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The Death of Private Practice: How the Rising Cost of Healthcare is Destroying Physician Autonomy

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THE DEATH OF PRIVATE PRACTICE: HOW THE RISING COST OF HEALTHCARE IS DESTROYING PHYSICIAN AUTONOMY

ABSTRACT

Over the past two decades, the number of physicians in private practice has dropped dramatically. This trend is the result of the financial pressure imposed by the federal government in response to the skyrocketing cost of healthcare. Physicians, frustrated by stagnant reimbursement rates in conjunction with increased administrative costs and overhead, are choosing hospital staff employment in favor of private practice. This trend is to the detriment of the physician, the taxpayers, and, most importantly, the patients. Patients treated in hospital outpatient settings have worse outcomes than those treated in private practice. In addition, hospital procedures cost both the government and private insurers more per procedure, adding to the increase in healthcare expenditures. This is due to the discrepancy in reimbursement rates; Medicare pays hospitals substantially more than private physicians for the same procedures. This Note attempts to clarify the financial and ethical consequences of hospital-centered healthcare delivery, as well to identify the major contributors to the rising cost of healthcare in the United States. This Note also proposes changes to the healthcare system that will lower expenditures by focusing on pharmaceutical drug costs, private health insurance, and the role of hospital systems.

INTRODUCTION

"It is naive to think that a patient's ability to pay wouldn't affect the practice of medicine."[1]

Imagine a healthcare system so unaffordable that a cancer patient must mortgage his or her home in order to pay for the drugs necessary to combat the disease. A goal that almost every American strives to accomplish, that is, owning a home, is gone in an instant. Imagine also that every routine checkup or mild fever required a trip to the hospital, having to see a different treating physician each time. In the absence of any personal relationship and continuity, a patient becomes just a number on a chart; healthcare in turn becomes just another industry. This scenario might appear to be a gratuitous and dystopian parallel of the United States healthcare system, but if the healthcare industry is allowed to continue on its current course, it could be a reality that millions of Americans will face every day.

Although the United States is one of the most advanced countries in the world, it continues to lag behind other developed nations in both healthcare

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1. Catherine Arnst, *Going Broke to Stay Alive*, BLOOMBERG BUS. WK. (Jan. 30, 2006, 12:00 AM), https://www.bloomberg.com/news/articles/2006-01-29/going-broke-to-stay-alive (quoting Dr. Leonard Saltz of Memorial-Sloan Kettering Cancer Center, discussing his concerns regarding the unsustainable price of cancer treatment drugs).

costs and healthcare delivery.[2] This can be attributed to the government's facilitation of the demise of physician private practice in favor of large companies—a misguided attempt to mitigate costs and improve patient care.[3] These excess costs are the result of shortsighted legislation, conceding guaranteed profits to the pharmaceutical industry,[4] subsidizing the health insurance industry,[5] and allowing anti-competitive hospital systems to continue to grow throughout the country.[6] If the United States healthcare industry stays on the current path, the unsustainable cost of Personal Health Care (PHC) will fundamentally change the way healthcare is delivered and managed in this country.

In an effort to mitigate the rising costs, and in spite of potential savings from the various industries, Congress is squeezing doctors out of private practice.[7] Due to Congress's refusal to increase physician reimbursements, while simultaneously imposing more regulation and compliance costs, physicians are closing down privately owned practices and clinics in record numbers.[8] This fundamental shift, from primarily a clinical to a hospital setting, has changed the way healthcare is delivered. The hospital model encourages consolidation and expansion, resulting in reduced competition and increased costs. Drug costs are increasing at an even higher rate than PHC. This is due in large part to Congress divesting the government of its ability to negotiate with the pharmaceutical industry.[9] Instead, Congress should look to cut costs without compromising the practice of medicine. The best way to accomplish this would be to negotiate with pharmaceutical companies, increase insurance companies' benefits floor, and de-incentivize a hospital-based system.

Cutting these unnecessary costs will not only save taxpayers hundreds of billions of dollars, but will return the practice of medicine back into the hands

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2. DEAN BAKER, REDUCING WASTE WITH AN EFFICIENT MEDICARE PRESCRIPTION DRUG BENEFIT (2013), http://cepr.net/documents/publications/medicare-drug-2012-12.pdf.

3. *See generally* EZEKIEL EMANUEL, REINVENTING AMERICAN HEALTH CARE: HOW THE AFFORDABLE CARE ACT WILL IMPROVE OUR TERRIBLY COMPLEX, BLATANTLY UNJUST, OUTRAGEOUSLY EXPENSIVE, GROSSLY INEFFICIENT, ERROR PRONE SYSTEM 18–36 (2014) (Ezekiel Emanuel had an integral role in shaping the Affordable Care Act, passed in 2010. He was a White House special advisor on health policy to the Obama Administration, and many of his opinions were fully realized in the final bill); *see also* Ezekiel Emanuel, *Inside the Making of Obamacare*, WALL ST. J. (Mar. 7, 2014, 1:32 PM), https://www.wsj.com/articles/SB10001424052702303824204579421553914382752.

4. *See* BAKER, *supra* note 2.

5. *See* Thomas Rice et al., *Challenges Facing the United States of America in Implementing Universal Coverage*, 92 BULL. WORLD HEALTH ORG. 894, 896–97 (2014).

6. *See* Anthony G. Charles et. al., *The Employed Surgeon: A Changing Professional Paradigm*, 148 JAMA SURGERY 323, 327–28 (2013).

7. *See generally* MATTHEW T. MILONE, OWNERSHIP OF MEDICAL PRACTICES AFTER THE AFFORDABLE CARE ACT, (ASPATORE) (2013), Westlaw 3772669.

8. *See id.* "Independent medical practices are facing increasing threats to their existence. In the face of declining or stagnant reimbursements, the costs of running a medical practice have increased dramatically." *Id.* at *4.

9. 42 U.S.C. § 1395w-102 (2012).

of physicians. These savings will enable Congress to divest both the health insurance and hospital industries of their power over physicians, allowing the professionals to dictate healthcare, instead of the profits. A reallocation of these resources will facilitate an increase in physician reimbursement, while simultaneously lower unnecessary costs. This will alleviate the financial burden on physicians and allow them to determine the type and amount of care each patient will receive.

This Note highlights aspects of the current healthcare system and the reasons for the massive increase in spending. Part I provides a brief history of the Medicare system, specifically Medicare Part B, and demonstrates the enormous discrepancy between physician reimbursements in relation to overall healthcare costs. Part II introduces the issues with Medicare Part D, the drug reimbursement program, and proposes a simple yet substantive method for cutting costs. Part III addresses the other two major healthcare industries, insurance and hospital systems, and highlights how Congress has enabled these industries to thrive. Part IV addresses the rising administrative overhead costs associated with private practice, which has led to its decline. In addition, this Note explains how the various parties and industries interact, with both each other and the federal government.

I. THE RISING COST OF HEALTH CARE

There is a common misconception that physicians are already well compensated and that they may actually be responsible for the rising healthcare costs in this country.[10] Comparing the relative salaries of United States physicians with those of their European counterparts often reinforces this misconception.[11] However, this comparison is not analogous and yields little to no accurate or useful information, because the comparison does not take into account the extraordinary costs of administrative compliance,[12] malpractice insurance,[13] or prescription drugs.[14]

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10. Elizabeth Rosenthal, *Medicine's Top Earners Are Not the M.D.'s*, N.Y. TIMES (May 17, 2014), http://www.nytimes.com/2014/05/18/sunday-review/doctors-salaries-are-not-the-big-cost.html?ref=opinion&_r=0.

11. Sarah Kliff, *What Doctors Earn When They Graduate, In One Chart*, VOX (May 8, 2014, 7:20 AM), http://www.vox.com/2014/5/8/5692058/what-doctors-earn-when-they-graduate-in-one-chart.

12. Lawrence P. Casalino et al., *Hospital-Physician Relations: Two Tracks and the Decline of the Voluntary Medical Staff Model*, 27 HEALTH AFF. 1305 (2008).

13. *See* Daniel P. Kessler, *Evaluating the Medical Malpractice System and Options for Reform*, J ECON. PERSPECT., Spring 2011, at 93–94.

14. *New Medicare Data Available to Increase Transparency on Physician Utilization*, CTR. FOR MEDICARE & MEDICAID SERVICES (June 1, 2015) [hereinafter *New Medicare Data*], https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-01-2.html.

The total cost of PHC in the United States amounted to more than $3.2 trillion in 2015.[15] Out of the $3.2 trillion, which amounts to more than one-sixth of the United States' gross domestic product (GDP), only $502 billion is paid to physicians.[16] The rest is split between hospitals (over $1 trillion), insurance companies (over $1 trillion), and the pharmaceutical industry ($324 billion).[17] Medicare and Medicaid costs alone consumed over $1.1 trillion.[18] PHC costs are projected to skyrocket to roughly 20.1% of GDP by the year 2025.[19] This staggering number has prompted Congress to take measures to cut healthcare spending in many different ways.[20] Physicians have borne the brunt of this reform via stagnant reimbursement rates.

In fact, in the past ten years, physician reimbursement rates under Medicare have barely risen at all.[21] Unable to keep up with ever-rising costs, physicians' private practices are continuing to shut down, leaving doctors with few options.[22] The number of physicians employed by hospitals has increased by 84% over the last two years.[23] There are a few obvious solutions to this problem; specifically, cutting prescription drug costs by removing the "no interference" clause in Medicare Part D, and cutting insurance costs by raising the premium-to-benefit rule from 80% to 90%.[24]

A. MEDICARE IN GENERAL

Congress created Medicare in 1965 under Title XVIII of the Social Security Act.[25] The concept of Medicare originated during the Great Depression, during which vast swaths of indigent and disabled Americans

15. NAT'L HEALTH EXPENDITURES 2015 HIGHLIGHTS (2015), https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/downloads/highlights.pdf [hereinafter 2015 HIGHLIGHTS].

16. *See* TABLE 9 PHYSICIAN SERVICES EXPENDITURES; LEVELS, PERCENT CHANGE AND PERCENT DISTRIBUTION, BY SOURCE OF FUNDS: CALENDAR YEARS 1998-2015 (Oct. 1, 2015), https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html; *see also* 2015 HIGHLIGHTS, *supra* note 15.

17. *Nat'l Health Expenditure Fact Sheet*, CTR. FOR MEDICARE & MEDICAID SERVICES [hereinafter *Fact Sheet*] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html (last updated Mar. 21, 2017, 7:58 AM); 2015 HIGHLIGHTS, *supra* note 15.

18. *Fact Sheet*, *supra* note 17.

19. *Forecast Summary*, NAT'L HEALTH EXPENDITURE PROJECTIONS, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2015.pdf (last visited Mar. 24, 2017).

20. *See* David Morgan, *Obama Administration Seeks to Negotiate Medicare Drug Prices*, REUTERS (Feb. 2, 2015, 5:50 PM), http://www.reuters.com/article/2015/02/02/us-usa-budget-medicare-iduskbn0l61ow20150202.

21. *See* MILONE, *supra* note 7, at *1.

22. *See id.*

23. Casalino et. al., *supra* note 12, at 1308.

24. Susan Adler Channick, *The Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Will It Be Good Medicine for U.S. Health Policy?*, 14 ELDER L.J. 237, 253 (2006).

25. 42 U.S.C. § 1395c (2012).

suffered from a lack of healthcare access.[26] The purpose of Medicare is to provide health insurance for elderly (aged sixty-five years and over) and disabled citizens, ensuring that these vulnerable citizens have access to critical healthcare resources.[27] Initially, Medicare consisted of only hospital insurance (Part A),[28] but Congress later expanded the program to cover physicians' services (Part B)[29] and prescription drug costs (Part D).[30] Over the years, the cost of Medicare and the state-run (but federally subsidized) Medicaid has grown out of control, imposing an unsustainable cost on taxpayers.[31] The Medicare system is integral to the American healthcare system; however, years of quick fixes and Band-Aid legislation have created an unstable and unsustainable behemoth, which shows no signs of slowing down.

Although there may be a myriad of factors contributing to this cost, including complexity and scope, there are clear and obvious ways to reel in Medicare spending, allowing a reallocation of resources to thereby improve healthcare delivery and patient care. For example, the Medicare drug reimbursement program, imposed by Medicare Part B and Part D, is financially unregulated.[32] These programs are costing the government billions of dollars in retail prices to pharmaceutical companies.[33] Instead of maintaining the status quo, Congress must make efforts to reduce the cost of drugs to reflect the costs that other government programs pay for the same medications.

B. MEDICARE PART B

Congress enacted Medicare Part B to provide Medicare beneficiaries with insurance to cover health services outside of a hospital setting.[34] Medicare Part B covers non-hospital physician, clinical, and surgical services, as well as drugs administered in the clinical setting, such as by doctors or other providers in private practice.[35] In 2015, the Obama Administration mandated that the Centers for Medicare and Medicaid Services (CMS) distinguish certain aspects of the Part B expenditures,

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26. *See generally* EMANUEL, *supra* note 3, at 18–36.
27. 42 U.S.C. § 1395c.
28. *See generally* EMANUEL, *supra* note 3, at 18–36.
29. 42 U.S.C. § 1395j.
30. *Id*. § 1395w-101.
31. *Health Profile Health Expenditure*, ORG. FOR ECON. CO-OPERATION & DEV. [hereinafter *Health Profile*], http://www.compareyourcountry.org/health?page=2&cr=gbr&cr1=oecd&lg=en (last visited Feb. 9, 2017).
32. Channick, *supra* note 24, at 253.
33. *See* Morgan, *supra* note 20.
34. *What Part B Covers*, CTR. FOR MEDICARE & MEDICAID SERVICES, https://www.medicare.gov/what-medicare-covers/part-b/what-medicare-part-b-covers.html (last visited Feb. 21, 2017); *see* BARBARA S. KLEES & CHRISTIAN J. WOLFE, BRIEF SUMMARIES OF MEDICARE & MEDICAID (2011).
35. KLEES & WOLFE, *supra* note 34.

specifically the amount paid out to physicians for actual services and the amount paid to pharmaceutical companies for drugs administered to patients in the clinical setting.[36] The lack of transparency between the cost of actual physician services and the cost of drug reimbursement substantially inflated the Medicare Part B figures.[37]

As healthcare costs in the United States continue to rise relative to GDP, one could logically assume that physician reimbursement would rise as well.[38] At first glance, however, it appears that the physician reimbursement rate has remained relatively constant in relation to the overall cost of healthcare. Physician reimbursement rates have risen from 4.9% of the total PHC expenditure in 1980, to 5.4% in 2012.[39] However, the lack of transparency in CMS cost reports resulted in significant inflation of the reimbursement rates for physicians.[40] This is attributed to the fact that Medicare Part B never reported the distinction between payments for services and payments for pharmaceuticals administered to patients in a clinical or practice setting.[41]

This data revealed that a substantial portion of physician reimbursement went to cover drug costs, and not to physicians as payment for services.[42] The drug reimbursement program is pre-set by Medicare and is essentially dollar for dollar, often leaving the physician's practice to operate at a loss. In fact, Congress set the reimbursement rate for physician-administered drugs at 106%[43] of the cost of the drugs, in a failed attempt to cover the cost of drugs and administrative overhead only.[44]

This distinction is not insignificant, as drug reimbursement costs can amount to *double* the reimbursement for actual physician services.[45] For example, the CMS released the Medicare Part B expenditures for the year 2013.[46] This information shed light on the previously reported[47] (and inflated)

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36. *New Medicare Data*, *supra* note 14.

37. *Id.*

38. *Health Profile*, *supra* note 31.

39. *See* TABLE 1.2 GROSS DOMESTIC PRODUCT (GDP), TOTAL PERSONAL HEALTH CARE (PHC) EXPENDITURES, PHYSICIAN PHC, TOTAL MEDICARE PHC, AND MEDICARE PHYSICIAN PHC, CENTER FOR MEDICARE AND MEDICAID SERVICES (Oct. 1, 2015), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/Downloads/2013_Section1.pdf#Table1.2 [hereinafter TABLE 1.2].

40. *New Medicare Data*, *supra* note 14.

41. *Id.*

42. *Id.* "This analysis shows that a large portion of the costs for several of these specialties is due to the cost of drugs administered." *Id.*

43. 42 U.S.C. § 1395w-3a(b)(1)(B) (2012) ("[I]n the case of a single source drug or biological (as defined in subsection (c)(6)(D) of this section), 106 percent of the amount determined.").

44. It can be inferred that the increase in drug costs do not contribute to actual physician income.

45. *CMS Releases Prescriber-Level Medicare Data for First Time*, CTR. FOR MEDICARE & MEDICAID SERVICES (Apr. 30, 2015) [hereinafter *Prescriber-Level Medicare Data*], https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-04-30.html.

46. *Id.*

47. TABLE 1.2, *supra* note 39.

reimbursement rates for physicians, which indicated that physicians received over $99 billion from Medicare during the 2012 calendar year.[48] For some specialties, the Average Medicare Allowed Amount per Provider Drug Services was double the Average Medicare Allowed Amount per Provider Medical Services.[49] To help illustrate this discrepancy, in 2013, Medicare reimbursed a hematologist–oncologist an average of $583,237 in drugs administered to patients, but only $225,379 in services rendered.[50] Similarly, a rheumatologist in the same year was paid an average of $265,011 for drug reimbursement, but only $128,187 in services rendered.[51]

Although these two specialties are admittedly on the high end of the spectrum (with respect to the value of drugs versus overall reimbursement), the lack of distinction between payments for drugs and payments for services illustrates the significant discrepancy in physician reimbursement rates.[52] It is clear that the amount of reported physician reimbursement under Medicare has been grossly inaccurate, inflating the perceived burden that physicians' services cost the United States. Even more alarming is the fact that any perceived physician rate increase can be attributed to rising drug costs,[53] not an increase in the physician fee schedule.

Although this data is now available, it has not yet been scrutinized. It is a step in the right direction; however, it is impossible to determine the scope and consequences that may result from shedding light on this distinction. Initial figures by the Congressional Budget Office indicate that the physicians Medicare fee schedule amounted to only $70 billion in 2014,[54] as compared to $262 billion for overall Part B costs.[55] Moreover, Part B expenditures are projected to increase by 12% to $295 billion in 2017, while the physician fee schedule is projected to decrease by 11% during that same span.[56] The accurate reporting of the Medicare Part B cost breakdown will allow a better and more complete understanding of the magnitude and burden that the pharmaceutical industry places on the PHC. In addition, it illustrates that

48. *See* TABLE 9.9 SERVICES, SUBMITTED AND ALLOWED CHARGES, AND PROGRAM PAYMENTS FOR MEDICARE PHYSICIAN AND SUPPLIER SERVICES, BY LEADING HCPCS CODES: CALENDAR YEAR 2012 (2013), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/Downloads/2013_Table9_9.pdf?agree=yes&next=Accept [hereinafter TABLE 9.9].

49. *Physician and Other Supplier Data*, CTR. FOR MEDICARE & MEDICAID SERVICES [hereinafter *Other Supplier Data*], https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier2013.html (last updated Dec. 20, 2016, 2:05 PM).

50. *New Medicare Data*, *supra* note 14.

51. *See* TABLE 9.9, *supra* note 48; *Other Supplier Data*, *supra* note 49.

52. *See New Medicare Data*, *supra* note 14.

53. *See id.*

54. *March 2015 Medicare Baseline*, CONG. BUDGET'S OFF. (Mar. 9, 2015) [hereinafter *March Medicare Baseline*], https://www.cbo.gov/sites/default/files/recurringdata/51302-2015-03-medicare.pdf.

55. *Id.*

56. *Id.*

physician reimbursement is not growing in relation to the overall PHC. The percentage of Part B expenses that go directly to the pharmaceutical industry is, in addition to payments under Medicare Part D, the major federal drug assistance program.

II. THE COST OF DRUGS AND THE PHARMACEUTICAL INDUSTRY

A. MEDICARE PART D

In addition to the discrepancy between physician services and drug reimbursement figures, the Medicare drug reimbursement program, known as Medicare Part D, represents a massive expense for the federal government.[57] Congress enacted Medicare Part D to help beneficiaries pay for prescription drugs, such as those prescribed by physicians but not administered in practice settings.[58] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 created the Medicare Part D program.[59]

Medicare Part D has become an essential aspect of the Medicare system, greatly alleviating the cost of drugs to Medicare beneficiaries. However, instead of enacting a fair program that allows CMS to negotiate drug prices, Medicare Part D provides the pharmaceutical industry with guaranteed profits.[60] One of the most concerning provisions of this legislation, called the "no interference" clause,[61] eliminated the power of CMS to set prices or negotiate with pharmaceutical companies.[62] As a result, the United States government pays full retail price for pharmaceutical drugs under Medicare Part D; "nearly twice as high per person spending" compared to other industrialized countries.[63]

57. "The dataset describes the specific medications prescribed and statistics on their utilization and costs. It provides data on more than one million distinct health care providers who collectively prescribed $103 billion in prescription drugs under the Part D program." *Prescriber-Level Medicare Data*, *supra* note 45.

58. 42 U.S.C. § 1395w-111 (2012).

59. *Id*.

60. *See* BAKER, *supra* note 2.

61. Channick, *supra* note 24, at 253 n.88.

62. "Reimbursement for Medicare Part D is not based on the prices for pharmaceuticals set by CMS. In fact, one of the most contentious pieces of the MMA is its direct prohibition of administered pricing or even negotiations of drug pricing by the director of CMS or the Secretary of HHS." Channick, *supra* note 24, at 253.

63. *See* BAKER, *supra* note 2.

B. PRESCRIPTION DRUG COSTS AND THE NO-INTERFERENCE CLAUSE

Although President Obama attempted to rectify[64] this legislation, his administration received considerable pushback from Congress.[65] The rationale behind the "no interference" clause is devoid of logic—other federal programs and agencies, such as Medicaid and the Veterans Benefits Administration, are able to negotiate and pay nearly *half* the amount the federal government does for the same medication under Medicare.[66] This statutory removal of bargaining power was, and still is, a boon for the pharmaceutical industry, allowing the corporate and profit-driven entities to set their own prices, with no ability for competitive market forces to combat these corporate interests.[67]

Congress has effectively guaranteed retail profits for drugs to pharmaceutical companies, with little or nothing in return.[68] The lack of negotiating power leaves the government at the mercy of pharmaceutical companies. With no protection from the market, annual Medicare retail prescription drug expenditures increased by 10.7% in 2013, compared with a .5% *decrease* in those same expenditures by private health insurance.[69] These drug expenditures consume a larger portion of the scarce Medicare resources, decreasing the amount of reimbursement available for actual patient services, such as preventative screenings.

The pharmaceutical industry's profit windfall since the enactment of Medicare Part D has helped fuel the massive wave of consolidation in the healthcare industry.[70] In 2016, industry leaders Pfizer and Allergan attempted a $160 billion merger, following the merger of Allergan and Actavis earlier that year.[71] Another alarming trend has been the substantial increase in

64. *See* Morgan, *supra* note 20 (explaining that President Obama acknowledged the rising cost of Part D drugs, and its increased burden on the Medicare budget. This was in response to a pharmaceutical company charging $84,000 for a single dose of an essential hepatitis drug).

65. *Id*.

66. Channick, *supra* note 24, at 253; *see also* Tami Luhby, *Here's One Fix for High Drug Prices*, CNN MONEY (Sept. 28, 2015, 9:41 AM), http://money.cnn.com/2015/09/28/news/economy/medicare-drug-prices.

67. *See* Morgan, *supra* note 20.

68. Channick, *supra* note 24, at 253.

69. *Retail Prescription Drug Expenditures; Levels, Percent Change, and Percent Distribution, by Source of Funds*, NAT'L HEALTH EXPENDITURE ACCOUNTS, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html (last updated Dec. 6, 2016, 8:00 AM).

70. Paul R. La Monica, *Health Care Mergers Are Out of Control*, CNN MONEY (Oct. 29, 2015, 1:34 PM), http://money.cnn.com/2015/10/29/investing/health-care-mergers-pfizer-allergan/index.html?iid=EL.

71. *Id.*

pharmaceutical industry CEO salaries.[72] Such salaries have increased two-and-a-half fold since 2004, from a total of roughly $75 million to nearly $200 million, including a $58 million jump during the first year that Medicare Part D was enacted.[73] This alarming trend reinforces the fact that the pharmaceutical industry is making record profits at the expense of the taxpayers.

If the federal government were allowed to negotiate drug prices and pay rates similar to those of other industrialized nations, the United States would save an estimated $541.3 billion over the next ten years.[74] In addition, beneficiaries would save $112.4 billion and state governments would save another $72.7 billion over that same period.[75] These staggering figures seem titanic in relation to physician reimbursement.[76] The savings from drug costs amount to nearly 80% of physician reimbursement over the same ten-year span.[77]

If just a fraction of this amount is instead reallocated to increase physician reimbursement, it may reverse the current trend and allow physicians to remain in private practice. Moreover, allowing the federal government to exercise its immense bargaining power would require drug manufacturers to maintain some semblance of price predictability, shielding sick patients from CEOs who can, for example, decide on a whim to increase the price of essential cancer and AIDS medications by 5,500% overnight.[78] Just in the past year, Mylan, the producer of the emergency anaphylaxis treatment, EpiPen, increased the cost of this product by over 500%.[79] The "no interference" clause invites such tactics by effectively disarming the government's ability to negotiate drug prices, and patients who can no longer afford to pay for lifesaving treatment are feeling the consequences.

Repealing the "no-interference" clause does not necessarily require the pharmaceutical industry to take a global economic loss. The United States should not be in the business of inhibiting or deterring the research and development of life-saving drugs. However, neither should it be in the

72. Ethan Rome, *Big Pharma CEOs Rake in $1.57 Billion in Pay*, HUFFINGTON POST (May 8, 2013, 8:19 AM) http://www.huffingtonpost.com/ethan-rome/big-pharma-ceo-pay_b_3236641.html.

73. *Id.*

74. *See* BAKER, *supra* note 2.

75. *Id.*

76. *March Medicare Baseline, supra* note 54.

77. *Id.*

78. Paul R. La Monica, *Martin Shkreli Quits as Turing CEO*, CNN MONEY (Dec. 18, 2015, 12:56 PM), http://money.cnn.com/2015/12/18/investing/martin-shkreli-arrest-turing-kalobios/ (Martin Shkreli, CEO of Turing Pharmaceuticals, bought the rights to the drug Daraprim, a drug used to alleviate the most debilitating symptoms of cancer and AIDS. Turing promptly increased the price of each pill from $13.50 to $750. With no generic alternative, Turing was able to price gouge Medicare for this necessary medication.)

79. *Epipen Makers to Pay Massive $465 Million Fine for Ripping Off Medicaid Over the Lifesaving Device*, DAILY NEWS, http://www.nydailynews.com/life-style/health/epipen-makers-pay-465-million-fine-ripping-medicaid-article-1.2822016 (last visited Jan. 1, 2017).

business of subsidizing the cost of drugs for foreign governments. Ideally, the outcome will merely shift the United States' disproportionate financial burden back to developed nations, who should be paying at least the same amount. This simple solution is an attempt at evening the playing field by restoring the government's ability fairly participate in the market place.

III. CORPORATE INFLUENCE

The American Medical Association (AMA) promulgated the Corporate Practice of Medicine Doctrine (the Doctrine) in 1934[80] to protect physician autonomy and dictate patient care by prohibiting corporate interests from interfering with medical judgments.[81] The Doctrine inevitably led to a healthcare model dominated by physician-owned private practices, supplemented with voluntary hospital privileges.[82] However, in light of the systemic problems that physicians face, their ability to maintain private practices is dwindling. Physicians are turning away from private practice in favor of hospital employment at an alarming rate.[83] This is due in large part to administrative burdens,[84] financial infeasibility,[85] and career dissatisfaction.[86]

Physicians' pay has essentially remained flat, averaging a 0.7% annual increase between 2003 and 2014.[87] One popular alternative is for physicians to join hospital staffs as attending physicians.[88] This trend carries a heavy burden—physicians are increasingly dissatisfied with their profession and work-life balance.[89] Given that physicians endure over ten years of post-secondary education and training and are the sole professionals qualified to deliver healthcare, it is concerning that the professional outlook is so bleak.[90]

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80. *See* MILONE, *supra* note 7.

81. *Id.* The Doctrine began as banning any entity other than a physician from owning a medical practice. *Id.*

82. Casalino et. al., *supra* note 12.

83. *See* Charles et. al., *supra* note 6, at 323–28 (physician self-employment dropped from 48% in 2001 to 33% in 2009).

84. Tait D. Shanafelt et al., *Burnout and Satisfaction with Work-Life Balance Among US Physicians Relative to the General US Population*, 172 JAMA INTERNAL MED. 1377, 1384 (2012).

85. MILONE, *supra* note 7.

86. Liselotte N. Dyrbye, et al., *Physician Satisfaction and Burnout at Different Career Stages*, MAYO CLINIC, Dec. 2013, at 1358–67.

87. *Actually, The SGR Has Slowed Health Care Cost Growth,* COMM. FOR A RESPONSIBLE FED. BUDGET (Mar. 13, 2014), http://crfb.org/blogs/actually-sgr-has-slowed-health-care-cost-growth.

88. Gardiner Harris, *More Doctors Giving Up Private Practices*, N.Y. TIMES (Mar. 25, 2010), http://www.nytimes.com/2010/03/26/health/policy/26docs.html?_r=1.

89. Shanafelt et al., *supra* note 84, at 1377.

90. *Id.*

A. HOSPITALS

Hospitals cost the United States $936.9 billion in 2013.[91] This figure represents an increase; hospitals were paid $882 billion in 2012, which was 5.4% of GPD.[92] The 2013 figure includes the $239 billion Medicare paid hospitals, which was 44.6% of total Medicare expenditures.[93] In comparison, $730 billion was spent on social security and $650 billion was spent on national defense that same year.[94] These figures do not include the cost of physician care—they only include the cost of administration, drug prices, and hospital upkeep.[95]

The increasing prevalence of hospital systems is the direct result of financial incentives created to further that purpose.[96] Prior to the 1980's, hospitals both expanded in size and grew in number due to many factors.[97] The most prominent factor was Congress' willingness to essentially guarantee profits with federal funds; hospitals billed Medicare for costs *plus* a percentage on the top intended for capital expenditures and growth.[98] Congress finally recognized this issue and changed the reimbursement methods. However, the proliferation of hospital expansion ensured hospitals' role in the healthcare system moving forward.

More indicative of the preference for hospitals over physician treatment is that CMS pays hospitals much more than it pays independent physicians for the same procedures. [99] For example, a colonoscopy procedure is reimbursed at a rate of $1,383 for hospitals, but only $625 for physicians.[100] This discrepancy is far reaching, including physical therapy services,

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91. TABLE 2 NAT'L HEALTH EXPENDITURES; AGGREGATE, ANNUAL PERCENT CHANGE, PERCENT DISTRIBUTION AND PER CAPITA AMOUNTS, BY TYPE OF EXPENDITURE, CTR. FOR MEDICARE & MEDICAID SERVICES (June 1, 2015) [hereinafter TABLE 2], https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html.

92. TABLE 1.3 GROSS DOMESTIC PRODUCT (GDP), TOTAL PERSONAL HEALTH CARE (PHC) EXPENDITURES, HOSPITAL PHC, TOTAL MEDICARE PHC, AND MEDICARE HOSPITAL PHC: SELECTED CALENDAR YEARS 1960-2012, (Oct. 1, 2015),https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaid StatSupp/Downloads/2013_Section1.pdf#Table1.3.

93. *Id.*

94. *See* EMANUEL, *supra* note 3, at 18.

95. TABLE 2, *supra* note 91.

96. James D. Reschovksy & Chapin White, *Location, Location, Location: Hospital Outpatient Prices Much Higher than Community Settings for Identical Services*, NAT'L INST. FOR HEALTH CARE REFORM, Research Brief No. 16, at 1 (June 2014).

97. *See generally* EMANUEL, *supra* note 3.

98. *Id.*

99. Reschovksy & White, *supra* note 96, at 3.

100. *Id.* at 2 ("Price comparisons are based on claims data for 16,566 colonoscopies with complete and clear information about the site of service—9,782 conducted in HOPDs and 6,784 in community settings.").

imaging services, and preventative screening tests.[101] Procedures are often paid at double, or even triple, to hospitals, with simply no justification.[102]

Hospitals are also becoming more economically unfeasible as the cost of care rises, considering the costs associated with the academic teaching aspects of hospitals, in addition to the large increase in staff positions as a result of failing private practices.[103] Physician-owned medical practices have decreased from 70% of overall private practices in 2002 to less than 50% in 2008.[104] During that same period, hospital-owned medical practices increased from 22% to over 55%.[105] The effects on the marketplace of the consolidation of medical care into large, unchecked hospitals have already shown to increase prices with less competition.[106] For example, hospital prices for a routine colonoscopy have between four to ten times,[107] with no correlation other than hospital market consolidation.[108] This trend is present in nearly all markets where hospital consolidation is present, and further reinforces the fact that less market competition inevitably leads to increased prices for consumers and the federal government.[109]

An even graver consequence of this consolidation is the uncertain economic outlook for physicians, which removes their ability to dictate care. A shift from static salaries to incentive or volume-based payment incentivizes physicians to treat as many patients as possible, with less regard for the actual care rendered.[110] This is a direct attack on physicians' ability to dictate patient care in favor of a corporation's ability to stay profitable.[111]

This shift has not even proven to be profitable for hospitals.[112] Due to administrative costs and other overhead expenses, hospitals actually *lose* $150,000 to $250,000 annually for the first three years after hiring a physician for a staff position (as opposed to an independent doctor with admitting privileges).[113] This further lends to the notion that physicians

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101. *See id.* at 3.

102. *Id.*

103. *See* EMANUEL, *supra* note 3, 18–36.

104. Robert Kocher & Nikhil R. Sahni, *Hospitals' Race to Employ Physicians—The Logic Behind a Money-Losing Proposition*, 364 NEW ENG. J. MED. 1790, 1791 (2011).

105. *Id.*

106. Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation*, ROBERT WOOD JOHNSON FOUND. (June 2012), http://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html; Kocher & Sahni, *supra* note 104, at 1791.

107. John Carreyrou, *Nonprofit Hospitals Flex Pricing Power: In Roanoke, Va., Carilion's Fees Exceed Those of Competitors: The $4,727 Colonoscopy*, WALL ST. J. (Aug. 28, 2008, 12:01 AM), https://www.wsj.com/articles/SB121986172394776997.

108. Gaynor & Town, *supra* note 106.

109. *Id.*

110. Kocher & Shani, *supra* note 104, at 1792 ("Although some physicians may not want to trade autonomy for employment, they must understand that hospitals are under pressure to implement cost-saving strategies, which may benefit consumers if savings are passed on through lower prices.").

111. Casalino et al., *supra* note 12, at 1308, 1312.

112. *See* Kocher & Sahni, *supra* note 104, at 1790.

113. *Id.*

fleeing to hospital staffs are not solving the financial problems of the healthcare industry, and in fact may be increasing overall PHC. It is evident that shifting to a hospital-based healthcare system will not be helpful in accomplishing a sustainable PHC.

The designers of the Medicare system must realize that centralizing and consolidating hospital systems run counter to the intentions of lowering costs and improving the quality of care. By removing the discrepancy between hospital and physician reimbursement rates, which only exists under the false pretense that hospitals have an increased administrative burden,[114] hospitals would have to prioritize the types of patients and procedures they will accept. This falls in line with the traditional notions of what types of services hospitals were intended to provide, while leaving the majority of healthcare to be administered by physicians in a private-practice setting.[115]

B. THE INSURANCE INDUSTRY

In addition to Medicare and Medicaid, private health insurance is a huge player in the total PHC. Although many of our European counterparts have shifted towards a one-payer system, where the federal government acts as a universal health insurer, the Patient Protection and Affordable Care Act of 2010[116] actually improved private insurances' financial position. When health insurance was at its infancy, President Roosevelt explicitly stated that any insurance that paid for physician services (as opposed to hospital services) should not interfere with physicians' ability to determine patient care, stating, "no third party should come between physician and patients, and the medical profession should control medical practice."[117] However, it was impossible to imagine the industry that health insurance would become in the modern world. A series of depression-era pieces of legislation, specifically the Stabilization Act of 1942,[118] established that insurance benefits to employees were not to be considered "income" for tax purposes.

In 1954, a tax exclusion codified this concept; it "explicitly stated that the monetary value of health insurance employers sponsored was not part of the workers' income . . . ."[119] That exclusion, in conjunction with unions gaining the ability to negotiate health insurance with employers,[120] created a

114. If the administrative costs are indeed higher, it only lends to the notion of avoiding these costs. By allowing the administrative behemoth to continue to grow by giving it more resources, Medicare is propping up a system that is *less* financially feasible.

115. Casalino et. al., *supra* note 12, at 1307–08.

116. *See generally* Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended at 42 U.S.C. § 18001 (2012)); Rice et al., *supra* note 5.

117. *See* Stabilization Act of 1942, Pub. L. No. 77-729, 56 Stat. 765 (1942) (codified as amended at 50 U.S.C. §§ 961–71); EMANUEL, *supra* note 3, at 29.

118. *See generally* Stabilization Act of 1942, Pub. L. No. 77-729, 56 Stat. 765 (1942) (codified as amended at 50 U.S.C. §§ 961–71).

119. EMANUEL, *supra* note 3, at 31.

120. *Id.* ("[I]n 1949 the National Labor Relations Board ruled in the famous Inland Steel Company case that unions, as part of their negotiations for wages, could negotiate for fringe benefits

huge incentive to acquire private insurance, due to the fact that a dollar spent by an employer and received by an employee was a tax-free benefit.[121] This led to the proliferation of health insurance across the country.[122] As a result, there was an increasing need to broaden the insurance pool so that the premiums paid by healthy individuals could offset the cost that sick individuals imposed in requiring constant care and medication.[123] To help illustrate this point, "[t]he 5 percent of the population with higher health care expenses (greater than $ 18,086 annually) was responsible for half (49.5 percent) of total health care spending, whereas the 50 percent of the population with the lowest expenses (less than $829) accounted for only 2.7 percent of total spending."[124] The increased availability of insurance has created the tendency for hypochondria, or illness anxiety disorder.[125] Essentially, the abundance of insurance, combined with the desire to use what you pay for, enables hypochondriacs to seek medical care and an abundance of preventative screenings, increasing the cost of overall PHC. Another term for this is "adverse selection," a process that leads to a feedback loop of increasing costs for the ill. This further de-incentivizes healthy individuals from purchasing coverage, leading to even higher premiums.[126]

What sets the United States apart from other industrialized countries is the use of private insurance companies, who act as middlemen between the government, beneficiaries, and physicians.[127] Medicare supplements are mandated to spend at least 80% of their net revenue on reimbursements.[128] This figure is taken after administrative and corporate costs, including often-exorbitant salaries for officers and directors.[129] Health insurance is, at its most fundamental level, a large administrative agency.[130] The industry acts as a contractor for the federal government; Congress delegated the administration

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like health insurance. The US Supreme Court affirmed this ruling, thereby encouraging unions to demand employer-sponsored health insurance.").

121. *See id*.

122. Rice et al., *supra* note 5.

123. 42 U.S.C. § 18091(2)(J) ("By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums.").

124. *See* EMANUEL, *supra* note 3, at 38.

125. *Illness Anxiety Disorder,* THE MAYO CLINIC (July 2, 2015), http://www.mayoclinic.org/diseases-conditions/illness-anxiety-disorder/basics/definition/con-20124064; EMANUEL, *supra* note 3, at 42.

126. EMANUEL, *supra* note 3, at 42.

127. Katherine Swartz, *Justifying Government as the Backstop in Health Insurance Markets*, 2 *YALE J. HEALTH POL'Y L. & ETHICS 89, 91* (2002).

128. *Rate Review & the 80/20 Rule*, HEALTHCARE [hereinafter *The 80/20 Rule*], https://www.healthcare.gov/health-care-law-protections/rate-review/ (last visited Feb. 21, 2017).

129. *Id.*

130. *See generally* Janet L. Dolgin, *Unhealthy Determinations: Controlling "Medical Necessity,"* 22 VA. J. SOC. POL'Y & L. 435 (2015); *see also* Timothy P. Blanchard, "*Medical Necessity" Determinations—A Continuing Healthcare Policy Problem,* 37 J. HEALTH L. 599 (2004).

of Medicare and Medicaid to private insurers, instead of handling the claims and billing in-house.[131] This middleman position between physicians, patients, and the government empowered the insurance industry to value its profits over the welfare of its beneficiaries. Although eliminating the "big insurance" industry altogether might be unrealistic, requiring a higher pay-floor, such as 90%, or legislating stricter regulations and government oversight, could provide the necessary financial relief necessary.

IV. RISING OVERHEAD COSTS

As physician reimbursement stagnates, the cost of running a private practice continues to rise. In addition to ordinary business insurance, physicians must also pay premiums for malpractice insurance, which has no benefit floor.[132] Some physicians pay over $100,000 annually in malpractice insurance, while nearly 80% of malpractice claims are considered frivolous.[133] In addition, 5% of physicians will face a malpractice claim annually, even in light of the majority of these suits being considered frivolous.[134] Specialists, such as neurosurgeons, face a 19.1% malpractice rate annually.[135] These factors indicate how great the insurance companies control of the healthcare industry is and how much they can profit off the top.

Physicians bill Medicare with a coding system, called the International Classification of Diseases (ICD), which was reworked in 2015.[136] This complex system often requires the hiring of administrative employees, whose sole purpose is to navigate this complex coding and reimbursement system.[137] The newly instituted ICD-10-CM codes are estimated to increase physicians' billing costs by nearly 300%.[138] The mandatory transition from the ICD-9-CM coding to the ICD-10-CM coding, effective October 1, 2015, required physicians to utilize approximately 68,000 different codes, compared to 13,000 ICD-9-CM codes, for the exact same number of diagnoses.[139] Every procedure performed by a physician or other healthcare worker (e.g., nurses,

131. *See* Dolgin, *supra* note 130, at 443–44; *see* Blanchard, *supra* note 130, at 606, 611.

132. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of The Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 4, 245 (1991).

133. EMANUEL, *supra* note 3, at 121.

134. Kimon Bekelis & Symeon Missios, *The Practice of Cranial Neurosurgery and the Malpractice Liability Environment in the United States*, PLOS ONE, Mar. 2015, at 2.

135. *Id.*

136. AM. MED. ASS'N, PREPARING FOR THE ICD-10 CODE SET (2014), https://www.unitypoint.org/waterloo/filesimages/for%20providers/icd9-icd10-differences.pdf [hereinafter PREPARING FOR THE ICD-10].

137. Dan Mangan, *Docs Face "Crushing" Costs from Diagnosis Code Switch, AMA Says,* FUNDAMENTAL REFOUNDING (Feb. 12, 2014, 7:08 PM), http://fundamentalrefounding.ning.com/forum/topics/doctors-face-crushing-costs-from-diagnosis-code-switch-ama-says?xg_source=activity.

138. *Id.*

139. *See* PREPARING FOR THE ICD-10, *supra* note 136.

physical therapists, physician assistants) must be translated into a unique ICD code.[140]

Independent of the merits of this recent change, the increased cost of billing should be reflected in physician reimbursement rates. The inability to navigate this expansive new coding system may render a physician unable to receive Medicare reimbursements.[141] Changes in technology are inevitable; however, to place this burden solely on physicians is unreasonable—it should instead be supplemented with tax incentives or payments from other areas of healthcare, such as insurance companies or Medicare.

Similarly, the introduction of Electronic Health Records (EHR) places an additional financial burden on physicians.[142] Physicians are required to adopt EHR for handling patient records, in order to streamline data and theoretically secure Protected Health Information (PHI) from unauthorized access and misuse.[143] Failure to transfer from traditional record keeping to EHR triggers mandatory reimbursement decreases for Medicare.[144] This deduction can range from 1-3% across the board annually.[145] It is seemingly unfair—the government imposes these technological requirements on physicians with little or no reimbursement for the substantial cost, in both time and money, and expects them to be able to survive on their own, with no increase in reimbursement rates that could help cover it.

The average cost to implement EHR was $44,000 in 2005, with an estimated $8,500 in annual maintenance costs.[146] Those figures do not take into account the additional hours physicians worked to learn the system.[147] The "incentive" to transition to EHR will only reimburse physicians up to a maximum of $8,500 annually for five years.[148]

Thus, physicians must now employ individuals for billing, coding, and record keeping.[149] A physician must hire, on average, five additional

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140. *See* Mangan, *supra* note 137.

141. *Id*.

142. *See generally* Robert H. Miller et al., *The Value of Electronic Health Records in Solo or Small Group Practices*, 24 HEALTH AFF. 1127 (2005).

143. *See generally id.*; *see also* Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models, 60 Fed. Reg. 77,008, 77,219 (proposed Nov. 4, 2016) (to be codified 42 C.F.R. pts. 414, 495).

144. CONGRESSIONAL BUDGET OFFICE: COST ESTIMATE, S. 1347 ELECTRONIC HEALTH FAIRNESS ACT OF 2015 (2015), https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/s1347_0.pdf.

145. *Id.*

146. Miller et al., *supra* note 142, at 1127.

147. *Id.* at 1127.

148. CTR. FOR MEDICARE & MEDICAID SERVS., MEDICAID ELECTRONIC HEALTH RECORD INCENTIVE PAYMENTS FOR ELIGIBLE PROFESSIONALS (2013), https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MLN_MedicaidEHRProgram_TipSheet_EP.pdf.

149. Carol Peckham, *Clinical and Office Staff Salary Report 2015*, MEDSCAPE (Oct. 28, 2015), http://www.medscape.com/features/slideshow/public/staff-salary-report-2015#page=4.

employees for each office, just in order to comply with the new coding and record keeping responsibilities.[150] This is in addition to receptionists and any allied health workers[151] the office employs.[152] Although Congress and Medicare imposed these complicated and gratuitous requirements, physician reimbursement rates have not reflected this change. This is a perfect example of Congress not doing enough to ensure a reasonable transition for physicians, but instead creating new law without paying for it.

CONCLUSION

Physicians should not have to bear the burden of healthcare reform on their own. In light of CMS' greater transparency through data reporting, it is apparent that physicians are reimbursed for much less than 5% of PHC.[153] The Medicare program must be revamped in order to achieve sustainable and predictable healthcare costs, and it can be achieved by cutting excess spending.

The "no interference" clause of Medicare Part D[154] should be amended to allow the Department of Health and Human Services and CMS to negotiate with pharmaceutical companies. The government already does this on a regular basis in other industries, and to have an absolute bar to negotiation costs the United States billions of dollars annually.[155] The potential savings will remove the need to continue freezing or reducing physicians' reimbursements, which will allow physicians to continue in private practice.

In addition, the continued prevalence of insurance companies throughout the process is a product of limited resources. By passing off the administrative headache to insurance companies, the federal government is subsidizing the middlemen, allowing them to profit 20% of net revenue for simply connecting physicians and patients.[156] Raising the minimum expenditure, or pay floor, from 80% to 90%, can help provide the necessary financial relief.

Hospital expansion and consolidation reduces competition and adds increased corporate influence over the delivery of healthcare. Instead of incentivizing the hospital setting by reimbursing procedures at double or often triple the rate of physician reimbursement, the rates should be the same. Physicians' overhead and administrative costs are increasing at least at the same rate, and therefore there is little to no justification for the reimbursement disparity. As a result of the ever-rising healthcare costs, due in large part to excessive pharmaceutical and insurance spending, physicians have less

150. *Id.*
151. This includes physician assistants, nurses, and registered nurses.
152. Peckham, *supra* note 149.
153. TABLE 1.2, *supra* note 39.
154. 42 U.S.C. § 1395w-111 (2012).
155. Luhby, *supra* note 66.
156. *The 80/20 Rule*, *supra* note 128.

control over the practice of medicine. Further, by improving reimbursement, physicians can spend more time per patient and improve the quality of care they provide. This problem can be addressed by finding ways to cut spending, by allowing the government to negotiate a reduction in drug prices, and by implementing tighter regulatory control over insurance companies.

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