

# Revising Health Care Reform

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Five hundred and twenty-five dollars a month may not seem like much to some, but for the two hard-working married electricians repairing my house it was out of reach. This is how much they *each* would have to pay for health insurance in Kentucky under the new high-risk pool. That adds up to \$12,600 a year with up to a \$3,000 deductible. The wife has a history of cancer, being in remission for one year, and the husband has heart disease. Both desperately needed health care, both worked, but neither, in this downturned economy, could afford coverage.

No wonder only 8,000 individuals across the nation were reported to have enrolled in health care reform's high-risk pools as of November 2010. Who can afford it? When you have a chronic illness with a major medical condition and do not have insurance, you likely to be deeply in debt and have had all of your savings taken by our health care system.

Unfortunately, along with the cost of health care, insurance is still increasing at an alarming rate. The latest example is Blue Cross Blue Shield of California, which increased the cost of an individual policy by 59 percent. And individual policies are used as the basis for setting rates in the high-risk pools.

The Massachusetts attorney general found that payments by major insurers to hospitals varied by more than 100 percent between facilities. And guess what? It was not the hospitals that took in and treated the sickest and poorest patients or the hospitals that delivered the highest quality of care that charged the most; it was the hospitals that had the most "market leverage" or domination within a geographic region. And these higher priced facilities were gaining market share.

Another important cause in rise in health care costs is the explosive increase in the number of services being provided. *The Wall Street Journal* reported that nationally, Medicare expenditures on spinal fusion with implants have increased nearly 400 percent over a 10-year period; the National Institutes of Health reported the use of CT scans has increased three-fold since 1993; and *Business Week* reported that Dr. Elliott S. Fisher, director of the Center for Health Policy Research at Dartmouth Medical School, estimated that almost 40 percent of

angioplasties are unnecessary.

What's worse is that there has not been a demonstrable benefit to the patient despite significant risks. For example, the rise in CT scan use is associated with an increase in the risk of developing cancer and one can only imagine the risk to a patient undergoing an unnecessary angioplasty or cervical spine surgery.

In the past, insurance companies were motivated to hold down costs by purchasing less care. Under health care reform, their profits plus overhead are limited to 15 percent to 20 percent of the premium. They are now motivated to buy more expensive health care and charge higher premiums to increase the dollar amount of their profit. There is reduced market pressure because of an antitrust exemption and insurance companies may not start expensive precertification programs to hold down unnecessary utilization at the expense of increasing overhead and reducing profits.

The Obama administration has responded by encouraging states to oversee and approve premium increases. However, if these increases are linked to the purchase of more expensive health care, determining what is truly needed will be difficult and beyond the resources of many states to untangle such a complicated issue.

Yes, Medicare has a lower administrative cost of 2 to 8 percent, but then it functions much like an ATM machine with attempts at recouping some of the money on the back end. Medicare is by law prohibited from regulating the practice of medicine. For my parents, a second opinion saved them from undergoing surgery for shoulder and knee complaints that were resolved in four weeks and have not since recurred. Medicare would have approved and paid for these procedures.

Medicare has not been able to control the overutilization of medicine using fee-for-service payments, but switching to flat yearly per-patient payment may create other problems with gatekeepers and rationing. Already, Arizona has cut heart transplant coverage under what has been described as "death panels." My niece who received a heart transplant three years ago at age 12 is very lucky she did not have Medicaid and live in Arizona.

Health care reform will need to be revised. Large health care systems must demonstrate they promote quality and lower costs. To do this, support of full transparency in quality measures, such as infection rates, is needed. Hospital boards will need to engage, for they are the governing body of the institution and legally and morally responsible for the actions of the CEO and medical staff. Without well trained and engaged boards and public transparency, the transformation into a high-quality efficient health care system is in jeopardy.

**Kevin Kavanagh, M.D., M.S., F.A.C.S., of  
Somerset is board chairman of Health  
Watch USA.**