

BY JACK BOBO

Ready, Fire, Aim

THE TITLE TO THIS PIECE REMINDS ME of the outrageous comment by Nancy Pelosi during the final days of the health-care debate.

“You have to pass the bill to find out what’s in it,” Pelosi said. Perhaps not the exact quote but close enough to it to indicate to members of Congress that they were firing a volley into the unknown. Now that it has passed and the smoke has cleared, it is becoming obvious that the aim was misdirected insofar as improving our healthcare system. As far as “what’s in it” is concerned, there is not much to like.

A bulletin put out by the Centers for Medicare and Medicaid in May tried to put the best spin on the new law—but upon examination, it falls short of the mark. One can start with the name of the bill: “Affordable Care Act.” In April, a month before the CMS bulletin, Medicare’s chief actuary, Richard Foster, totally destroyed many of the claims for the bill made by President Obama and the forgoing bulletin. To cite a couple of examples, Americans would likely be subject to \$120 billion in fines for not having the prescribed coverage. Additionally, CMS actuaries estimate 14 million people would lose coverage because increased costs would lead employers to discontinue existing coverage.

In May, at the same time the CMS bulletin was extolling the virtues of the law, the Congressional Budget Officer revised its cost estimate upwards by \$115 billion. Most observers believe that even this upward revision is woefully inadequate.

Obviously, the American Medical Association (AMA) does not like the 21% cuts in Medicare payments. They are currently running a national ad program urging Senators to get back to work and fix what they see as a major problem likely to have an unfavorable impact on seniors and others. Such price controls have not worked in the past, and there is little evidence that these cuts will be beneficial. I believe it is instructive to follow the goings-on in Massachusetts to see the results of such action. According to an April 9 article in the *Wall Street Journal*, it was impossible to buy healthcare coverage in that state because of price controls Governor Deval Patrick imposed upon health insurers. The issue was supposed to go to court April 12, and I do not know if it was resolved and in whose favor. Interestingly, all of the major insurers in Massachusetts who were denied rate increases are nonprofit organizations.

The new federal law requires insurers to accept anyone, regardless of insurability, pretty much the same as the Massachusetts law. Now that is a good thing—but to suggest that it can be done without increasing premiums or taxes is ludicrous. Blue Cross Blue Shield of Massachusetts reported a big uptick in short-term customers who

ran up costs more than four times the average, only to drop coverage within three months, according to the *WSJ*. Similar results were experienced by Harvard Pilgrim, another Massachusetts insurer. The *WSJ* added that between April 2008 and March 2009, about 40% of its new enrollees stayed with it for fewer than five months and on average incurred costs about 600% higher than the company would have otherwise expected.

One of the key points emphasized in the May CMS bulletin is better access to care. Really! Others opine that while you may have access, the average wait to see your doctor would be 44 days. Sounds a lot like Europe. Supporting this claim is a new trend that could have serious implications to access: The Mayo clinic has announced a new program (limited initially to 300 people) that guarantees access to their care facility. The cost: \$5,000 per year for an individual or \$8,000 for a couple.



“This is one of the most successful heart institutes in the country, and they are having a hard time staying afloat. So much for price gouging by providers.”

The physician for a friend of mine has instituted a similar plan for immediate access to his services at a cost of \$1,500 per year. Because it was important for my friend to receive immediate access, she signed up for the program. If this trend spreads, then the wait time for those who cannot afford the annual access fee would most certainly be longer than 44 days. So much for better access.

The subject of an article in the April 10th issue of the *WSJ* was a bit nostalgic for me. The article covered the closing of St. Vincent’s Hospital in Greenwich Village in the heart of Manhattan. I remember St. Vincent’s well, for I spent three weeks there in 1935 recovering from a burst appendix. It was a wonderful and caring facility and they saved my life. According to the article, however, they are closing after emerging from bankruptcy in 2005 and piling up \$600 million in subsequent debt. No suitor could be found to rescue the hospital.

I was reminded of this again when a local heart hospital announced the closing of five ancillary facilities because of the costs. This is one of the most successful heart institutes in the country and they are having a hard time staying afloat. So much for price gouging by providers.

To their credit, there was one frank admission in the CMS bulletin. In the final paragraph, they pointed out that high-income people will pay higher premiums. Even that feature was presented as a positive in the spirit of keeping Medicare strong and solvent.

When insurance companies ignore the advice of their actuaries, the result is usually an operating loss or even insolvency. When government ignores its own actuaries, the result is almost always higher taxes or huge deficits. Regulators can control un-sound practices by insurance companies, but who is going to control government when doing the same thing? Perhaps the voters will have to return fire, but this time by taking aim first. ■