is currently $6,350 for single coverage and $12,700 for a family. As a result, all this extra money spent does not even count against this total. So a program that was sold on the premise of stopping medical bankruptcies will, in actuality, encourage it at the whim of the insurance company and government through reference pricing.

Oh, one more thing. If you think this only will apply to the new insurance exchange plans, think again. It is also supposed to apply to most job-based insurance as well. Yep, that is you, me and everyone we know. As the non-partisan Kaiser Family Foundation notes, "the problem … from the patient's perspective is that at the end of the day, that is who gets left holding the bag,"

Where will my practice be in 5 years?

I am sure you have wondered where you will be in the next 5 years (a not-too-distant time horizon). According to the New York Times, the days of employer based coverage may be numbered. According to studies by S&P Capital IQ, **90%** of individuals who currently have job-based coverage and work for large companies, will be getting their health insurance through the Obamacare exchange system by 2020. The laws mandates, fees and taxes will increase healthcare costs for large employees to the point that it will not be economically sound to continue to provide healthcare benefits. The numbers are quite astounding. The S&P researches estimate that this shift will save American companies about $700 billion between 2016 and 2025 or about 4% of the total value of these companies. The number could reach $3.25 trillion if all companies with 50 employees are counted. As our nations companies save this money, exactly who is going to pay the bill...the American public in the

form of more taxes. Put the tax issue aside just for a fraction of a moment...if you can. Just get your hands around the idea that about 1/2 of the health care delivered in this country will be controlled by the government very, very soon.

I suggest you take a look at some of the administration fees that companies need to pay to understand the drive to government medicine.

- Fee to fund "Patient Centered Outcomes Research Institute (PCORI), a government-sponsored organization charged with investigation the relative effectiveness of various medical treatments.
- Temporary Reinsurance Fee to help "stabilize" premiums in the individual insurance market. One company in the American Health Policy Institute survey said with 10,000 employees, the estimated cost was about $15.3 million between 2014 and 2016.
- 40% excise tax on expensive insurance plans - those with premiums greater that $10,200 for individuals and $27,500 for families. One company in the same survey said this would cost them $378 million in 5 years.
- In 2015, employers with 100 or more employees must provide insurance or pay a fine. In 2016, those with 50-99 employees need to provide insurance or pay a fine.
- All covered plans must also cover adult children on their parent's policies to age 26. This has already raised the employer health insurance cost up to 3%.
- All plans must cover 100% of "preventative services"

Therefore, Obamacare could cost large employers $151-$186 billion a year or $4800-$5900 per employee. Employers will pass along these costs to their employees, 80% of companies are considering raising deductibles as a result. The ultimate result will be that employers will simply opt to pay the Obamacare fine and save the money. The rest is to be funded by you, the tax-payer.

Subsidies? An incorrectable wrong!

Subsidies received for Obamacare are determined by an individuals income. These subsidies are paid for by you the tax-payer. In the latest news, hundreds of thousands of individuals are receiving the wrong subsidy, many of those are getting too much. Its not hard to tell, the government has noted a discrepancy between the IRS forms and the Obamacare sign-ups forms. But as with other computer issues, the government is simply unable to fix the problem. So the government will continue to overpay and under-perform. What if that was your excuse?

What on earth is an Observation Day?

I don't know if you noticed, but hospital "readmissions" within 30 days are dropping. Is this because a sudden rise in phenomenal care? Uh...no, in actuality a little musical chairs is going on. You see, Obamacare Section 3025 punishes hospitals if a senior is readmitted to the hospital within 30 days if discharge. Now, when a senior returns to the hospital, he is put under "observation" which may mean nothing on the surface because he/she is placed in the same room or has the same tests run. But unless the patient stays two nights, the hospital does not bill Medicare for the stay and the frequently the patient is left with the cost. Seniors don't even know they were "under observation" until they get the bill. So while the administration is proclaiming a decrease in re-admissions, there is a compensatory increase in observations...and cost shifting. Tell your patients to ask if they are "under observation" if you think this maybe happening to them. Dr. Ashish Jha, a professor at the Harvard School of Public Health says its bogus to equate declining re-admissions with quality. Instead the gold standard for quality is how many patients survive a specific disease.

Is the VA scandal a harbinger of the future of Obamacare?

I don't like to call something in which people die a scandal, in fact the better word is a crime. Is it just my opinion, or do you believe we have the highest level of obligation is to those individuals who have put their lives on the line for this country. If you have not heard, the Veterans Administration at 7 sites, so far, have been lying about their waiting times, this has resulted in, at least, dozens of deaths. But stepping back, what does this say about the future of a larger government run health care system. It is currently estimated that 344,000 claims for care are backed up in the veterans system.. It takes 160 days or over 5 months for the average Veteran to be approved for benefits with an almost 10% error rate in processing. A veteran who uses all the appeals process is in for a 1598 day wait or more than 4 years. This is not unusual for a single payer system. In 2012, it was discovered that 7000 Scottish patient had been removed from surgery waiting lists so that targets could be achieved. In the UK, National Health Services (NHS) patients wait an average of 8 weeks for treatments that require admission to a hospital, four weeks for out-patient treatments and two weeks for diagnostic tests. NHS patients do not have a choice of hospitals, they can not choose their specialist. This is around the corner for us, as well. Canada is frequently touted as a healthcare nirvana. In 2013, those requiring orthopedic surgery had to more than 9 months and an appointment with a neurosurgeon was 4 months. Cancer patients in need of radiation therapy waited about one month. 2013 results were worse than 2012.

When you have vast bureaucracies and high demand with random time-lines you are sure to get simply awful service. As many as 40 veterans in Phoenix alone died because they couldn't get care. Apparently the VA hospital administrators there, and in other areas, established secret waiting lists and falsified reports so that the "numbers" would look good on their bureaucratic reports. Those people who served their country were left to die so that the statistics looked good. We are just starting to see this in the readmission/observation data of Obamacare. Care is secondary to numbers and statistics. How many seniors were not readmitted in fear of a hospital becoming an outlier in the readmission "game". If this is not a big red flashing warning sign, what is?

When is the next networking event?

Due to popular demand, we will have another networking event in June, be on the look out for your invitation. Last month was a real success, and we hope to build upon this. We have arranged for these to be sponsor-free so you can simply introduce yourselves to your colleagues and exchange thoughts and ideas. We welcome you to participate!

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