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Practicing During the Economic Crisis

The United States is witnessing the worst economic downturn since the Great Depression. Factories are closing and Wall Street is in distress. Corporate stalwarts such as General Motors and Bear Stearns have filed for bankruptcy. Even before this crisis, the number of uninsured or underinsured patients was unacceptably high. Now, with unemployment rates soaring, the number of people with limited access to health care is skyrocketing to never-before-seen levels.

During tough economic times, people's health care needs persist. However, as a result of job loss and an uncertain financial future, those health care needs may be ignored or delayed. Patients may choose to forego necessary treatments or postpone care, leading to problems that may have been preventable with timely intervention. In this installment of "KOL Corner," we asked several thought leaders about how their practices have been affected by the current economic climate and what they are doing in response.

THIS ISSUE'S KEY OPINION LEADERS:

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How has the economic crisis affected your practice? Are you seeing fewer patient referrals?

DB: Surprisingly, no. Houston has a very diversified economy that has been less affected than the country on average. Also, much of our practice is tertiary referral, and patients tend to take care of serious problems (brain surgery, retinal detachments) irrespective of their economic issues.

SG: Fortunately, in our area, we have not seen a significant drop in referrals. However, certainly the retail components (eyeglasses and LASIK) of our referral sources have been impacted. We find more of the referral sources focusing on the medical part of their practices rather than retail, which recently has increased our referral rates.

RS: Our volume has flattened as the economic crisis has unfolded. Our referral ophthalmologists say their volume is down 10–20 percent.

RD: Although we have not to date seen a decline in the number of patient referrals, we have seen a slight increase in the number of those referred patients who fail to show up even after confirming their appointments, in addition to an increase in no-shows with follow-up patients (presumably due to insurance co-pays).

MH: Thus far, we have not seen a decrease in retina referrals. However, we have had a small number of patients who have lost their jobs and are increasingly concerned about the cost of office visit co-pays as well as prescription medications.

LH: We have seen a tangible change more in our general community than in our practice. While the drop in housing prices has prevented some people from selling their homes, at the same time we have felt an increase in the migration of people to South Florida, which had slowed down a year ago. And yet, the flow of new patients is flat, rather than growing, and this is certainly a sign of the economy.

It is interesting to note that this is occurring while we make dramatic advancements in treatment and technology. And with these improvements come increased prices for acquiring the best equipment and services for our patients. Many in our field have seen a serious drop in the value of their investment portfolios, while our homes are less valuable, and the government is threatening to cut our incomes. This trifecta of bad news is the perfect storm for all of us, and it requires us to be extra-thoughtful in planning our futures.

Are you seeing more patients who are uninsured or underinsured?

DB: We are seeing more of a shift to managed-care plans and higher deductible plans as employers try to control their health care costs.

SG: This is the biggest change we have seen. We have a number of patients with HSA plans or high deductibles who will get the service and then not pay. It is often hard in retina to collect those kinds of dollars up front. However, we may need to learn from our dental and oral surgeon colleagues and improve this process. We are already trying to get predetermination of patients' deductibles and HSA status to do a better job of billing at the front desk. This will become more critical with time, as these insurance plans are increasing in demand.

RS: No change.

RD: Over the past six to nine months, we have seen a slight increase in those patients who are between jobs and are transiently uninsured, and at this time have not seen an increase in underinsured patients.

MH: Yes. There is a slight increase in seniors with Medicare as their only insurance. We see very few uninsured patients, as the state of Massachusetts has a mandatory requirement for health insurance for all citizens of the commonwealth.

LH: We have definitely seen more patients who are under financial strain. Patients are worried about paying their co-payments and their deductibles. And concern over the cost of medications has also intensified. South Florida has had its share of job losses, and with the job goes health insurance. So we certainly have more patients who are uninsured.

That said, we continue to take care of those patients who can't afford care. We try to reach out to these people, and continue their care while minimizing their financial responsibility.

Are fewer patients scheduling surgeries (and if so, which surgery types have been most affected)? Have you observed patients delaying either elective or compulsory treatments (either medical or surgical)?

DB: We're actually seeing the opposite. Many patients seem to be trying to get their elective medical care done before they potentially lose their insurance or it changes to higher out-of-pocket costs.

SG: I have not seen this as much. Some of the patients earlier in the year wanted to wait because they had large deductibles. However, this was not the case at the end of last year and now.

RS: Our surgical volume so far appears unchanged. I suspect that retinal surgery is considered not elective by most patients.

RD: We have seen a few more patients in the past six months delaying elective laser treatments or compulsory treatments based on their current economic situation. In certain circumstances we do counsel them to proceed despite this, as they are at risk for complications that could entail even higher costs, and we simply work out a payment plan for those individuals.

MH: There has been no decrease in scheduling retina surgeries thus far.

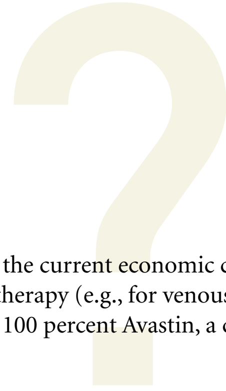
LH: I have definitely seen patients who have not purchased prescribed drops due to the expense. We all know that the financial burden medications place on patients can be severe. Patients who have retinal emergencies like tears, detachments, and the like are still getting immediate treatment. I personally have not seen elective surgery such as puckers diminish, but those who can't afford the surgery may not be coming into the practice in the first place.

What steps have you taken to circumvent each of these changes?

DB: I always try to determine what the best treatment option is for each patient without looking at their insurance status, and then figure out how to help the patient get the care. Every time I try to "save money" for the patient, I usually get burned. If a pneumatic retinopexy won't work for a wealthy patient, it won't work for a poor patient. We typically discount the "working poor" to Medicare rates and often work out payment plans.

SG: We added software solutions to get predetermination of deductibles, and started more aggressive collections at the front desk. We encouraged our referral base to be more medical-based practices, which leads to a greater number of screened patients requiring our specialized service. We work with state agencies to help sponsor uninsured patients, and participate in clinical trials to help in the drug-development process, increase revenues, and create access to innovative treatments for our insured and uninsured patients. We try to create more efficiencies in the office. And last, we try to increase margins and quality by increasing physician and employee productivity through using practice patterns and processes that are reproducible for a given disease.

RD: When we discuss offering a treatment to someone in an occupation that is economically precarious or in an industry we know to be shaky, we actively engage them in a discussion about the amount of time off required and the issues of potential COBRA coverage, and relate this to the dates we schedule their procedures. Some patients working in factory jobs are fearful of being laid off if they are away from work too long. We do our best to accommodate their



time needs (even if it requires scheduling surgeries on days we don't normally operate).

MH: Our practice has a policy for assisting Medicare patients with no secondary insurance so that care can be rendered, and we are in compliance with the Medicare fraud and abuse regulations. We also assist patients with access to prescription medications (through foundations and pharmaceutical company programs) when the patients are unable to afford the medicines.

LH: I have made an effort to speak even more openly about financial issues to give patients an opportunity to express their concerns. And, whenever possible, I try to help them to contain the personal costs of obtaining state-of-the-art care.

For my practice, we have tried to further improve efficiency, and we are hesitant to make significant financial commitments until we feel that the economy has stabilized. We have always avoided debt, and have almost always purchased equipment with cash, certainly helping us to feel more comfortable despite the fear of impending financial hardships.

Like many practices our size, we were in the mode of taking a new associate almost every year. Now, with this downturn in the economy, we will look very carefully at when we would consider adding a new physician to our practice.

Retina surgeons will almost certainly see an increase in personal income tax, both on the federal and state levels. College tuition and other financial responsibilities will continue to increase. Therefore, I believe that personal spending may need to be scaled back so that personal saving can continue. Avoidance of debt of all types, including mortgage and credit cards, is critical as well.

How has the economic crisis affected how you treat certain diseases such as neovascular age-related macular degeneration? Are patients electing to forego treatment or to switch treatments (e.g., from Lucentis to Avastin because it's cheaper)?

DB: With the Genentech access programs (Chronic Disease Fund, etc.), for most patients Lucentis is less out-of-pocket cost. We do have some managed-care plans that try to persuade us that their patients should get Avastin as opposed to Lucentis. Hopefully, the CATT trial will provide us data to determine the differences (if any) between these therapies.

SG: I don't think that our practice patterns have really changed, unless the patient has no insurance or insurance that does not cover Lucentis. We use Avastin exclusively in patients that don't have insurance or are not covered.

RS: Surprisingly, there has been no change. I would have expected our Lucentis volume to lower (we use Avastin 70 percent, Lucentis 30 percent), but it has not.

RD: In the two Southern states in which we practice, Avastin is covered by Medicare and has been the predominant treatment modality selected by patients after discussion of injection frequency and co-pays. We don't feel that the current economic climate has influenced the choice of pharmacologic agent used. Moreover, in our South Carolina office the sales tax imposed on the provider for the purchase of Lucentis made it rarely used even before the current economic crisis unfolded. Expanded uses of anti-VEGF therapy (e.g., for venous occlusive disease and diabetes) is almost 100 percent Avastin, a choice that has been driven by costs.

MH: We have had more questions regarding the use of Avastin as a less costly alternative to Lucentis. No patients have elected to defer treatment.

LH: There are certain managed-care plans that are demanding significant co-payments for either of the two drugs, and this has created a bit of a disincentive. Lucentis Assist has helped this a bit, and we are definitely trying to get as many of our patients as possible registered with this program.

Are any of the current economic challenges specific to academic or private practice?

DB: We refer to our practice as an "academic private practice," as we do more clinical research and typically publish/present more than most university-based retina groups. It does seem, however, that the university-based practices are having a more difficult time adapting to the changing economy. As a private practice, we are able to make decisions quickly without multiple layers of bureaucracy. We recently outsourced our billing/ collections services as a response to increased employee costs.

SG: I think the private sector, at least in our practice, seems to be functioning fine. I think the academic centers may have a harder time given the larger overhead structure and less efficiency.

RS: I do not think so.

RD: Certainly in private practice, the credit crunch and uncertainty concerning the possible directions that the federal government will undertake in the near future make expansion of the clinical and surgical facilities all but impossible to plan confidently. My impression is that most of our colleagues are holding off on any new undertakings, and are completing only those physical plant expansions and equipment acquisitions they had already committed to prior to the unfolding of this economic crisis. Only after we review the implications of any new government interventions can we make any reasonable financial projections of the potential benefits of these expenses. I should think these same considerations apply to the academic setting.

MH: Both academic and private practices will face the same challenges in the present economic environment. There is, however, a significant possibility of increased use of the emergency rooms for the uninsured, which would impact the hospital/academic practices more than private practices.

LH: I think that in academics there is probably a bit of a disconnect between the finances of a huge institution and the individuals in that institution. However, knowing that it is more difficult for a large institution to become more efficient, I think those in academics have their work cut out for them. In private practice, you have to write the checks and pay the bills, so there is more of a connection. And yet, physicians are trying to manage the big business of running a practice, and dealing with millions of dollars of medications that flow through the practice.

What would your advice be to the Obama administration as it looks to restructure health care?

DB: When I use my VISA card, the merchant knows exactly whether or not I have access to credit or not. However, almost all of our patient visits require an actual person-to-person telephone call to verify their specific health care benefits. Our group has 4 four employees dedicated just to just "Verification". This increases our cost but doesn't improve patient care. Mandated electronic swipe cards that tell insurance status and what the patient's co-pay is for each procedure would be an easy first step in reducing costs.

Another suggestion is to have insurers offer comparable plans. Currently, Blue Cross offers over 90 different combinations of PPO plans in our market, with different co-pays, deductibles, limits, etc. Insurers should have a Cadillac plan, an Oldsmobile plan, a Chevy plan, and a Hyundai plan. Then employers could shop for the Oldsmobile plan with several different insurers and truly know that the plans were comparable. Also, when a patient showed up in the retina clinic with Hyundai insurance, you would know they needed primary care referral, had a $200 co-pay, needed precertification for an OCT, and, once they got precertified for surgery, were only approved to have their operation at the scariest hospital in town.

SG: Everyone pays the price in the long run for people who are uninsured. If we are truly going to overcome the health care crisis, we need to create a plan that will allow the people who do not have insurance or the money for traditional insurance plans to be covered. We will lose money on our sicker patients but will make it up on some of the healthier ones. This will also allow for more focus on prevention, as long-term strategies for DM and HTN will have a return on investment for society.

We as physicians, however, are going to need to step up on cost containment. How can you have an economy that is not growing and an industry that as a net utilizes resources from the GDP at a faster and faster pace without creating an exportable product? In the end, if the economy is not growing, health care costs are going to need to be contained as a percentage of GDP for us as an industry and as a society to be successful in the global economy. So what are we going to do to help?

First, we can set up better diabetic and macular degeneration screening systems at the primary care level.

We can also create practice patterns within retina that are based on evidence—I think most of us know that we can determine if a CNVM is leaking based on an OCT. Why is it that a lot of our colleagues do an FA every time or quarterly? Why is everyone not practicing treat-and-extend strategies for AMD? Why not determine the best centers in cost containment and surgical outcomes and 96 percent success on primary detachments, and shift the work to those centers? There are many other ways to save money and deliver better-quality care than the system is currently delivering. Unless we want the government to dictate how it will be done, as they are doing with financial institutions and TARP money, I think we need to be proactive and track costs, outcomes, and ROI for the American public. We need to help our colleagues conform to these best practices both on quality and costs.

RS: Health care has three major components: technology, access to all, and cost. You can fulfill two of the three, but not all three. American society has picked one: technology (or best care, quality, etc.). Help us pick the other.

RD: I feel that the administration would be well advised to stay away from a single-payer system, which has proven to be financially unsustainable, to have restrictions on access to resources, and to be associated with unacceptably long waiting lists. This scenario has already played out in Canada (where I previously practiced both in primary care and as a vitreoretinal specialist before moving to the Southeast). This should not be taken to imply that the current situation in America is not in desperate need of reform. However, a wholesale takeover by the federal government of this huge segment of the U.S. economy will only stifle the innovation, research, and efficiencies realized by those individuals on the front lines of the delivery of care. I think a system of individual tax incentives with insurance costs being "community rated" and not tied to individual risk factors (determined by independent auditors with some regulation and government oversight) would allow each individual to select from private and nonprofit insurance carriers, and the market would then determine the costs and menu of services available. By mandating health coverage for each individual, setting ceilings on the costs of obtaining such coverage, preventing denial of coverage to individuals with preexisting illnesses, and means-testing of lower-income individuals (who can be offered a federal/state subsidy), the administration can achieve the dual goals of universality and sustainability.

Finally, the costs of both generic and nongeneric pharmaceuticals need to be reigned in while still leaving incentives for ongoing research. Canada and European countries have done a better job than we have with generics, and the price of nongeneric medications should be negotiable by Medicare Part D due to the volumes of drugs being purchased.

MH: Some thoughts . . .
Physician involvement in the process is critical.

Electronic medical records need to be designed and tested with input from each specialty in medicine, not mandated from above—one size does not fit all when it comes to EMR!

Pharmaceutical prices are out of control; if pharmacy benefit managers can negotiate discounts, then why can't Medicare?

The inefficiencies in the system are significant—not simply at the physician level. When commercial health insurers refer to their medical loss ratio, they mean the amount spent on clinical care—which should be their goal, not referred to as a loss! However, there are numbers of 10-20 percent of the health care premium that are used to run these commercial plans, far more than a Medicare intermediary spends.

LH: Mr. Obama has taken a very adventurous path for our country. Whether you agree or disagree with the details, he certainly hasn't shied away from the difficult issues facing our country.

I would tell the current administration to be careful about removing incentives to make a retina practice busy and successful. I would encourage the president to reward excellence; and since most retina surgeons are excellent, we would be in good shape. ■