Miscellany 46: On Health Care Reform

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Miscellany: Commentary on Recent Events and Reading

Some Background Information

The US Congress is currently grappling with the problem of health care reform. For an economically developed country, the US health care system is bizarre. It offers very good but extremely expensive care to a large portion of the population, but an estimated 45 million people (out of about 310 million total, of which perhaps 290 million are citizens or legal residents) do not have access to medical care at an affordable price. The problem is that the system is a high-cost insurance-based system, and many people cannot afford either to pay for medical services out-of-pocket or to pay for the insurance.

Prior to about 1950, the cost of medical care in the US was reasonable, and most people did not have and did not need insurance to cover the cost. The system was based on private doctors and hospitals. Doctors' earnings were modest, and no higher than other professions. The cost of a hospital bed was

about the same as the cost of a good hotel room. Starting about that time, the US government and the American Medical Association conspired to increase doctors' pay. Admission to US medical schools was restricted. Gradually, with the supply of doctors restricted, doctors' earnings started to increase. By the 1960s, doctors' earnings began to exceed those of other professions, such as engineering. At the present time, many US doctors earn many times what similarly trained professionals in other fields earn, and vastly more than doctors in other countries. Another factor leading to increased health care costs was the US government's policy of "socializing the costs" and "privatizing the benefits" – funding basic research from taxes, but allowing private businesses to reap the profits from the research developments. Starting in the 1950s, the US government started making massive investments in health care research. Although this investment was funded by the US taxpayer (most taxes in the US are income taxes, 80 percent of which are paid by the middle class), it was the private medical establishment that reaped the benefits. New medical technology was developed that could treat exotic medical problems. This included new medicines (drugs) and other technology, such as computerized tomography ("CAT scans"), nuclear magnetic resonance imaging ("MRIs"), heart surgery, kidney dialysis and even organ transplants.

Since people will cling to life and good health at any cost, the new medical technology was like a drug to an addict – people demanded the new technology even though they could not afford it. As life expectancy increased, people faced many more years of poor health. With the aging of the population, the demand for medical care surged and the cost burden of medical care reached oppressive levels. The US government had used US taxpayer funds to develop high-cost medical technology that everyone wanted but few could afford – but which generated massive wealth for the medical establishment.

The basic problem was that this technology was very expensive to use, and average wage earners could no longer afford the cost of medical care – even basic medical care at modest cost, since health care providers no longer offered it. More and more people started buying medical insurance, and many employers offered it as an employment incentive ("fringe benefit"). For quite a while, the cost of insurance was within reach of most Americans. As decades passed, however, the government's policy of enriching the medical establishment drove the cost of medical care so high that many people could no longer afford even medical insurance, or very good medical insurance. Furthermore, with the advent of globalization, many firms were paying so much for health insurance benefits that they were becoming uncompetitive in the global marketplace, and so they started dropping medical insurance as a fringe benefit. Today, an estimated 45 million Americans have no health insurance and cannot afford access to basic medical care, and many American families are "one serious medical incident" away from bankruptcy. High medical bills are the leading cause of personal bankruptcy.

The current US medical system works very well for the insurance industry and the medical establishment (doctors, hospitals, pharmaceutical companies, manufacturers of medical equipment and supplies). It does not work well for the American people. It offers good care to many people at a very high cost (about twice the cost of care in other developed contries), and little or no care to a significant portion of the population. US medical care is the most expensive in the world, both in terms of cost per person and proportion of gross domestic product. There has been much discussion of health care reform in the press, and many statistics describing the situation and proposed legislation are available from those sources. The August 10 issue of *Time* magazine and the June 27 – July 3 issue of *The Economist* present articles on this topic. Here are a few sample statistics. The American health care system consumes 16 percent of economic output (gross

domestic product). This is the most for any country in the world, and about twice the level of most economically developed countries. The cost per person works out to about $7,000 per person (compared, e.g., to Canada at about $4,000 per person and Britain at about $3,500 per person. (These figures are from *OECD Health Data 2009* – they include all health care spending, both public and private. In the US, the public spending is a little less than half of total spending, and about 80% of the private cost is covered by insurance.) The breakdown of how people obtain their insurance is: 53% from employers; 5% independently; 26% from a public program (Medicaid (for indigent), Medicare (for elderly)); and 15% uninsured. The "45 million uninsured" figure that is often quoted is obtained from (total US population) x (proportion uninsured) = 310 million x .15 = 46 million.

Town-Hall Meetings

It is rather amazing the degree to which health-care reform has attracted attention. It has attracted so much attention because it directly and immediately affects people financially. The effects of other changes, such as illegal immigration, which are far more destructive to our culture in the long run, are not as evident, since they do not have an immediate and substantial negative financial impact. In response to the interest in health-care reform, many senators and representatives are hosting "town-hall meetings," – small, informal question-and-answer sessions with their constituents. Yesterday (20 August 2009), I attended two of these, one hosted by Senator Jim DeMint (at The Beacon restaurant in Spartanburg, SC – about 375 people) and the other hosted by Representative Bob Inglis (at R. D. Anderson Applied Technology Center in Moore, SC – about 400 people). Unlike many similar meetings featured in the television news, these meetings were peaceful and the audiences were respectful.

The meetings were very interesting. It seems that most people are concerned that the system be kept as a private-enterprise, insurance-based system. They are opposed to President Obama's "public" system, based on a single insurer. There was no discussion (from the speakers or from people asking questions) of any system other than a private-enterprise, insurance-based system.

I had gone to both meetings planning to summarize my views in the matter, but when I saw that my views are very different from what people seem to want, I simply listened to the others. Here, for the record, are my views in the matter.

1. The current system, a private-enterprise, insurance-based system, is badly "broken." Only 58% of the population is covered by normal medical insurance. Twenty-six percent are covered by Medicare or Medicaid. For Medicare, it is necessary to purchase "supplemental" insurance (Parts A and B for hospitals and doctors, and Part D for medications). This insurance is low cost – about $100 - $200 per month, but the "copay" amounts are substantial (e.g., several thousand dollars per year for Part D). There is no way a retired person living on Social Security can cover the medical costs associated with that stage of life, out of his Social Security benefits (e.g., about $800 per month). Fifteen percent of the population have no insurance at all, almost all because they cannot afford it (either because their income is low, or because the insurance is prohibitively expensive because of "pre-existing" conditions). The current system works fabulously well for insurance companies and the medical establishment, making many in the system fabulously wealthy, but it does not work well for many Americans.

2. Congress is not interested in “health care reform.” It is interested only in “health insurance reform.” All through last year’s presidential election, politicians would deceptively refer to “health care reform,” and then speak only of health insurance reform. Just recently, after about a year of dissimulation, the term “health insurance reform” is now being used. The Congress is not interested in the health care status of the population. It is interested only in preserving the gargantuan money-machine that our health care system has become, to continue to funnel vast wealth to insurers and the medical establishment.

3. In the 1940s, prior to the government’s taking steps to make medical care a “cash cow” for insurers and the medical establishment, people could afford medical care. There was no need for medical care to be socialized. Now that the government has caused it to be extremely expensive, there is. It does not serve the people well to operate a health care system that generates massive wealth for the wealthy elite, but is unaffordable for a large proportion of the population. Since many people can no longer obtain access to medical care at these high prices, the rationale for a public health care system is now strong. Moving to a public system is publically criticized on several points. First, there is the concern that the quality of care would be poor, such as in the (public) Veteran’s Administration (VA) hospitals. Second, it is believed that allowing any sort of public option would eventually drive the private system out of business. Third, a public option is “socialized medicine,” and capitalistic American culture is opposed to socialism. This third argument appears vacuous, since there are many aspects of American society that are socialistic, including public education, Social Security, unemployment insurance, national defense, environmental programs (such as river-basin management or anti-pollution programs), and even

major parts of the current health-care system, including the national health research programs, the Public Health Service, Medicaid and Medicare. If education were allowed to be "privatized," and 15 percent of the population could not afford access to it, the people would not stand for it. The argument that public health clinics and hospitals necessarily have to offer a low quality of service also is without merit. The education system works. The defense system works. The largest component of the current public US health system – the programs of the National Health Institutes – work very well – the research they fund is world-class. The argument that a public health system would drive the private system out of business is also specious, since such systems work well in other countries, such as France. As a systems engineer, my approach to designing systems is to identify or synthesize alternatives, compare them according to performance criteria, and make a selection of a preferred alternative. It appears that there is no desire on the part of Congress to examine any alternative other than a private-sector insurance-based system, since this is what the wealthy elite who control the country want.

4. At the town-hall meetings, the point was made by Senator DeMint and Representative Inglis that if all people were required to have insurance, then the cost would go down. This is not true. The price of insurance might go down on a per-person basis, but the cost would not. (Part of the confusion in the current debate is the difference between expense (or price) and cost.) The essential health-care delivery system would be the same, and more people would have access to it. The cost would go up, both overall (total) and on a per-person basis. The per-person health-care costs quoted above are per person *in the population*, not per person *covered*. It is not the case that everyone who is not presently insured has no access to health care, or that he

has access and is getting a “free ride” (although many, such as many illegal aliens, certainly do). Moreover, the cost of insurance for those who could not afford it (or choose not to pay, such as many illegal aliens) would be covered mainly by taxes, not from their own funds. The assertion of Sen. DeMint and Rep. Inglis that if everyone were insured, then the cost per person would be less, is not correct. Even if everyone were insured, the cost of the same basic private system would not decease – it would increase (both per person and total). In fact, it would increase substantially, since insurance companies now reject high-cost or high-risk people having “pre-existing conditions.” Their assertion that if insurance companies were allowed to compete freely nationwide (rather than having to register with state insurance commissions in each state), the cost would drop substantially, is not correct. The proposal to reform the insurance system, leaving the underlying health-care delivery system basically intact, will not reduce the total cost of the system. It will still be the most expensive system in the world, and it will still cost about twice per person, compared to other developed countries. It will simply be paid for in a different way (i.e., by forcing taxpayers to cover the cost of those who cannot afford insurance). The town-hall meetings reminded me of lawyer Billy Flynn in the film/play *Chicago*: “We’ll razzle-dazzle them.” It was all smoke and mirrors – a complicated, elaborate con. Just as Plato predicted, the people in a democracy will elect leaders who promise them anything. Sorry, folks, but you can’t get more high-cost care for less cost, simply by changing the way you pay for it.

5. It is interesting to note that the public portion of health-care spending is about the same, per person, in the US as in all other developed countries (the US spending is still the largest, but by a small margin). What is different in the US is

that, after spending all that public money on health care research and the development of exquisitely expensive interventions, the US citizen is then forced to pay through the nose for the medical care that he receives. The private medical establishment reaps tremendous benefits from the government-funded research, and the citizen does not. The health (e.g., longevity) of the US citizen is no better than in most other countries, and worse than in many. In the town hall meetings, there was no discussion of the fact that the US government policy is to socialize the costs and privatize the benefits (i.e., pay for research using taxpayer funds, and then let the health care establishment keep the profits from utilizing the research results). Instead, the calls were "we don't want socialized medicine." The US citizen has paid, through taxes, an amount sufficient to cover the complete cost of world-class health care, and then he must pay this same amount all over again, to the medical establishment. It is a complete rip-off, and the citizenry does not seem to realize it. Amazing!

6. The government and the media grossly misrepresent alternatives to the present US system. They refer to the fact that in Britain, although health care is available to everyone, it is "mediocre." They do not represent the British system as "universal basic health care," but as "mediocre health care for everyone." British health care is very good. Canadian health care is very good. French health care is very good. The level of health care is very good in every developed country with socialized medicine – those cited plus Switzerland, Netherlands, Germany, Sweden, Italy and Japan. It is very good care at about half the cost (per person and as a fraction of GDP) of the care in the US. The present US system provides very good care to perhaps half its people, reasonable care to perhaps another 35 percent, and poor or no care to perhaps 15 percent – at twice the cost!

The assertion that a public health care system and a private health care system cannot coexist is not true (since it exists elsewhere, such as in France). What the country needs is basic health care for everyone – the same as in all other developed countries. It does not need elegant care for a few and no care or extremely high-cost care for many.

7. The US system has failed not because it is private-sector based or insurance-based. It has failed because of deliberate government actions to design the system so that it produces massive wealth for the wealthy elite. Through government action, the cost of health care has been driven to such high levels that many people have little or no access to health care or to reasonable-cost health care. Physicians, hospitals and pharmaceutical companies have no incentive to offer basic care at modest cost, when the government has designed and subsidized an exquisitely expensive system and encourages them to offer only high-cost services – that is where the money is. Forcing all people to pay for the insurance will do nothing to reduce the cost of health care to reasonable levels, such as in other developed countries. Allowing insurers to compete freely in all states will not reduce the cost to the levels of other developed countries. Simply changing the way that we pay for high-cost medical services and doing nothing to change the cost of those services will not lower the cost of those services. It has been estimated that up to one-third of the cost of US medical care is caused by our legal system (excessive litigation, "defensive" medicine that includes much unnecessary testing), and that tort reform would reduce this cost. Effective tort reform would help reduce the total cost somewhat, but this is not going to happen in a country where most of the Congressmen are lawyers.

8. The US system has evolved to a monster that is funneling massive wealth to insurance companies and the medical establishment (and trial lawyers), but it is sucking the people dry and denying care to many. It is an evil, corrupt system that leaves many in the country unserved, and is costing many others much more than they can pay or need to pay. The system is now so expensive, and functions so poorly for so many, that it is collapsing. There is no way that insurance reform (such as competition among insurance companies, or a single-payer system) will save it. The present system is crashing because of its extremely high cost and poor coverage, and it cannot be saved. It will be replaced by a totally different system, such as in the other developed nations. The US could have maintained the private-sector system that existed just after World War II, but it opted on the side of greed, to enrich insurance companies and the medical establishment. Unfortunately, this greed-based approach has not served the citizens well, and it is now collapsing. The government killed the goose that laid the golden egg. It could have had a private-sector system, but its greed to use the system to transfer wealth from the citizen to the wealthy elite has destroyed it. Now that the government has destroyed the private-sector system that existed in the US in 1950, it is very likely that the new system will be socialized medicine. Humpty Dumpty is broken and all the kings men – the government lackeys of the wealthy elite – will not be able to put it back together again.

9. Global industrialization, and its leading proponent the United States, will not last much longer. The petroleum resources that support this system are depleting, and will be gone by 2040. The world is running out of oil (Hubbert's Peak is passing), and the economic system that depends on it will soon be gone. The world's large population was enabled by

oil, and as oil depletes it will return to pre-oil levels – a few hundred million at most. The world will soon return either to an agrarian society or a hunter-gather society. The only issue is the timing – whether the decline of global industrialization will occur gracefully or catastrophically. In either event, the US should now be spending its precious remaining energy resources on preparing for that future, not on continuing the present exquisitely wasteful system until it collapses, leaving us unprepared for a quite different future. In preparation for this new future, it would be advisable for the US to move to a society in which people can walk to all of the places that they need to go – to work, to school, and to medical care services. To this end, it makes sense to eliminate the private automobile, establish mass rail transportation, establish neighborhood schools, and establish neighborhood basic-care health clinics. That is the only alternative that makes sense in view of the coming low-energy world. It will happen in any event. The only issue is whether we plan for it and construct it now, while we still have access to massive amounts of cheap oil, or wait until this system is forced on us by a low-energy world, and we then have no resources to build it. Some may argue that if the world as we know it will soon disappear no matter what we do, what is the point to doing anything – let our children take care of themselves, even if we destroy their planet. Well, if we are going to use all of the world's remaining petroleum in the next few decades, why not spend it on things that will be of much use to us now and of some use to our children, even if we care nothing for generations in the distant future. If we spend a portion of the remaining oil resources on light-rail mass transportation and on neighborhood schools and clinics, many people will be put to work – all of this construction can be done in a self-sufficient manner, with no reliance on foreign countries at all. These programs would quickly get the US out of its recession.

Along with other simple measures, they would enable the US to be self-sufficient and thereby regain control of its destiny. In just a few years, the US will cease to exist as we know it. As oil exhausts, all nations of the world will collapse. At that time, you may characterize health care as totally socialized or totally private-sector, since neither a functioning government nor a functioning economy will exist. Until then, however, the design and choice of America's health care system is still pretty much up to us. The government has destroyed the insurance-based, private-sector system. It is time to adopt a different alternative. That alternative is not the present system, paid for in a different manner.

10.

Some Personal Anecdotes

The fact that the cost of US health care is extremely high is reflected in the cost per person and the cost as a proportion of GDP. Evidence of this high cost is also reflected on a daily basis in the high bills that Americans receive for health care services. Here follow a few examples of insurance problems and high medical costs, from my own personal experience.

<u>Some Examples of How Medical Insurance Works</u>

A recent retina procedure.

In August of 2005 I suffered a retinal "tear" (hemorrhage of a blood vessel in the retina), and went to a local retinal specialist in Spartanburg for treatment. If you don't have retinal tears treated, the differential pressure that holds the retina to the back of the eye may collapse (before the rupture heals), in which case the retina detaches. In this instance, the doctor used "cryopexy" to treat the tear – freezing of the rupture with a metal probe into which liquid nitrogen is momentarily injected. The procedure is

minor, can be performed in the doctor's office, and takes about 15 minutes.

In the past, I had had much more serious eye operations in South Africa (in a hospital – the Pretoria Eye Institute), and the cost of these was a few thousand dollars. You can imagine my surprise when the bill for this quick office procedure was $5,125. Although surprised by the amount – far more than my hospital eye operations – I paid the bill at the end of the office visit, by check.

This would have been the end of the matter, but for the fact that a lady called me from the doctor's office a few months later to ask for my Social Security number. Unless required by law, I do not release my Social Security number. At the time, I was not yet enrolled in Medicare (I was 63 years old at that time), which does require the use of the Social Security number for identification. The lady said that this was not a problem, but while I had her on the line, it occurred to me to ask her whether I had been overcharged for the cryopexy. I asked her specifically whether I had been charged more than a patient who had medical insurance. She would tell me. I then wrote a letter to the doctor, asking whether I had paid more than an insured person. Below is a copy of that letter, which I sent by fax.

Joseph George Caldwell
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15 February 2006

Dr. James G. Hall, M.D.
Retina Consultants of Carolina, P.A.
480 N. Church Street
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Dear Dr. Hall:

Last year, on 19 August, you performed a procedure on my retina. The results have been very good. Had you been involved with my retinal problems from the beginning, I doubt that I would have the defective vision that I have today.

Yesterday, a lady from your office telephoned me, asking me for my Social Security Number. I explained to her that I do not release it, unless required by law. (I do this in an attempt to reduce the chance of identity theft, which is a serious problem now that so many organizations are asking for it and storing it in their data systems, which are being stolen with increasing frequency.) She said, “No problem.”

Since your office already had me on the line, I asked her whether she could check on something for me. I told her that when I consulted you for treatment last year, I had told you that I was unemployed and without medical insurance, and that I needed to be aware of the cost of whatever was done, beforehand. You replied that your office would “work things out.” The procedure was performed, and I went to the front desk to settle. The lady told me that the amount was $5,125.00, which I paid her by check.

Last year when I saw you, my wife and I had recently returned from Africa, where we had lived for much of the past 15 years. My wife is 67, and, now that we were back in the US, she was able to take advantage of Medicare medical insurance. The thing that we quickly learned is that not everyone pays the same amount for the same medical services. It became very clear that those with insurance pay less, and in many instances, far less, than those without insurance.

With this new awareness, I had become concerned, since your billing lady had not discussed any aspect of the fee, that the fee that I had been charged may not have been what you intended, or reasonable compared to what others paid for the same service. So I asked her to check with the billing office to determine whether the amount that I had paid was comparable to what others had paid. She held me on the line for a minute, and then returned, telling me that the amount that I was charged "was not discounted." I asked her whether it should have been. She then referred me to a lady in the billing department. I don't recall her name. It may have been Norma.

I repeated my explanation to that lady, and asked her whether I had paid what others paid. She told me that a "flat rate" was charged to everyone, and that is what I had paid. (The conversation was rather lengthy and repetitious, and I will simply summarize here.) I told her that my concern was that I had paid more than others for the same service, and that I would like to know whether insured patients paid less (regardless of what "flat rate" was "charged"). She told me that she could not tell me that. I pressed the issue, and she admitted that different prices were negotiated with thirty or forty insurance companies. I asked her whether the amount that I paid was comparable to what they paid, or was more, or much more. She insisted that she could not tell me. "Can't tell me or won't tell me?" I asked. I pointed out that she worked in the billing department, and she certainly must be aware of what was paid. She repeated that she could not tell me. I told her that she was not being helpful, and that it would be very helpful to me to know whether I had paid just a little more than others or a great deal more. For example, did I pay twice as much, I asked. She told me that the prices were negotiated with the insurance companies, and she could not tell me the amounts. She told me that since I was an individual, there was no negotiation. I stated that I was getting the impression that I had paid the maximum price, even though I had paid cash on the spot.

At that point, she became very cool and asked whether there was something else she could help me with. I asked her to have you call me back.

Since I did not hear from you, I am writing to you to ask you, first, whether the price that I paid was what you had intended that I pay, and, second, whether it is your policy for uninsured individuals to pay more than anyone else for your services, i.e., the maximum rate. If so, this policy does not seem at all fair to me. Why should people who pay their own medical bills pay more than anyone else? Is this part of a collective effort on the part of the medical establishment to force everyone to have medical insurance, and thereby cause medical costs to be far greater than they would otherwise be (as in earlier times, when very few people were insured)? Or what?

I am very puzzled why I, who paid cash on the spot, with no medical claim forms for you to complete, would have to pay the greatest amount, since it now appears that that is what I paid. I can understand why you would cut a lower rate for an insurance company that sent you many patients, and I would not expect to pay as low a rate as such a customer. But by paying on the spot, however, I would expect that my rate would at least be comparable to the average amount paid, or the average amount paid by the insurance companies that send you few customers, or the average amount paid by Social Security.

I feel very good about the medical care that you provided me, but I do not feel good at all that I may have been charged substantially more than many others for this care, when I settled my account in cash, immediately. I would appreciate any information that you could provide to me in this matter.

Sincerely,

Joseph George Caldwell

[End of letter.]

Soon afterward, a lady in the doctor's office telephoned me to discuss the matter (I don't recall now whether this was the same lady). She told me that the bill was being reduced. The figure that she quoted was on the order of $1,500 – 2,000, and she told me that she would send me a check for the difference between what I had paid and this amount. I don't recall the exact figure. It was an "odd" amount (an exact dollar amount, not to the nearest hundred) – something like $1,642 sticks in my mind. I was taken aback by the amount of the reduction. Because the reduction was so large, I assumed that the doctor was "patronizing" me, and I said something like, "Oh, my, this is embarrassing." All I had expected and asked for was a fair shake, not charity.

Well, that was the end of that. I never received the promised check, and I never heard further from the doctor's office.

In the July 19, 2009, issue of the *Spartanburg Herald-Journal* newspaper, Lane Filler wrote an article entitled, "Universal health care closer than you think." Here follows an excerpt from his article.

Some people enjoy testing their wits with a crossword. Others like Sudoku. But when I'm looking for a brainteaser to solve, I sit down with a billing statement from a health care provider and chew on that for a while.

"That doctor charged $30 for an `ASSAY OF CK (CPK)- 82550,'" I said to my wife.

"How do they get away with it?"

Angela was listening to the Black Eyed Peas on her iPod, something she likes to do when she fears I might try to share my thoughts, and replied, "I couldn't agree more, dear."

Me: "But the `RBC SED RATE, AUTOMATED-85652' was $34. In my day, for $34 you could take a gal to see 'Who Framed Roger Rabbit,' fill up the Chevette and still have money for a bottle of Boone's Farm Strawberry Hill."

Angela: "I don't know how women lived with men before it was possible to pipe loud music through headphones. I wouldn't last three days."

The bill, for an office visit and some lab work, listed 16 mysterious services and came to $1,118. According to the bill, we owed $273. The insurance company owed $845.

But further perusal indicated the insurance company only had to pay $198.18, or 23 percent of its bill.
"A-ha," I thought. "I'd also like to pay 23 percent of my bill."

So I called Spartanburg Regional Healthcare System's physicians billing service, which handles the moneygrubbing for the doctor, so when you complain that the bill is written in Klingon, the doctor says, "We don't handle that," and when you complain to the bill people that, "For $275, the doctor could at least warm his `Mr. Freeze' hands before he ... investigates," they say, "Sir, we only handle the billing."

I got the very nice Amy.

"Amy, let's get right to it," I said. "I would like the 'Payor Adjustment' option, the same one you gave the insurance company for their portion, for my 77 percent discount."

Amy: "We don't do that."

Me: "Why not?"

Amy: "I can't explain that."

But I knew why all along. The real price of the services is $471.18, the sum of my share and the insurance company's. The $1,118 is what an uninsured person would be billed, 2.5 times the real price, because lots of uninsured folks won't pay, so they jack up the price to the ones who will to make it up.

So, a few true things:

- Most people in America can get medical treatment even when they can't pay for it.
- The price to those who can pay is already raised to cover the cost of those who can't, via insurance premiums, medical bills and taxes.
- That means we already have a universal health care system, albeit a hypocritical, inefficient, ridiculous one.

So maybe it's time we stopped arguing about whether we should adopt a universal health care system we've already adopted, and instead talk about how to make it work.

[End of Lane Filler piece.]

Well, this was quite a shocker. In retrospect, if what Mr. Filler says is true, I was as a matter of course charged far more than an insured patient, and it appears that the lady who called me was in fact quoting me the insurance price, not a “charity” price.

It is a disgusting development when someone who pays cash on the barrelhead for medical services is charged far more than a person who pays via insurance, which involves considerable “red

tape” (handling the insurance, processing the claim, waiting for payment).

A thwarted insurance scam

Some years ago (November 1985), my son was involved in an automobile accident, which left him paralyzed from the waist down. He was a passenger in someone else’s car, and the owner of the car carried only $25,000 insurance. A second passenger was also paralyzed, so the amount of insurance was totally inadequate to cover the cost of medical treatment for my son, which was estimated at the time to be about 1.2 million dollars in his lifetime.

I have always carried a substantial amount of insurance on my automobiles, including “uninsured” and “underinsured” coverage, in case any of my family members are involved in an auto accident involving an automobile that is uninsured or underinsured. In this case, my policy covered several hundred thousand dollars for my son’s injuries. In addition to my automobile insurance, I also had medical insurance through my employment with Combustion Engineering, the firm the managed the Electromagnetic Environmental Test Facility of the US Army Electronic Proving Ground.

Collecting this insurance money, however, is not as simple as it appears. The carrier of the automobile insurance paid, but the carrier for the medical insurance tried to defraud me of what was due my son under the policy. I filed the claim, but before I was paid, I received a request to sign a “subrogation” agreement, under which the proceeds from the automobile insurance would be paid to them, not to my son. I could not believe what I was reading, and so I immediately hired a lawyer. Since the claim appeared to be so simple – a claim for the stated amounts on the policy – I arranged to pay the lawyer a fee per hour worked, not a

“contingent fee,” which can often range up to a third of the amount recovered.

After being contacted by my attorney, the insurance company backed off – for a while. It tried the same scam several times later – after half a year, after two more years, and about a half year after that. Each time that they requested me to sign a subrogation agreement, I reminded them of my attorney’s letter in the matter, and I did not hear anything further for a while. The fourth time was the last time that I heard from them. At some point, the matter became moot, because my son became too old to be claimed as a dependent on my policy.

Here follows the text of a typical letter that the insurance company sent me, asking me to subrogate the automobile insurance proceeds (or any other insurance proceeds, of which there were none).

John Hancock Mutual Life Insurance Company
Combustion Engineering Claim Office
Call Box #999
Bryn Mawr, PA 19010
(215)525-5050

Date: 7/20/87

Mr. Joseph Caldwell
3826 Snead Drive
Sierra Vista, AZ 85635

Re: Steve

Dear Mr. Caldwell:

Prior to our issuing any Combustion Engineering Medical Plan benefits for treatment due to an accidental injury, we request that you complete the attached Right of Reimbursement Agreement and Accident Report.

The Right of Reimbursement provision under your medical plan states,

> "No payment will be made for expenses incurred in connection with injuries received for which a third party is liable except to the extent that third party liability is satisfied in an amount less than the amount otherwise payable under the contract".

Your plan also coordinates benefits with No-Fault insurance.

Upon receipt of the signed and completed Right of Reimbursement Agreement and Accident Report, your submitted charges will be considered. Please make sure the Accident Report is completed fully so your benefits will not be delayed.

If you have any questions, I will be happy to answer them. A self-addressed stamped envelope is enclosed for your convenience.

Sincerely,

Mary Garner
Medical Claims Approver
John Hancock Companies

[End of John Hancock letter.]

Here is the text of the letter from my lawyer, after the first attempt by the insurance company to get me to sign the subrogation agreement.

Davis, Siegel & Gugino, P.C.
Attorneys at Law
2730 East Broadway
Suite 250
Tucson, Arizona 85716

January 31, 1986

Equitable Life Assurance Society Attention: Linda Berkheiser
Case Management Services Division 400 Rouser Road
Building 2, 6th Floor
Coraopolis, Pa 15108

Re:
Your Insured: Joseph George Caldwell / Dependent Son Steve Caldwell
Branch: Bell Tech Operations Textron
Group No. 555 123
Branch: 11002
I.D. No.: 222-22-2222

Gentlemen:

This firm represents Joseph George Caldwell and his son, Steve for injuries that Steve received in an automobile accident in Tucson, Arizona on November 25, 1985.
(Copy of police report attached hereto as "Exhibit 1")

I have been informed that your company has requested Joseph George Caldwell, the employee under the plan, to agree to subrogation to his son's position under 'his policy.

In reviewing your policy, specifically page 53 entitled "Coordination with other plans", I find no provision which permits you such subrogation.
Equitable Life Assurance Society January 31, 1986

Neither Joseph George Caldwell nor Steven Caldwell maintain a plan as defined in paragraph 3 on page 53.

The only other insurance which may be available arises out of the insurance of the operator of the vehicle at the time of the accident and automobile policies taken out by Joseph George Caldwell.

Arizona does not have no fault provisions nor is there any other group insurance of any nature available to Joseph George Caldwell nor his son, Steven.

Accordingly, it appears that your plan is fully obliged, without right of subrogation, to pay benefits up to and including the maximum limits under the policy.

Mr. Caldwell has informed me that he has had conversations with representatives of your company about this matter. I have attempted to telephone your company and, when the lines are not busy, left a message which has been unreturned.

By this letter and in accordance with your policy of insurance, we fully expect your company to fulfill its contractual obligations on behalf of Joseph George Caldwell and his son, Steve.

If you disagree or there is information available which is not contained in the life and health care plan, please make me aware of it immediately.

Very truly yours,

Barry M. Davis

BMD/be
Enclosure: Accident Report

[End of Davis letter.]

My son Steve's medical expenses were very large, and would have consumed all of the money from the automobile insurance. Had I signed the subrogation form, all of the medical claims covered by the medical insurance would not have been paid, until all of the automobile insurance had been used. The automobile insurance was very helpful in making my son's life more comfortable, enabling him to purchase a car, home and other benefits not covered by the medical insurance. Both of those would have been lost, had the fraud attempted by the medical insurance company been successful.

The attempted fraud would have cost my son several hundred thousand dollars, to which he was entitled, and for which I had paid. This was not a single, inadvertent mistake on the part of the insurance company (John Hancock). It kept trying, over a five-year period, to get me to sign the subrogation agreement.

The High Cost of Medications

The Price of a Purgative

A few years ago I was having digestive problems, and my doctor recommended a gastro-intestinal X-ray. Prior to having the X-ray done, I was to take a purgative, to "clean out" my digestive tract. As I recall, what he prescribed was a bottle of sodium citrate – a sort-of strong lemonade. It was inexpensive – a few dollars – but very effective.

Recently, my wife's doctor recommended that she have a colonoscopy, and she was required to take a purgative the day before. I picked up the purgative that the doctor prescribed for her at a local drug store. Was this a surprise! The retail price of the purgative was $42.99, of which my insurance paid $25.97. The product was called NuLYTELY, manufactured by Braintree Laboratories. It is a mixture of polyethylene glycol, sodium chloride (ordinary table salt), sodium bicarbonate ("baking soda") and potassium chloride (a weakly salty tasting no-sodium substitute for sodium chloride; "low-salt"). All of these ingredients are readily available without prescription and very inexpensive – less than a dollar a pound retail. Polyethylene glycol (PEG, also known as polyethylene oxide, PEO, or polyoxyethylene, POE) is a water-soluble polymer used in many products, including laxatives, ointment bases, skin creams, lubricants, toothpastes and film coatings. A gallon of the NuLYTELY mixture (of which only a few cups is needed for purging) consists of the following amounts: 420 g of polyethylene glycol ("PEG 3350"); 5.72 g of sodium bicarbonate; 11.2 g of sodium chloride; and 1.48 g of potassium chloride.

Surprised by the high cost of something containing such ordinary and low-cost ingredients, I asked the pharmacist to explain why the cost was so high. He said that the reason for the high cost was not that any of the ingredients were patented, but that the *combination* of ingredients was patented by the drug company. I asked him if he could sell me the separate ingredients, and he said, yes, he could. I then asked him how much the sodium chloride (table salt) would be. He told me that his price was eleven dollars per gram. I was amazed. The price of pure gold is only about thirty dollars per gram. The cost of a box of Morton's table salt is sixty cents for a one-pound, 10-ounce box (737 grams). This works out to about $0.0008 per gram. His price was 13,500 times as much.

Why a physician would prescribe a product worth only a few cents of readily-available materials in a “branded version” costing 43 dollars is difficult to understand. This rip-off does not directly benefit him. Why a drug store would sell table salt for 13,500 times as much as it is worth is much easier to understand. This incident puts the Department of Defense’s legendary $435 hammer to shame – it was sold for only 29 times its original price of $15. It illustrates graphically how “out of control” our health care system, controlled by the venal medical establishment, really is.

The Price of a Blood Thinner

(Excerpted from *The Late Great United States*.) I recently (November 2007) suffered a “transient ischemic attack,” or “ministroke.” The doctor prescribed daily doses of Plavix (clopidogrel), costing about five dollars a pill. I immediately suffered bad side-effects from the Plavix, which included a swollen tongue. I did a quick search of the Internet to find out about Plavix. I could not find any information that it was more effective than aspirin, which costs a few pennies a pill. I asked my doctor about this, and he told me that aspirin was about 90 percent as effective as Plavix. Why would a physician, without discussion, prescribe a medication that is only marginally better than aspirin, but costing hundreds of times more and having serious side-effects?

The Cost of Malaria Treatment in the US

While I was consulting in Ghana a few months ago (February – March 2009), a colleague of mine mentioned that he had contracted malaria in Benin a few months earlier. Malaria takes a few weeks to “incubate” before the symptoms become manifest, and my friend did not fall ill until a few weeks later, when he was back home in Chicago. The cost for treating his malaria, paid by

his employer's medical insurance, was about $60,000. He was in hospital for about a week. This is an absolute disgrace. It should not cost $60,000 to treat malaria for a week. Our insurance-based private-sector medical care system is horribly broken.

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