MEDICAL-LEGAL
HEALTH SYSTEM REFORM

Potential Physician Dilemmas Created by Federal Health Care Reform

by Harvey M. Tettlebaum, JD

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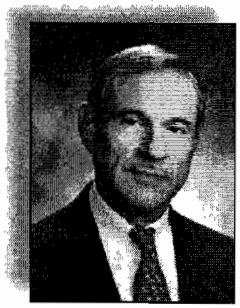

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I am a great believer in markets - the marketplace of ideas, the marketplace of commodities, the marketplace of services. A competitive marketplace produces the best ideas, the lowest prices and the highest quality.

At the time of this writing, both the House and Senate bills pending before the Congress represent a loss of faith in the marketplace. As with many pieces of proposed legislation introduced in the Congress, the title to the legislation and the description of its provisions obscure its true purpose and effect and misrepresent its contents. That is certainly true of The Patient Protection and Affordable Care Act. It does little to protect patients and it hardly represents a step forward toward affordable care.

Much has been written so far about both the House and Senate proposals. The purpose of this article is not to duplicate those efforts. Rather, I have been asked by *Missouri Medicine* to provide my views on what dilemmas this legislation presents to physicians and their patients from the prospective of the physician's duties to his or her patients, the rights of the patients and the standard of practice. (I am sure that I do not need to remind the reader of the primacy of the physician's obligation to his/her patient dates back to the time of Hippocrates or earlier.) I attempt to accomplish that while noting the paradoxical provisions which affect private insurance and the payment system which it fosters and supports.

While there has been precious little honest debate about so-called "health reform" or even the latest iteration "insurance reform," there has been no debate or discussion about the role states play in setting standards of medical practice and maintaining a viable and solvent health care insurance industry. An understanding of both of these issues is necessary to recognize why and how both the House and Senate proposals will not accomplish what they claim to accomplish, but rather will create a single payor system operated by the single largest third party payor, the Federal Government, without regard to patient preference, choice or rights. Allow me to explain the impact of this situation on physicians.

In every state in the Union, the regulation of the practice of medicine is a state function. While the Federal Government nibbles at the edges through its enforcement of the Federal False Claims Act and the Federal Anti-Kickback statute, on a day-to-day basis, the standard of practice in large measure is set at

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the state level by the state licensing board such as the Missouri State Board of Registration for the Healing Arts ("Board") and its sister agencies around the country. Other state agencies regulate narrower aspects of the practice such as the Missouri Bureau of Narcotics and Dangerous Drugs ("BNDD"). In some respects, the standard of practice is a creature of the civil tort system in each state whose state licensing board frequently adopts standards set by specialty groups and professional associations to apply and enforce. There is no national licensing of physicians. While the Drug Enforcement Administration ("DEA") issues permits to physicians to allow them to dispense and prescribe scheduled pharmaceuticals, the real enforcement work is done at the state level by agencies like the BNDD. A physician who is grossly negligent in the way he or she practices medicine is subject to sanction by the state licensing board which can limit privileges or take away the privilege of practicing medicine all together. In many instances these standards are articulated in statutes and regulations but more frequently find their way into court cases decided on specific facts which describe how medicine is to be practiced in order for physicians to meet their duty of due care to their patient.

When I read The Patient Protection and Affordable Care Act ("Act") I was struck by the many provisions which, in effect, duplicate the functions of state licensing boards. As one example, in Section 334.100.2(4)(f), Missouri's Healing Arts Law makes a physician subject to sanction for "performing or prescribing medical services which have been declared by board rule to be of no medical or osteopathic value . . . ." Section 3403 of the Act creates an "Independent Medical Advisory Board" to create the same standards which Missouri law allows the Board of Healing Arts to create under Section 334.100.2(4)(f) and even gives them the force and effect of law unless Congress acts to legislatively veto them. Section 3007 of the Act requires the Secretary to "establish appropriate measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part [value based modifier] that reflect health outcomes." Needless to say, conflicts between state and federal standards are likely. Whether the Act in part contains provisions which contravene the 10th Amendment to the United States Constitution requirement that ". . . powers not delegated to the United States by the constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people . . ." remains to be seen. Again, whether the delegation of legislative authority the Congress gives to the Executive branch contravenes the "Separation of Powers" clause implicit in the United States Constitution will be determined most likely in a future lawsuit.

There is much discussion about the "public option" or some variant thereof in both the House and Senate bills. Proponents of the "public option" have touted its need to impose competition on the marketplace forcing insurance premiums to be reduced thereby lowering the cost of access to health care. However, like the practice of medicine, insurance is regulated solely at the state level. Federal legislation in the form of the McCarran-Ferguson Act leaves to the states the regulation of insurance and has done so since its enactment in 1954. As a result, each state becomes a separate marketplace for insurance. Some states regulate insurance rates while some states do not directly set insurance rates but allow insurance rates to fluctuate pursuant to market forces. Some states require prior approval of insurance forms other states merely require insurance forms to be filed with the state regulators prior to there being used. One common denominator in the regulatory scheme is that the state regulators want to make sure that insurance companies stay solvent so that when claims are filed, be it under life insurance, casualty insurance or accident and health insurance, there are sufficient assets to pay the claims. For that

reason, all states require insurance companies to have prepared for filing with the insurance regulators actuarial studies which contain certain assumptions which are used as the basis for rate structures. If rates are too low insurance companies are likely to become insolvent. Insolvent companies are unable to pay benefits. If rates are too high then in a well regulated and competitive marketplace competitors will enter to lower the price. If prices get too low insurance regulators will force companies to raise their rates in order to maintain solvency. Part of the solvency process requires insurance companies to maintain reserves sufficient to pay claims as they mature. Predictability is greater for life insurance companies than it is for casualty companies. Health insurance companies on the other hand are also affected by mandated coverage requirements passed by state legislatures as well as by events such as epidemics or pandemics as we are reputed to be experiencing with the Swine Flu. The regulatory process together with the marketplace creates a dynamic and sensitive market which can be influenced by many outside factors including spurious lawsuits which are factored into actuarial assumptions which result in increased premiums and higher costs for health care.

This brings us to the "public option." Proponents of the "public option" claim that it will create a entity which will force insurance companies to lower their rates. The public option is a governmentally-operated entity which will not be subject to any state controls nor to any of the solvency standards to which private insurance must adhere. By "private insurance" I am talking about not-for-profit, mutual and stock companies. If the "public option" company were required to adhere to certain actuarially calculated solvency standards, then it is possible that it might provide an innovative entity which would force greater competition in the marketplace. However, if history is a teacher, governmentally-operated entitles have shown themselves more affected by politics and bureaucracy than the types of market forces which produce efficiency and quality from true competition. What, therefore, is the purpose of the "public option" if it will not necessarily create competition with private insurance? It appears its goal is to eliminate insurance by driving the price of insurance to the point where private insurance companies will become insolvent and go out of business. The result will be the single payor system that the current President touted in 2005 as the proper system to pay for health care in this country. The latest iteration of the "public option," which came from the effort by the Senate Democrats to assuage the concerns of their "moderate" brethren, does not much change the goal or effect of the "public option" even in the form of a plan to negotiate insurance rates by the Office of Personnel Management.

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With a single payor system, government is then free to decide for what care it wishes to pay but also for which age cohorts among the population and what portions of which socio-economic classes. To achieve the cost savings which have been represented as a goal of this legislation requires the single payor to decide for what care it will actually pay and under what circumstances. In other words, it results in the rationing of health care in the sense that unlike the current health care system, wasteful though it may be, which allows an individual to use his or her resources to decide how much health care is appropriate and needed, governmentally imposed standards will take those decisions from the individual and impose them on the collective.

This brings us back to the individual physician and the standard of care. The proposed legislation can create an ethical dilemma for the physician. The patient presents himself or herself to the physician, the physician diagnoses the condition and prescribes a course of treatment. The government indicates that it will not pay for all of the treatment because it

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is not necessary. The physician treats the patient as the Federal government suggests. The patient experiences a bad result and sues the physician for failing to meet the standard of care under state law and regulations. Unless the Federal law preempts state licensing standards or state judicially imposed standards of care, once the physician elects to treat the patient he or she may be obligated to provide all treatment required under the standard of care regardless of payment or suffer the consequences. It appears that the Congress, in the Act, has no appetite to preempt state standards of care which could serve as a basis for malpractice lawsuits.

Under another scenario, the patient presents, for example, for an examination. For discussion purposes the patient is a 40-year old woman. Pursuant to Federal guidelines, the physician advises against the woman getting a mammogram. A year later the patient develops breast cancer and sues the physician for malpractice and complains to the State licensing board about the shoddy practice standards of the physician. So what does the physician do in that situation? What is the standard of care? Is it what the state licensing board or the State professional organizations, define it to be? Is it what the courts have defined it to be through adjudication of malpractice cases? Do the federal payment standards and guidelines preempt state law? The most recent draft of the Act resolves none of these issues at the present time.

As someone who has practiced health law for over 40 years, I am frequently asked by my health care provider clients what I think the solution should be. In order to talk about the solution you have to honestly talk about the problem. There has been little honest debate about the "problem" unless you believe the problem is that the federal government is spending too much on health care. If that is the "problem" sought to be solved, then it is not a reform of health care we are talking about, but the single largest third party payor attempting to manage its costs of purchasing services and items from health care providers and demanding that those providers somehow deliver "health care" with the money paid for those health care related services and items.

From conversations with my provider clients over the years it has become obvious that the single most important element necessary to provide quality health care is the time for the physician to be able to obtain the information from the patient needed to evaluate all factors and symptoms which must be considered to determine the true nature of the disease state of the patient and the appropriate treatment. This is not paid for by the government or, for that matter, by most private third party payers. While the Act does pay lip service to this situation authorizing pilot projects and studies to create "health care homes" and other methods to better coordinate care through a primary care physician, the Act contains more provisions creating additional punitive sanctions and disclosures further exacerbating the adversary situation created by asking providers and their employees and patients to become "whistleblowers."

Having read the entire Senate version of H.R. 3590, it is apparent that the legislation, if passed, would give unprecedented authority to the Secretary of Health and Human Services to approve research for various types of studies that create the very care standards which currently are mostly developed by private accrediting bodies, professional associations of physicians and state licensing bodies as described above. While there is no way to predict the final product of the Congress, the trends seem clear. If passed, the government will mandate certain practice patterns by physicians and various care standards. We will have to await the results of the outcomes from their use to determine if this is good or bad. Some will work and some will not. What is likely to result is a system where physician judgment and discretion will be narrowed and the penalty for failing to follow government-imposed standards will certainly result in the loss of reimbursement and may well result in prosecutions and a consequent loss of freedom.

By the time this article is read, we may know the outcome of the efforts by the Congress on the Act.

Footnote

The information contained in this article should not be construed as legal advice or legal opinion on any specific facts or circumstances. The contents are intended for general information purposes only, and readers are urged to consult their own attorney concerning their own situation and any specific legal questions. **MM**