

Insurance Reform – Yes; Health Care Reform – ???

Why has there been a major concern about the health care system in our country?

After all, don't we have the best system in the world? Eighty-five percent of our 304 million citizens are covered by insurance. And besides, eighty-percent or more are satisfied with their coverage. If anyone gets really sick, all he or she has to do is go to the emergency room and be seen and treated until stable. That's the law. I know! I know! We spend 16 or 17% of our Gross Domestic Product on health care. Can't we just keep it there? What? You say we spend \$1.2 trillion or so annually. I bet we spend that much or more for tobacco and alcohol or on sports and gambling. Did you say that more than 60% of personal bankruptcies were medical in origin in 1970? People should spend their money more wisely. Did you say that there are 730,000 uninsured in Indiana? All they have to do is sign up. Isn't that correct? What do they do in other countries?

Other countries are far ahead of us in terms of covering their citizens. The first country to develop universal care was Germany in 1883. Initially it only covered the low income workers. It gradually expanded to cover most of its citizens through a mandatory public health system. The income level necessary to utilize the private system may be adjusted as needed. Health care costs consume 10% of the GDP. There was a health care reform law passed in 2004 in an attempt to reduce costs by increasing co-payments and higher payroll deductions. Again, as reported in the July 7, 2010 WSJ, The health ministry made decisions to increase the co-payment for those insured from 1% to 2% of income. Also payments for hospitals, doctors, medicines, and administrators were reduced. It has been projected that this will result in savings of \$439 billion.

France began in 1945 after the ruins of the war. It covers about 88% of its 65 million people. The other 12 % are mainly farmers and small business owners. Its system was reformed in 1999. It is primarily controlled by a central government agency, the Assurance Maladie. It controls who is covered and keeps the fees of doctors under control. Medical education is free and malpractice insurance is cheap. A tax has been levied on drug makers since 1999 when their revenues reach a certain point. The World Health Organization (WHO) has ranked France first overall of 191 countries world wide. By comparison the United States was ranked 37th.

The British National Health Service (NHS) was developed in 1950. Free medical care is offered to all 61 million of its citizens. Approximately 10% of its citizens have private insurance. It tightly controls treatment and drugs given and there are long waiting lines. For example, it may take 5 months to see an orthopedic surgeon. In the late 1990s it established the National Institution for Health and Clinical Excellence or NICE. It limits cost primarily by rationing. It has strict guidelines which must be followed regarding surgical procedures and drugs used. It also tries to keep the cost of treating terminal patients at \$22,000.

The Canada Act of 1960 initiated a single payer system by collecting appropriate taxes to cover it. A Care Card is issued to all 33 million of its citizens. Drug prices are negotiated with the pharmaceutical companies. Preventive care and early detection are strictly encouraged. In 2006 it spent 10% of its GDP on health care and approximately \$4,867 per person compared to \$7,290 in our country. Because of long waits and rationing, private clinics are increasing and more patients who can afford it seek medical care in the United States.

Switzerland has a more consumer-driven health care system – much like the “managed competition” health care plan proposed by the Clintons in the early nineties to care for its 7.5 million citizens. Most of the people are insured and purchase their own insurance. Subsidies are given by the government to prevent any citizen from paying more than 10% of income on insurance. Despite this, the Swiss government pays but about 25% of its health care costs – compared to about 45% in our country. All insurance is private and competitive. Physician fees are negotiated between doctors and insurance companies. Balance-billing is not permitted and insurance premiums are not paid by employers. Overall, the citizens are happy with their system.

History of Health Care in the United States

The delivery of health care was relatively simple for our country for the first century. Colonial medicine was relatively simple. The use of drugs and procedures were simple and not costly. Medical schools were established later and the American Medical Association was founded in 1847. Universal coverage was in the platform of Teddy Roosevelt in 1912. The American Association of Labor Legislation asked for national health insurance in 1915, and later it was a part of the New Deal of Franklin Roosevelt in the early 1930s. It was opposed politically, however.

An important development occurred during the Second World War. With wage controls, labor unions bargained to have large employers pay for the insurance premiums of their workers. These were not taxed and became a primary benefit for workers and a base for the cost of health care in this country. Initially, the large auto and associated companies could afford the cost. Later, with competition from foreign auto makers, the cost became a burden.

Another significant event occurred during the presidency of Bush when part D of Medicare was passed. It provided assistance in paying for medications. Unfortunately there was a “donut” in which the recipient would have to pay for the drugs until another level of cost would occur. However, it did give relief to seniors who had very high drug costs. Also, later, the government developed the Medicare Advantage Plan in which the administration of Medicare payments was done by the insurance company. Among other things, most insurance companies raised the co-pay to specialties from \$10 to \$35.

Other presidents tried to encourage the acceptance of a national health care program. For example, Nixon tried to promote universal health but Watergate was a hindrance. Fortunately, L. B. Johnson, with his political skills, was able to get Medicare and Medicaid bills through congress in the 60s. Later in the early 1990s the Clintons introduced a monstrous 240,000 word document to Congress. It was very complex and met with overwhelming resistance from lobbyists representing the AMA, pharmaceutical and insurance companies. After a year of debate it was rejected.

Health Care Reform in the United States

Because there are nearly 40 million people not covered by health insurance and the cost is rapidly rising attempt at reform became more tenable. Unlike Clinton, Obama asked Congress to develop a bill and send to him. The “tri-committee” of the House composed of the Ways and Means, Energy and Commerce and Education and Labor – drafted a joint product. Comments were to be committed by interested parties. The discussion draft related to medical education and providers. They included: a program to provide scholarship and loan repayment for students, physicians and others who provide “primary health care services” who agree to serve in shortage areas designated by the

Secretary of Health and Human Services; limits on the building and expansion of physician-owned hospitals; payments to hospitals for disproportionate share (DSH) for caring for patients who do not have insurance in the emergency rooms; eliminating the scheduled 21% cut for physicians' reimbursement for caring for Medicare patients; extension of the Physician Quality Reporting Initiative (PQRI) through 2012 with incentive payments to physicians in counties with low rates of Medicare per capita spending for physicians services. The "Blue Dogs", a group of conservative Democrats, did not support the issue of a public option. There were many other provisions among the 1 thousand page, 250 amendment document. It did pass the House on November 7, 2009.

Meanwhile, in the Senate, the Health, Education, Labor and Pensions (HELP) Committee drafted an equally long document which passed on Christmas Eve, December 24, 2009. It was known as The Patient Protection and Affordable Care Act (PPACA) It included among other items: directing the Institute of Medicine to make recommendations on reducing unnecessary hospital readmissions; addressing legal and regulatory barriers that prevent hospitals from providing hardware, software, and technology support to other community providers. There were hearings on the single payer system; the formation of co-ops for selection of insurance; cautions that adding large number of people to Medicaid would burden state budgets; the necessity of maintaining Disproportionate Share Hospital (DSH) payments during the time of enrolling the uninsured. The "Gang of Six" was a bipartisan group of six senators who were attempting to form a coalition to agree on a few basic provisions to improve passage of the bill.

Each chamber passed its bill. A conference committee would have had to determine the final contents of a bill which would then be presented to the President. However, after the death of Senator Ted Kennedy, his seat was won by a conservative Republican. This act did not assure the Democrats of 60 votes to prevent a filibuster. After compromising, the Democratic-controlled House agreed to pass the Senate bill. It was then signed into law by President Obama on March 27, 2010. Several agreed-upon compromises were made. The President then signed the final bill on March 30, 2010 – The Health Care and Education Affordability Reconciliation Act of 2010 (HCERA). It is essentially an insurance reform measure, which will become effective over several years and definitively by 2020. It is to cover approximately 32 million more citizens. Several of its provisions will no doubt be challenged in court. For example, “Can the government mandate that every citizen have health insurance?” “Can employers be required to provide insurance for their employees?”

Major Provisions

Insurance Reform

1. Coverage to be extended to 32 million Americans – beginning in 2010 with completion by 2019
2. Insurers cannot deny coverage for pre-existing conditions – beginning in 2010 for children and 2014 for adults
3. No lifetime caps on coverage
4. Children can remain on parents’ insurance until age 26 – begins in 2010
5. Exchanges and co-ops created to allow pooling of coverage by individuals, high risk patients, and small businesses – beginning in 2011

6. Tax credits for small businesses for coverage of employees
7. Subsidies for low-income families and individuals to purchase insurance
8. At least 80-85 % of premiums to cover direct patient care - beginning in 2011
9. Processing of insurance claims to be standardized to lower overhead costs
10. Insurance plans will be required to provide for preventive care and services with no co-payments or deductibles – starting in 2010; Medicare to start in 2011 and all other others by 2018
11. Steps to close the “doughnut hole” – Prescription costs above \$2,830 to \$4,337 will begin in 2010 with a \$250 rebate and close completely by 2020
12. The uninsured to be covered by expanding Medicaid to cover everyone below 133% of the Federal Poverty Level (FPL) – currently about \$29,000 for a family of four. Subsidies to be provided for those earning up to four times the FPL (currently about \$88,000 for a family of four)

Cost and Funding

1. Cost estimate to be approximately \$950 billion with additional cost for administration to about \$1.2 trillion over 10 years according to the Congressional Budget Office (CBO) and others
2. Major funding of approximately \$500 billion by eliminating abuse and fraud in Medicare, Medicaid and other insurance programs.
3. Employers with 50 or more employees must provide coverage or pay a penalty of \$2,000 per one fulltime employee after the first 30 beginning in 2014. Part time employees will be counted 2 for 1 as the hours reach 40 weekly

4. Require all adult citizens to have minimal essential coverage through public programs, employers, insurance exchanges, military or individual market. Otherwise, fines of \$95 per person up to \$285 per family or 1% of taxable household income, whichever is greater beginning in 2014. This penalty will gradually increase annually up to \$695 or up to 2.5% of income in 2016
5. Medicare payroll tax will increase from 1.45% to 2.35% for those earning \$200,000 and married couples earning \$250,000 or more. Investment income will also be taxed as well as well as non health related distributions from health savings accounts (HSAs)
6. An excise tax of 40% will be imposed on high-cost employer provided polices (\$10,000 for single or \$27,000 per family) beginning in 2018
7. Fees charged to medical device and pharmaceutical companies
8. Hospital DRG payments gradually reduced
9. Fee for service payment system to be converted to a pay for performance system with emphasis on cost effective tests, drugs and devices.
10. No federal funding for abortions or care, except emergency, for illegal immigrants

Health Care Delivery Reform

It is with the provisions for the actual delivery of health care involving the patient and providers regarding prevention, treatment, medical education, tort reform where the rubber meets the road that I and others think that there is a shortfall. It is true that the Reform Bill does provide grants for studies for voluntary testing of medical liability; for comparative clinical effective research to suggest ideal therapies; preventive and wellness

initiatives promoted and funded; funding for electronic records to prevent duplication and errors; funding for establishing community health centers; advisory committees to advise Congress and the President. All of these are admirable, thoughtful, and needed.

There are several areas in which I would recommend a specific action rather than grants for voluntary participation.

1. One of my colleagues stated that she could solve the health care dilemma by doing two things: impose taxes so that a pack of cigarettes cost \$100; and impose a \$10 annual tax per pound on every citizen who is overweight. These would be draconian measures but certainly make a point. As stated by an editorial in the Indianapolis Star, September 8, 2009 -“Let the debate proceed, but lest we forget, health-care reform like health care, begins at home....Lest we forget, however, no set of rules or professional protocols can accomplish what the individual fails to do. It is a sad commentary on public awareness that low-income health care is largely funded with tobacco taxes.” I have read, but have forgotten where, that every \$10 increase in cost of a pack of cigarettes reduces their use by 4 %. The habit should certainly be curtailed. They are the cause for many illnesses, like cancer of the lung and other organs, COPD, hypertensive cardiovascular diseases, stroke, etc. Of course obesity is the etiology of many health problems, like diabetes and cardiovascular diseases. Specific taxes and programs should be instituted to diminish the use of tobacco and exercise and dieting.
2. Since 50% or more of healthcare costs are related to 10% of patients with certain diseases with difficult problems, centers of excellence to care for them

would be beneficial – patients with severe diabetes, obesity, arthritis, severe hypertensive cardiovascular diseases, asthma. The centers could be established by medical centers or other entities and staffed by specialties in these diseases with appropriate, nursing, dieticians, social services, home health to manage these patients and reduce their hospital admissions.

3. Medical education should be evaluated and adjusted as needed. Dean Brater of IUSM projects that there will be a shortage of 159,000 physicians by 2025. More students must be accepted. An excellent program is present at IUSM . The student must pass the 9 competencies in addition to the required courses: effective communication; develop basic clinical skills; using science to guide diagnosis, management, therapeutics, and prevention; lifelong learning; self-awareness, self-care and personal growth; the social and community contexts of health care; moral reasoning and ethical judgment; problem solving; professionalism and role recognition. The AAMC recently reported that every medical school in the United States had added a core of competences in their curricula. One or two visits to the medical licensing board would be helpful as well as a course in medical jurisprudence. As an aside, a group of students asked me to attend a session in which the senior student was teaching a group of junior students. A case of a patient with abdominal pain was presented. After listening to the junior, the senior student asked “Why do all of that questioning and physical. A CT scan of the abdomen would suffice.” I had to interrupt and suggest that the junior was on the right course of doing an H&P first.

4. Physicians must be more compassionate. There is no excuse for less.

Professionalism and integrity must be the order of the day. When I served on the Admissions Committee at IUSM, my associate interviewer would always ask the question: "What would you list as the most important attribute of a good physician?" After he had heard a barrage of answers as he listened attentively, he would interrupt, "And what about integrity?"

5. The issue of illegal immigrants must be addressed. There are an estimated 10 million in this country. I do not know the answer and it is highly political. But we are paying dearly for their care. If any of them visit the emergency room they must be seen and treated until stable. That often requires testing and monitoring. Besides, they are usually sicker when they arrive.
6. I believe that health reform without a specific tort policy and procedure will cause cost of care to skyrocket. Yes! Providers do order additional tests and procedures to evade frivolous malpractice suits. A recent survey published in Archives of Internal Medicine disclosed that 91% of a nationwide group of doctors revealed this. It included ER doctors, other specialists and family practitioners. Five of six doctors in Massachusetts also concurred with this problem. Certainly, a provider, when negligent, should be sued and the plaintiff compensated. Indiana has a good procedure, I think to diminish frivolous cases. Any lawsuit of this nature requesting \$15,000 or more would be reviewed by a committee of his/her peers with an attorney as chairman. The plaintiff and defendant may choose their physicians of the same specialty to review the case. All relevant information is reviewed , interviews done and

a decision made. The suit could go forward but the review panel's conclusions would be admissible in court. Believe you me an extensive and objective appraisal is provided. Many frivolous suits are avoided. There are some estimates that defensive testing costs only 2 or 3 % of the health care dollar. Mort Zuckerman, editor and chief of US News & World Report reported in Financial Times that "Cost control, not coverage, is the key to health reform." He estimates that defensive medicine raises the cost of healthcare by 18%. Charles Karauthammer of the Washington Post reported that defensive medicine, estimated by the Pacific Research Institute, wastes more than \$200 billion a year. "...Half that sum could provide a \$5,000 health insurance grant to the uninsured and poor in this country."

Conclusion

The United States has instituted a very good beginning in health care reform. The insurance aspect is comprehensive and if it survives legal scrutiny will be appropriate but very expensive. In my opinion there will still be one question mark left. To remove it the five players must play their part and fit together like fingers in a glove or parts of a puzzle. There must be developed a three legged stool consisting of of adequacy in each leg – access, quality, safety, and a re-enforcing crossbar of cost effectiveness in each leg.

1. The patient must be more responsible for his/her health care. He must develop good health habits and may require a change in lifestyles: cessation of tobacco use, weight control, exercise, accept appropriate vaccinations and examinations, like mammograms, colonoscopies, etc.

2. The physician and hospitals, as providers, must give accountable care-evidence based, cost effective, compassionate-which will eliminate many frivolous lawsuits, promote patient compliance and satisfaction. Accountable Care Organizations (ACO) may be an appropriate vehicle-where the physicians form these groups independently or as employees of the hospital. The ACO will provide electronic record keeping which will help reduce duplication and medical errors. Medical care can be monitored and provide bonuses for favorable outcomes, cost effectiveness and patient satisfaction.
 3. Medical Education – with requirements for competences instead of regurgitation of information: knowledge, technical skills and problem solving, life-long learning, professionalism, community involvement
 4. Congress – provide funds for necessary programs. Tackle the political problems of tort reform and immigration head-on.
 5. President – Support programs outlined above including tort reform and immigration reform. Appoint a Commission, with Congressional approval of members, to evaluate health care reform and make recommendations to the President and Congress .
- With each of these five fingers working together, we can remove the last question mark and move up in the rankings of nations from #37 by the WHO to # one where we can and should be ranked.

Selective Bibliography

1. American Cancer Society:www.acs.com

2. www.aamc.org/advocacy/library/washhigh/062609/sstart.htm#1
3. www.aamc.org/reform
4. CNN.com/healthcare
5. www.cbsnews.com/8301-503544-162-20000846-503544.html: Health Care Reform Bill Summary: A Look at What's in the Bill
6. www.hsreform.org-AMA
7. Competencies at IUSM:
<http://meca.iusm.iu.edu/body.cfm?d=80&oToppID=17>
8. www.siswise.com//newsletters/01/03/05
9. McCullough, Campbell&Lane, LLP: Summary of Medical Malpractice Law, Indiana
10. NPR.com/healthcare
11. Financial Times: www.ft.com/ushealth
12. Indianapolis Star/healthcare reform
13. Herzinger, Regina; JAMA 2004;292 (10):1213-1220
14. Daschle, Tom: Critical, What We Can Do About the Health-Care Crisis
15. Timeline: History of Health Reform in the U.S.,<http://healthreform.kff.org/>
16. <http://healthreform.kff.org>
17. www.BLACKENTERPRISE.COM/healthcoare
18. LANDMARK – The Inside Story of America's Health Care Law
19. Health Care Reform: Defensive Medicine;Arch Intern Med/Vol 170 (NO 12) June 28, 2010; p 1081-1083

20. Jay, Stephen J. MD: Questions to Ask in Debating Reform; Indianapolis Star /health care, 2009
21. Brater, Craig, MD: Health Reform Could Swamp Doctors; Indianapolis Business Journal, Oct 5-11, 2009
22. Myers, Woodrow, MD: For Healthier Hoosiers, We Need Reform Now; Indianapolis Star/health care, 2009