Reimagining Healthcare: The Personal Option Webinar Transcript

Christian Stellakis 00:18
Thank you all for carving time out of your busy schedules to join us this Wednesday. I know how valuable your time is. So I appreciate everybody being here. I want to give folks a minute or two to hop on. So before we go ahead and kick things off, I wanted to set the stage a little bit for this webinar. We all know our healthcare system doesn't work for everybody. It's confusing. It's expensive, and it's driven by large systems that can make people feel helpless. And despite what you might hear, more government intervention won't fix things. It's only making things worse. So, the big question is this: how do we make things better? And we thought it made sense to hear directly from healthcare professionals on the frontlines of care. For those who don't know me, my name is Christian Stellakis, and I am the Director of Media and Public Relations here at the Commonwealth Foundation. I'm joined today by a fantastic group of healthcare experts to discuss the current state of Pennsylvania healthcare, and our vision for the future. For everybody's awareness, my comments as well as the panelists involved in today's webinar all are on the record and can be used in your stories. Now, with that out of the way, allow me to introduce our panelists. First, Dr. Kimberly Corba is a practicing physician and family medicine specialist. Dr. Corba, can you give us a brief overview of your background and your expertise?

Dr. Kimberly Corba 02:03
Thank you for having me. This is going to be a great webinar, a lot of hot topics. I have been in practice for 27 years have been—and still board certified all 27 years, and have my own solo private practice that is 21 years old. I took insurance for 13 years, but 10 years, I'm sorry, 12 years and 10 years ago, I decided to stop participating with insurance and switched my model my payment model in the office to direct primary care. I've been in the same location for 21 years, I grew up in this area and trained in Philadelphia, but moved back. So it's been very rewarding to get back to my hometown and take care of my community.

Christian Stellakis 02:54
Awesome, thank you for that. Up next, Dallas Riley is a registered nurse practitioner and the owner of Hall and Riley Comprehensive Health Care. Dallas, can you tell us a little bit more about yourself?

Dallas Riley 03:14
Sure, um, I am born and raised in a small town called Melville, Pennsylvania. After grad school and certifying as a nurse practitioner, I started working for the Berwick Hospital Center, which subsequently closed in 2022 without any warning. My business partner and I started our primary care practice, about 10,000 patients were left without health care. So we kind of pulled up our bootstraps and started our own primary care clinic. We opened our second clinic a few months later and have grown to about 3500 clients

at this point, we do take insurance. And, you know, I'm here to kind of talk about the limitations of how that's affected us and our clients. And, you know, happy to be here.

Christian Stellakis 04:00
We're happy that you're here as well. And our last—and our last panelist today is Elizabeth Stelle, our Director of Policy Analysis here at the Commonwealth Foundation. She's the brains behind much of the research into the issues like healthcare that we conduct. Elizabeth, would you like to introduce yourself?

Elizabeth Stelle 04:19
I'm happy to be here today to speak to you a little bit about some of the state level policy changes we can make in health care. You know, we've been looking at these issues for a long time. And I think there's a misunderstanding that healthcare is all federal now and there's nothing at the states can do. But there's actually a lot of things that Pennsylvania could do to make health care more accessible and more affordable. So I'm excited to talk a little bit about those reforms and to have folks on the front lines as well to talk about about you know, the theory and how it's actually applied in practice, and give you all I think a more comprehensive understanding of where our system is and where it should be moving in the future.

Christian Stellakis 05:04
So we're going to be hearing from each of these panelists today. And they're going to be providing their unique perspectives about the issues facing our healthcare system, and what Pennsylvania lawmakers can do to solve these problems. We're also planning on taking Q&A at the end of the call today. So you can submit your questions at the—by using the Q&A function on Zoom. Feel free to submit those questions throughout today's call. And we'll go ahead and read those out and answer those at the end, you should be able to find the Q&A function at the bottom bar of your Zoom window. And so one other thing, just as a reminder, all of our remarks today, including the remarks of our panelists are all on the record and can be used with your stories. So with that, I'd love to go ahead and get the ball rolling. Let's start with a broad question to all of our panelists. What do you see as the major problems or challenges facing our healthcare system that need to be addressed?

Dr. Kimberly Corba 06:17
Who would you like to go first? Would you like me to go first?

Christian Stellakis 06:22
Yeah, Dr. Corba, take it away.

Dr. Kimberly Corba 06:25
Well, having made the switch from the insurance based model to direct primary care for the physician side, we can talk about those issues, but I want to talk about the patients. And when they come to seek out an alternative form of primary care, like direct primary care, I hear all of their complaints. And we all know, the cost is number one, access is number two, and attention is number three, those are the top three complaints cost to access getting an appointment in a timely manner, seeing the same, or a few of the same providers is always an issue. They like to see the same providers, and they're not they're not getting

to see this, there's their—their favorites. And then the, the attention, the visits are short, and they tell me that they feel like they're rushing out the door. So they're paying a lot of money for services that they're not really not happy with.

Dallas Riley 07:26
I would absolutely agree with that. Those are the top complaints that I hear in my practice, while access, the biggest limitation, as I stated, you know, our local hospital closed down and with that a lot of the providers had left, and there's only four of us left to serve, you know, our local area. In some of the bigger institutions, you know, continuity of care is a big problem, because, like Dr. Corba said is, you know, patients are kind of shuffled to whatever provider that's available for the timeframe that they've seen, they're very rarely seen by the same person. And I think that patients are seeking kind of more natural treatments, which causes you know, I mean, maybe not for you, Dr. Corba, but with your direct primary care, but for reimbursement purposes and stuff, it's really hard to treat patients the way they want to be treated based on the guidelines that are kind of forced upon us as providers.

Dr. Kimberly Corba 08:29
I would agree with that. 100%. And, you know, I'm in an area here that saturated with two large hospital systems. And I was, I was sad to hear that Berwick hospital closed. So it was still one of those small community hospitals. But even here with the saturated area, the the you know, time getting an appointment can be very difficult, especially with primary care. And then the patients end up in urgent care, or the ER when 80% of what get walks into the ER and the urgent care can be handled by good primary care access, that drives up the cost. And then, and that's fractionated care. I, you know, I will add that with the amount of providers in these large practices, like Dallas mentioned, there, the continuity is not there. When the there's sign out is not there that, you know, there's there's fractionation and care things get missed and not on purpose, just that they're moving so fast, and it's hard to get to know a patient when you walk in for the first time if they have 10 medical problems. So we I do see in patients sense that the patient's sense that fractionation they're looking for, for home base, somebody who really knows who they are and knows their problems.

Elizabeth Stelle 09:53
Yeah, and I think you can see that partially manifested by sort of the attitude of government on how to Solve the access problem. And the way we've tried to solve it for the past, at least 15 years, say, Well, if everybody has insurance, then then we're good. Everybody has access to care. But it's very clear that insurance is not the same as access to care, you know, a card is not care. And so just because you have an insurance card doesn't necessarily mean the patient is going to be able to get the care they need when they need it, how they want it. And so that's why we've talked about our slate of reforms as the personal option, because it's really about personalizing healthcare. Again, it's about allowing providers to build those personal relationships, continuity of care, everything that that's being said here, is really what's driving our reforms. And it's really designed to make sure that the patient becomes the center of care again, and not the payment model, or some of the other competing priorities. Because when you look at resistance to reforms at the state level, or the federal level, it always boils down to how providers get paid. So like Christian said, when you have more government intrusion involvement, you have more focus shifted away

from the patient, and to the payment systems. So there's a lot of things that Christian is going to bring up in this call. But it all, it all goes back to that principle of patient first expanding access to care, not just access to insurance.

Dr. Kimberly Corba 11:26
If I can add something, it's not just about the how the providers get paid, spent all the layers in between the patient and the provider, and all of the that money that's going to various entities that are smack in the middle. And you know that that's why I'm doing what I do. We got rid of the third, you know, the third party in the room, it's just between me and the patient now, but there are so many places where the money is just flowing, and it's not flowing back to lower premiums for patients.

Christian Stellakis 11:56
And so, Elizabeth, one of the common things that we would hear from a more big government advocate, somebody that wants more government involvement in the healthcare system will go along the lines of something like this: they would say, while the Affordable Care Act has had some bumps along the road, well, it did lead to millions more Americans gaining health care coverage, through Medicaid expansion and subsidies, they're probably asked, aren't people better off with at least some kind of insurance? Even if it's government provided Medicare rather than going uninsured? What would you—how would you respond to that?

Elizabeth Stelle 12:36
So I think the best way to look at how valuable is that insurance coverage is to ask the patients themselves, how much do they value it. And what you find is that patients either number one don't even know they're enrolled in Medicaid, which I mean, this this was shocking. This came out. I think, in May a study that found 1/3 of Americans who were enrolled in Medicaid, didn't even know they had that coverage. So they weren't using it. Many of them were double insured, they had an employer insurance at the same time, they had Medicaid coverage, because of all the turmoil from the pandemic. So it really tells you that that form of insurance isn't valued by patients. So what is you know, what, what's the sort of form of insurance that people want when they have a choice? And so I would reframe the conversation again, it's not about are you insured? And what is your plan? Like it's about can you can access care in a timely way, in an efficient way and the way that you want to be seen, and that's really where we have to get away from this idea that it's all about, you know, insurance, insurance, insurance. And it's more about how much care is the patient using where are they encountering providers? And how can we empower the patients? Because right now, especially if you are, you know, a Medicaid patient, you don't have a lot of leverage, right? You're kind of just a cog in a system. And so there's lots of policy reforms that we could implement that would actually empower the patients, actually let them control more of the dollars. And then that way, we, you automatically realign the incentives so that it's all about what that person needs. And it's not about, you know, what a lawmaker thinks Medicaid should cover or, you know, some other middlemen entity that's dictating what's an acceptable health care procedure and what's not. So we have a lot of reforms that would realign that system to empower the patient regardless of what sort of payment system they're in. But what I want to highlight really quick because I'm so excited about it, and I don't know if we'll get there later, so I'm just going to jump the gun and talk about it now. This is this came out right after our platform, our

personal care option platform work that we've that we've put together. This is a brand new reform that started to take hold in Tennessee and Texas. And the idea is that if you're a patient, you're insured, let's say you need an MRI, and you know, you have time to shop around, it's not something that you urgently need. If you ask for the cash price, and then you find a cash price that's less than what your insurance is going to pay, you can get that counted towards your deductible, you save the insurance company money, and you drive down the costs of health care. Right. So I mean, that's so a lot of steps to get there. And not everyone's going to take the time to do that. But you're seeing the beginnings of this move to empower patients and get back to, you know, actual pricing that matters. And not all the markups and you know, fractured lack of transparency that currently exists in health care.

Christian Stellakis 15:55
Yeah, and building on that some critics like to criticize the conservative healthcare vision as merely one that seeks to repeal existing laws, rather than offering positive solutions of our own. So Elizabeth, how would you say that the personal option proposal differs from that perspective?

Elizabeth Stelle 16:16
Well, it's proactive, it's not reactive. It's not a bunch of things we're not going to do, or a bunch of things we want to take away. It's about what we want to add. It's about empowering the patients. And I know that our panelists will speak to some of this in more detail. But the broader framework is transparency and accountability. Accountability, specifically in how we enroll folks and keep folks in the Medicaid system, empowering patients to shop and to save their transparency, creating more convenience in this system, we just had a telemedicine law signed, but there's a lot more that we could do to make it more convenient to access care the way you want it, what do you want it removing limitations on providers so that they can serve more patients and spend less time pushing around paperwork. And then keeping the things that do work, you know, protecting direct primary care, for example, allowing association health plans, again, allowing health care reimbursements from employee employers, which is a federal thing, expanding healthcare savings accounts and other federal thing. But lots of there are lots of examples of things that people like. But they know that the system as a whole is broken. So when you when we did our polling on health care, you saw that message come through very clear. But there are some things people like about their health care system, and they want to keep it, but they don't like everything. And there's a lot of things they want to change. So let's keep what's working and expand it, strengthen it, and change the things that aren't working, we can do both. And I think too many times people get in a mindset that we have to throw everything out to start a new one. And that's not the case. No, we wouldn't ever design a healthcare system from scratch the way it currently exists. But we can preserve the good while fixing, you know, the problems at the same time. So lots of ideas. This is an area rich in in policy ideas. And so anyone that would think that there is no free market, you know, reform out there really just isn't paying attention.

Dr. Kimberly Corba 18:18
You bring up a good point. Choice and control are two buzzwords I hear from my patients choice and control. And they feel like they don't have much of either one.

Christian Stellakis 18:33

And Dr. Corba, one of the things kind of building on that a lot of frustrations that we seem to hear around the healthcare space, deal with issues around bureaucracy and government over regulation, how have those issues impacted your ability to properly care for patients as a physician.

Dr. Kimberly Corba 18:55
Well, one of the reasons I decided to and I had a full panel of patients in my small practice, and was doing you know, once they implemented all the crazy rating scales and quality measurements, I was performing extremely well. But what I didn't like is my visits were getting shorter on the insurance company wouldn't let me do a physical and an acute visit in the same visit it had to be one or the other. So then you're asking the patient to come back for a second visit more time off from work another copay, possibly more money towards their deductible. It was just getting it was that was one of the things that really, really put me over the top and, and so the insurance was dictating how I could practice and how I wanted to take care of my patients. But if I want to do a physical and they have a sprained ankle on the same visit, why can't I address both? Why bring the patient back? That's so inconvenient, and they're paying for this insurance and it really wasn't making anything easier for them. And you know, costing them another copay and more deductible and time out of work. Those are, those are intangible losses for the patient. So I just, you know, I just decided that I didn't want to be, I didn't want to have to be following what the insurance companies were mandating and how I care for my patients. So with direct primary care, and Elizabeth brought up a good point, you empower the patient to pay, they pay me directly, I'm accountable, I'm workout, I'm very accountable to them to do a good job. Because they're paying me directly they're paying me this monthly fee. And they're, they're accountable to me. So you, the patient feels more empowered, because there can they're paying, you know, me directly from for my services. So it empowers both of us. And it really, it's really changes the doctor patient relationship and changes the dynamic between us and it gives, my visits are 30 minutes long, we get time to do the shared decision making that USPSTF recommends and talk about the benefits and disadvantages and help guide them through talk about alternative treatments, just like Dallas talked about it gives me time to look things up if I don't know what they're, you know, if I'm familiar with something they're asking. So they feel really feel empowered, and like their real part in it, that they're really participating in their health care. And at the end of the day, when you're paying for your insurance, you want to feel like you're getting something for like the product is performing for you. And even though I'm not an I don't take insurance, but they're paying me they feel like they're getting their money's worth.

Christian Stellakis 21:47
And Dallas, as a nurse practitioner, I'm sure you've dealt with significant regulatory barriers, restricting your scope of practice. Can you talk a little bit about your practice the types of patients you see and describe the challenges that you typically face without full practice authority?

Dallas Riley 22:12
Yeah, absolutely. So when we started our practice, you know, we were looking at the clients and what they had lost, I mean, very little to the difficulty and the obstacles that we will be facing. So I think I'm kind of in, I don't know, a unique situation. But um, when we opened our practice, first thing was the hardest. Because, you know, a lot of insurances don't recognize nurse practitioners as primary caregivers, they

have to be a DO or an MD, had to get our collaborative physicians, which for me, I was very lucky, because a lot of people were affected. So some of the docs that are still in the area actually came to us and said, Please don't leave can we do to help you get started? So I have my collaborative physicians. You know, I had to list them on all of my credentialing documents. So if you think 13, insurances, and the amount of time it took to do all of that credentialing and have those those agree to all of that, it was just a lot of work. So that was for starters. And then reimbursement, I mean, NPs only get reimbursed 85% of the Medicare allowable, reimbursement, max reimbursement. And that's all based on documentation, right? So, you know, if I don't meet my nips, I might have a penalty, right, like, so my only get reimbursed 40% of what the criteria would be. And then, I mean, other things like writing orders, so you know, with my certification, insurances, and the government views me as capable of caring for a diabetic patient, I can write orders for insulin, things that may actually kill the patient if they're used incorrectly, or the orders written incorrectly. But I needed an MD to sign off on diabetic shoes because of the laws, which I think is kind of silly. You know, so there, there are a lot of like, really ridiculous limitations for, you know, nurse practitioners in primary care. And I think kind of to piggyback after off of what Dr. Corba said, is that, you know, the patients want to feel empowered. So if somebody comes to me, and they have, you know, A1C of 6.5 and they know, it's all diet-related, why can't I prescribe them a diet? Why is that not a treatment? Why does it have to be Metformin to start? Why do I have to put them on medications that their insurance may not cover down the line anyways? You know, or newer, heartburn medications, you know, if my documentation doesn't say that the patient tried Omeprazole, you know, they will, the new medicines that are already working for them, right, because I've given them samples. So, there's a lot of obstacles, I think, related to, you know, clients not having the decision making capabilities.

Dr. Kimberly Corba 24:55
One way we—I just dispense out of my office. And providers in Pennsylvania are allowed to dispense generics out of their office. And they have been for decades in the state of Pennsylvania. In fact, most of us who grew up here probably remember going to our family doctor, when we were little walking out with our little white envelope of amoxicillin if we needed it. So I do dispense. So although I do still deal with prions and finding the insurance companies for coverage of medication. Even though I don't bill insurance anymore. We have a nice way of bypassing it if we can get the generics at wholesale—near wholesale price through dispensing through the office. So I personally think every independent office in Pennsylvania should be dispensing and using that benefit. But it's a little bit of a process. It's not, it's not that hard, but it really helps bypass some of the difficulties Dallas is talking about with the insurance companies, when you have to jump through hoops to get inexpensive medication covered.

Dallas Riley 26:06
Right, what the other thing I think that a lot of the patients are talking about is, you know, the medications themselves, like, Are there more natural remedies, you know, if you give a patient a little bit of education, you know, like, again, diabetes is a pretty easy, easy example. You know, you teach them how to count their macros, how to count their calories, you know, the difference between proteins and carbs. And a lot of them do very well, they just need the education. However, that's not viewed as a treatment plan, you know, by the guidelines. And so it's very difficult to get reimbursed like that.

Dr. Kimberly Corba 26:40
And it takes time to do that. You can't do that in 10 or 15 minutes, that's a longer visit.

Dallas Riley 26:48
Right, but I think it's also better-quality health care, right? You know, because then they learn to trust us, and, you know, understand that their health is in our best interest is what our interest is.

Christian Stellakis 27:05
And building on that, Elizabeth, one of the personal option, reforms that is currently getting traction in the Pennsylvania legislature is giving nurse practitioners full practice authority. How could policies like that help improve accessibility and availability of care?

Elizabeth Stelle 27:22
So we did some research asking that very question. You know, it makes sense that if you reduce some of the paperwork, you don't do the two collaborative agreements for nurse practitioner in Pennsylvania, that you would have more time to see patients. But we wanted to actually study that and run some models and see, you know, is that actually how it pans out? And yes, it does. Our modeling, found that nurse practitioners, giving them full practice authority across Pennsylvania would give them generally speaking, an additional 109 slots, additional 109 patient appointments in the course of one year, so how many more you know, primary care appointments, they have longer appointments, it just really opens up more flexibility in the system. And we know that our practitioners are more likely to locate in rural areas in low income areas and physicians, and are shortages for primary care most acute in her rural areas. So they're and we're talking about a reform, that isn't going to cost taxpayers more money, right, it's actually going to save money. So it's sort of a win, win-win. And so that's why we've been working on practice, or petitioners for at least eight years. But I know it's been a topic in the legislature for far more than that. And since that time, it's gone from a handful of states to 27 states that now allow this, and it's moving in the Senate. We don't know if it will make it all the way to the governor's office. But it's it's getting more traction than it has been a very long time. And I think it's because of what's being discussed here. The frustration of patients on the ground that can't see providers or, you know, have very short and truncated time with their providers. They tend to have more time with their NPs. And so they rank very highly when we asked them, you know, what kind of providers do you see and who do you prefer to see? You know, NPs are near the top because they tend to have a more involved relationship with patients. So for lots of reasons, we're supporting that bill, but we can talk about expanding the scope of practice for more than just nurse practitioners. I mean, we're looking at reforms to do that. For pharmacists, nurse anesthetists. There's a lot of artificial barriers that are put in place that limit ways that providers can serve patients even though they might have the training to provide that service.

Christian Stellakis 29:56
Yeah, and Dr. Corba, Dallas mentioned some of the constraints So not having full practice authority. From a physician's perspective, how important is it to embrace a more comprehensive approach to care delivery?

Dr. Kimberly Corba 30:09
Well, we certainly have to address the shortage as of the rural areas. And the nurse practitioners are a major part of the team. When that come, you know, when we talk about those underserved areas. One other thing I'd like to mention is the family practice, residency, match rates have dropped data that I that I found, they've dropped from 2019 to 2024 have dropped 16.6%. We also need to recruit more doctors into primary care and get them incentivized to go to the rural areas. My—I've met I've I precept, third year medical students, and I have for over 10 years. And the majority of them save, you know, primary cares out. And this includes peds general internal medicine family practice, because the pay is so low, and they're coming out in debt up to their eyeballs. So no, a lot of these rural areas will be underserved areas, and they can't have loan repayment. You know, and the nurse practitioners are certainly filling the gaps. But we also need to figure out how to encourage more medical school graduates to choose primary care.

Christian Stellakis 31:32
Now, I'd like to shift gears a little bit to another personal option emphasis, and that's being empowering patients as consumers through things like price transparency. So Dallas, what has your experience been like with the lack of pricing information and tools available for patients? And how does that kind of impact their ability to make informed decisions on the cost?

Dallas Riley 32:02
Um, so we in in our area, and in my experience, we have a lot of self pay clients, people without insurance. So you know, it was important for us to help keep their costs down as well. So my business partner and I, we did a lot of the legwork to try to figure out what the best cash prices would be in the area. For things like imaging and lab some of those basic necessities. What was a little bit more difficult was specialty services, pharmaceuticals, that kind of stuff, hard to do some price shopping on those. And so I think a lot of the patients are going either without their treatment or without seeing the specialties. Just because they're not, they can't plan for that they can't budget for that. So I think that, you know, the personal option, making that more transparent, would absolutely empower the client help the client and help me to make better decisions for the clients for their treatment.

Christian Stellakis 33:11
And Elizabeth, can you perhaps expand a little bit more on the Personal Option's proposals when it comes to price transparency and our market based policies aimed at the consumer side of things?

Elizabeth Stelle 33:23
Sure. So there is some progress on the federal level to begin to force some of this transparency, there was a regulation put in place that requires hospitals to post their charge master service level prior prices. The problem is, a lot of hospitals are not compliant. As of last year, about a third of Pennsylvania hospitals were non compliant. And even if they are, if it is posted, it's hard to find, it would be really hard to read. It's a huge long spreadsheet with lots of codes and numbers that, you know, regular people don't understand. So even though we're beginning to get access to the raw data, it hasn't been, it hasn't been actualized in a way that makes shopping easy. So we need more tools. And more of those tools I mentioned earlier is the idea of getting at getting the cash price and then getting a credit towards your deductible if you do find a

cheaper cash price than your insurance price. And I always encourage people to ask if they have insurance, what is the cash price first, because a lot of times people are surprised how much cheaper the cash price is. And one thing I get charged, even using their insurance. So those are some small steps we can take. And we highlight that and there are some states that are getting really creative with this hospital transparency requirement. Colorado has a law that prevents hospitals from sending certain bills to collections if they are not compliant with this price transparency. So creating a little more accountability in the system, I think is a good way to go. But it's also I think, a challenging space because we know that mandates tend to beget more mandates. And if there's one thing we don't need in healthcare, it's more mandates. So I think we need to be very careful about how we go about incentivizing price transparency, that it's not just top down mandates on hospitals and providers. But we look at ways to empower patients and make them the shoppers. And one way we could do that on the federal level is expanding HSA as healthcare savings accounts, so that they can apply to more health care expenses. And then that way, it's, you know, their own money—there's skin in the game, applying HSAs, to more than just high deductible plans, there's lots of ways that we can give patients that incentive to go and shop and find the best price reference pricing is another thing that's been tried and had some success credits from your insurer for saving money choosing, you know, preferred provider, there are lots of different tools out there at our disposal. But I'm really excited to see, you know, the kind of the first steps with this hospital transparency requirement. And I think over time, you're going to see that innovation take hold, people are going to figure out a way to digitize this data, and apply it so that you can go on the website and just saying, you know, I'm looking for an MRI, you know, in this zip code, give me the prices for, you know, every facility within 50 miles, and they'll be able to do that, and it will be accurate. Because right now, you know, it takes all the time and effort to price shop, unless you're doing direct primary care, some sort of alternative system. So moving in the right direction, but there's a lot more that needs to happen to empower the patient. Was

Dr. Kimberly Corba 36:40
Elizabeth, wasn't there a regulation that just came out that the hospitals are required at the time of service to provide both the cash price and what it would cost you through insurance?

Elizabeth Stelle 36:51
Yeah, there is something that's emerging in that I'm not clear about how well it's being implemented yet.

Dr. Kimberly Corba 36:56
Probably not much.

Elizabeth Stelle 36:59
I don't think people really know that that's something that they have to do. That's right. Experience has been unless you ask, you're not told. So a lot of the, you know, there's an element of consumer education right? Here too. And it's not always necessarily in the interest of the insurer to do that, either. I think that's where people get hung up, because they just assumed that the insurance company wants me to get a lower price. Not always the case.

Dr. Kimberly Corba 37:25

Well, they're missing out on the billing, then if you're paying cash, they're missing out on the billing part of it.

Elizabeth Stelle 37:30
Yeah, so it's so many things, healthcare, it's complicated, which is why the personal option platform really advocates towards pushing more leverage back to the patient, and you know, less some of these other entities, because the patient is going to make the most efficient decisions. You know, we do that with every other aspect of our economy, right? Um, you don't go to the grocery store, and they tell you, your bill, after you've checked out, you know, and you have no idea, you know, how much is head of lettuce, I don't know how to check out to figure out the prices, right? It's not how it works. But that's how it works in healthcare. And you're starting to see more people asking for the cash price, you're starting to see more policies that incentivize that behavior, Healthcare Bluebook, there's lots of different tools out there, that can give you an idea. But we haven't quite gotten to the place yet where it's easy for any patient to get, you know, cash price, insurance price, and make informed decisions. There's pockets. You know, there's there's innovators, I think there's a company in California that's doing this, and they found a way to use the charge master data. But it's, it's not universal yet. And so we definitely want to make sure that we're at the very least not passing any new laws or regulations that would inhibit that sort of innovation.

Dr. Kimberly Corba 38:47
I'm so glad you said that. And the 10 years, I've done direct primary care. I've seen people really become consumers of their health care, and they're the one especially my patients with high deductibles, they'd rather save it for the catastrophic issue. And they'd rather pay cash for that X ray, that chest X ray that we can get for $60 down the street and, you know, hope pale blood work for $100 Rather than going to deductible. So people are definitely not everybody. But it's been really encouraging to see people becoming more consumer savvy with their health care.

Christian Stellakis 39:24
And speaking of these reforms, another thing that the Personal Option that we also prioritize tackling rising costs, through reforms to government programs like Medicaid. Elizabeth, what has and hasn't worked at the state level when it comes to these sorts of reforms, and what's the path forward here?

Elizabeth Stelle 39:45
Well, Medicaid is the largest program in our budget per state budget, and it's growing faster than anything else in our state budget. It's growing faster than the revenue coming in, is going back to education. Any program we're going to talk about that the state's been As money on Medicaid out spends it and Medicaid spending, it's accelerating faster than those programs. You don't hear people talk about it a lot. Usually people are like, Wait, Medicare, like, no, it's Medicaid. So you have to start, you know, the difference between Medicaid and Medicare. Medicaid is for traditionally for low income or disabled folks. But over time, we've expanded it to include a lot of what we call able bodied or healthy folks as well. So now we're at the point where almost a quarter, little more than a quarter of Pennsylvanians are on Medicaid, that is their insurance provider. The problem with that is it's you know, it's very impersonal. It's a capitated payment system. So we're paying for them every month as taxpayers, whether they're utilizing any health care or not.

And it's taking resources away from those folks who have a lot of chronic conditions who need a lot of around the clock care, to the point that we have a waiting list for long term care services, and for services in a community setting versus in like a nursing home setting. So we've seen this program exploding costs, also explode in terms of, you know, the population that we're serving, but we're not really seeing any improvement in health outcomes. When you ask folks you do like your Medicaid, they're like, Well, you know, thank God, my health care is free. But they don't really have anything else good to say about it, just that it's there if they need it, and half the time they go to the emergency room anyway, because it's more convenient. So what are we getting for all this? Well, not what we wanted. So the question is, how can we refocus Medicare on the people who actually need it, and direct folks who are healthy and able bodied to other more appropriate forms of insurance. And so what some states have done, they've experimented with community engagement requirements, where you have to volunteer or look for work in order to maintain your Medicaid eligibility, what we find is that when people are out in the community, they see those opportunities for work. They, they, they, they get back in the workforce, they get access to better quality insurance, and they move up and out of the system, which is the intention of the program. Anyway, Medicaid was never meant to be a safety net for healthy adults. But that's what it's become. So we have a lot of work to do, really on the enrollment side, and making sure that people are actually eligible, that they're not just assumed eligible at the hospital when they come into the emergency room, and that we're following up with them on a regular basis and saying, Okay, what's your income? Now? What's your status? Now? Do you live here? Are you alive? I mean, there's some very basic things that we don't cross check on a regular basis. So we have Medicaid rolls that are far larger than what we think they actually should be. And I'll just kind of, you know, this is a problem across the scope with government insurance. With the exchange programs in Pennsylvania, it's called Penny. But with exchange programs nationwide, they found that there are more people insured and qualifying for the subsidies. And there are people that are even in that income level that even exists in the United States. So something is wrong here. The system's being gamed, and the benefactors are not necessarily the patients, you know, it's it's the insurance company to the folks in the middle, that have found a way to make this system work for them. And that's not to the benefit of patients. That's not to the benefit of our providers. And so I'll just summarize it all by saying we really need to get better at how we enroll folks and Medicaid, following up with them, using it more as a tool for folks to transition up and out and not as a permanent solution to their health care needs. Because that's not what it was designed to do.

Dr. Kimberly Corba 43:40
Well, they increase the subsidies and income levels. So that was that's, that's first problem. Second problem is something you said earlier, and I was unaware of that there's a percentage of people who are enrolled in Medicaid and don't even know and have a second plan. How come Medicaid is not verifying that when they enroll, that is a waste of money?

Elizabeth Stelle 44:05
Yeah, I mean, part of it is an outgrowth of the pandemic where they have this thing called continuous enrollment. So for years, they didn't follow up with folks and you were eligible, whether you got a job and became your income grew, under normal circumstances, you no longer be eligible. But under this continuous enrollment policy, you were able to maintain your Medicaid indefinitely until the public

emergency ended. So in March of 2003, we started going through the rolls and basically re enrolling everyone and making sure everyone was still eligible. But we still have a much larger Medicaid population than we had before the pandemic. And I think, you know, that's not going away. Because more people became aware of it and more people, you know, found the resource and now, you know, that's just that's going to be I think, a legacy from COVID that will always have a larger population. But that said, We could do a lot, a much better job of continuously checking in on people, requiring them to do things like filling out their enrollment forms. There's some interesting strategies that are being used now where it's all automated. So if you don't respond, they just fill out the forms for you based on the information that they have, which may or may not be correct. And you know, and so, you know, and then you folks get concerned that other people are being unenrolled, because they're not responding to requests about their paperwork, well, they're probably not responding to your requests for paperwork, because they have a job now they're not eligible anymore. Like, you take the time to fill out a bunch of forms if you knew it was a program that you weren't qualified anymore. No. So I think, again, the focus is on the wrong thing. The focus is all about insurance, insurance, it's not about are these people getting access to care in a timely fashion? Are they getting care the way they want it the way they need it? Are they able to, you know, build relationships with providers? That's not the question. Those aren't the questions we're asking. And in fact, I'm working on a study right now looking at Medicaid for kids. Oh, and seeing, you know, what, if anything, are we seeing in terms of kids ability to get consistent, you know, primary care on the Medicaid program? And is there any distinction between states that have more limitations on providers and states that don't, in terms of how easy is it for these kids to get regular follow

Dr. Kimberly Corba 46:27
up are interested in kind of like a spin on the Merritt Hawkins study for 2017 on Medicaid and Medicare Access and cities? Yep. Very interesting.

Elizabeth Stelle 46:35
Yeah. And what we're finding so far is that kids ever could get access, but states with less barriers, they get longer appointments, which is, I think, an indication of a better quality care.

Christian Stellakis 46:47
Well, we're coming up on the Q&A portion of our webinar today. But before we get to that, I did want to just ask, bring up one more topic for discussion. Dallas, I wanted to bring you into this. We've seen many rural hospitals closing their doors in recent years, creating health care deserts, as they're called, what role can policies like expanding telemedicine and increasing practitioner scope of practice play in improving access to care in these underserved areas?

Dallas Riley 47:24
I mean, expanding the scope of practice just gives us I think, more freedom to do what the patient needs without, you know, hesitation. I think that, you know, as a nurse practitioner, just the requirement of having a collaborative physician, that just means that I can't renew my license, right, without that, without that agreement, I was able to do everything I'm trained to do. However, those collaborative agreements can be super pricey for a lot of people. And again, I was pretty lucky just because close, so I don't have to pay my

collaborative anything. But for a lot of NPs, they have to pay between three and $5,000 a month for a collaborative physician, and a lot of these physicians, that's their entire income. I mean, they have no limitation on how many agreements that they can have, you know, so you get, you know, 10 NPs, you're making 30,000 a month. For, you know, to sit there and do nothing, I mean, our collaboratives, my collaborative has never stepped foot, my office, I call them sometimes because I need them to sign, you know, orders for things like diabetic shoes, or nurse family partnership, right, I can care for an infant. But I can't say that a mom might need a nurse to come in and help her care for an infant once a week. You know, but other than that, you know, the physician doesn't know my patients. You know, he doesn't help me run my practice, you know, so I think that just puts limitations on silly things, you know what I mean? It doesn't increase my scope at all, like, I'm not going to start doing surgeries, I still am only going to do the small procedures for which I'm trained. So like, the things I'm allowed to do doesn't change at all. It just means that now I can hold a license without having that agreement with a physician.

Christian Stellakis 49:19
And with that, I'd like to open the floor for questions. If you do have anything, please feel free to drop it into the Q&A function on Zoom and I'll be sure to read the question out to our panelists and get you an answer. Or if you would prefer, you can always reach out to me personally, if you'd prefer to ask a question anonymously. That way. You can text me or give me a call. My number is 315-720-3561. Or of course you can email me at cjs@commonwealthfoundation.org. So while we wait for any and all Q&A questions to come in, I did want to ask one more quick question to the panelists a bit of a fun one. If you had a magic wand that you could wave it and make one change to improve the healthcare experience for patients and providers, what would it be? Elizabeth, we can start with you.

Elizabeth Stelle 50:26
So I'm going to be very selfish here. And my answer would be different if it was federal, but at the state level, the one thing I would do is change the next care from where the physician is, to where the patient is. So we have or start from when the patient is to where the physician is reversed. And I'll explain why we published a piece a couple months ago with a doctor who is speaking to us about how she has a hard time answering her patients phone calls when they call her and they're on vacation, because she's you know, she's not licensed in the state they're calling her from technically, it's illegal for them to have a consultation, because her patient is not in a state where she is licensed to practice, you know, and that creates a lot of issues. I have the same thing in my own family. My son specialist is in Ohio, and Pennsylvania. And every time I schedule an appointment, they say, Well, you could do it, you could do a virtual claim if you like, because this is a maintenance appointment, they have his bloodwork, all they really need to do is check some numbers, you know, talk to us a little bit, make sure we're good to go. We don't need to be there in person. But the only way I can legally do a telemedicine appointment is if I drive across the border from Pennsylvania to Ohio, because this provider is only licensed in Ohio, I live 20 minutes from the border. It makes no sense why I can't have a telemedicine appointment with a doctor, we have an established relationship. They know my son, they know the patient. But technically it would be illegal for him to service in that way, because he is not licensed to practice in Pennsylvania. So if I had a magic wand, I would change that. So that providers could serve Pennsylvanians no matter where they were, as long as they were in good standing at their state. This would be transformative, transformative for

people who have, you know, specialists on the other side of the country, you know, people with rare diseases. I mean, it's to me, it's immoral, that we make sick people travel across the country to see a specialist when they could be doing something virtually, and save a lot of money a lot of time. And, you know, they sacrifice a lot of physical comfort to do that. So that's what I would change.

Dr. Kimberly Corba 52:36
I thought very thoughtful, Elizabeth, you know, it's all about the money with the board between teammates for each state. It's always about the money. The one thing I would do to wave a magic wand is make my dad very happy. He still talks about the major medicals, that we grew up with the insurance plans that were just covered the catastrophic stuff to buy a rider for immunizations, you could buy a writer for diabetes, just like you buy a rider on your homeowner's policy and your car insurance. I don't think primary care and the basic tire rotations and windshield wiper changes should be insured. And that's what primary care is. So if I could make wave a magic wand, I'd bring back the option for major medical insurance plans that are affordable, and stop ensuring affordable basic care.

Dallas Riley 53:28
I think for me, I would like to remove the bureaucracy, the bureaucracy that limits like the way I can order things. So for example, you know, somebody comes in with a rotator cuff injury, like it's classic textbook rotator cuff insurance means makes me do an X-ray, which I know isn't going to show anything. So they pay for that. And then I pay for physical therapy, you know what I mean? And then finally, I can get an MRI that, you know, validates what I was thinking all along, and then they can see an orthopedist. You know what I mean? So I think those types of things drive up costs pretty significantly, when in reality, if you know, it's textbook, I know an MRI is going to show it, why can I not just get the MRI and get them to where it needs to be instead of all of the last time. And all of the administrative time for us as providers. I mean, that's, you know, say an additional two hours with signing everything and reviewing all of the consult notes and the imaging and, you know, whatever. I think that would be fantastic thing.

Christian Stellakis 54:38
That's great. Now it looks like we do not have any Q&A at this time. Just wanted to let everybody know that if you guys do have any questions at all, please again, feel free to reach out me privately and I'd be happy to get those questions answered for you. But with that, I just wanted to ask any closing remarks from the panelists? Anything you guys wish to add, before we conclude today?

Elizabeth Stelle 55:04
I would just like, again, reemphasize healthcare. It's not a market, it's anything. But the reason it's become so disconnected from the patient is because we've constantly added layer upon layer of government intervention. So it's all about restoring personal care. And the way you do that is put the money back in the patient's hands. And there's lots of things that Pennsylvania could do, regardless of what's happening in DC, but things Pennsylvania could do, to move in that direction, making health care more affordable and more accessible.

Dr. Kimberly Corba 55:35

Dallas, you want to go before me?

Dallas Riley 55:39
Feel free, go ahead.

Dr. Kimberly Corba 55:42
I agree with what Elizabeth said, the patient has to know that they have the power, they're the consumer. And they're the ones paying for this service and for their insurance, that they can't feel so crippled, or helpless, and have to start understanding their policies and being consumers. And I don't think the patients have to be the ones who really, you know, the providers, we're all speaking up, we've been beating the pavement for the past 10 years, the patients are the ones who can really ignite the change. And so I would love to see patients becoming more empowered, and stepping up and asking for changes from our lawmakers.

Dallas Riley 56:25
I would agree with that I think, you know, an enhanced personal option would probably give more practitioners freedom to practice independently, which would, you know, increase access to health care, especially in rural areas. I mean, it's almost impossible to make it in private practice anymore. If you're depending on reimbursement, and, and, you know, the guidelines and following all the rules and that kind of thing, it's almost impossible. So giving the patients the option to see who they want, you know, and pay for their own things. And I think it would really improve access, and also, you know, the success of private practices.

Dr. Kimberly Corba 57:05
You know, Dallas, that's a sad statement that it's impossible to make it in private practice in rural areas. That should not be the case. That's a huge problem. That's a huge problem.

Dallas Riley 57:17
Yeah, I mean, I'm, I'm okay, giving my personal business, but I mean, with our first year in practice, I think I brought home like $24,000. Because

Dr. Kimberly Corba 57:29
I believe that reimbursement—

Dallas Riley 57:31
I mean, and that's poverty to be loved, right, like, so I was a Medicaid patient, because that's all I could get, you know, because I only made 24,000, which is what, like 70% of poverty level at this point, because I had independent. So and, you know, that was, I'm already almost twice that much in debt because of my education. So, you know, you spend life trying to care for other people. And you can't make it me because, you know, of government over regulation.

Dr. Kimberly Corba 57:59

It should not be that way. Now, you look at some of the salaries and some of the money being made by some of these hospital systems. And in you hear stories like that, and we all know, I mean, I know, I'm family practice, and there's, there's huge discrepancies and display disparities, that this should not be the case for the rural areas, and for providers, like you who are willing to work in those areas. Absolutely unacceptable.

Elizabeth Stelle 58:34
Yeah, and I think I think sometimes you there's, it's kind of, there's this false sort of, versus situation that comes up where people think, you know, well, your doctors are concerned about being micromanaged, right? Or you don't have or, or any provide, you know, the flexibility, the freedom to treat patients the way you want to treat patients. And so then they're like, Well, why is no one going to medical schools? Why isn't Doctor wise, you know, and it's like, it's a self fulfilling prophecy? You know, we've we've created, you know, that that barrier we we've made, I think, in many cases, some of these professions very unattractive. It's so I think, you know, in some ways, we're sort of, you know, policy matters, and we're seeing the ramifications of that. But that doesn't mean we can't change policy.

Dr. Kimberly Corba 59:23
That's correct. Yeah, they can be changed can be changed.

Christian Stellakis 59:27
Well, with that, I want to thank everybody for joining us for our webinar today. A special thank you to each and every one of our fantastic panelists for offering their expertise and their insight. Again, if any of the attendees have any questions, please feel free to direct those to me and I will go ahead and get those answered. Otherwise, thank you all again, and I hope you have a great rest of your day.