



Letters to the Editor

Taking Issue with Dr. Snook

I read Dr. Snook's article (A Solo Physician's View on a CalPERS Data Bill) in the May/June '07 *SSV Medicine* with great interest. Several of his observations merit comment. He cited a class action lawsuit against Blue Shield of California alleging unlawful, unfair and fraudulent business practices. Blue Shield is a not-for-profit entity - a mutual company whose shareholders are the subscribers they cover for health care services.

I discovered the lawsuit was filed after Blue Shield made a variety of changes to its Individual and Family Plans. Like life insurance, Blue Shield has multiple risk tiers for this product. Applicants, when they first enroll, are assigned to a tier based on multiple factors. Blue Shield has been on a mission to make health care coverage more affordable for Californians. In keeping with this, one change was to create a new, lowest risk tier - into which the company moved the lowest risk members.

The class action lawsuit was filed on behalf of remaining members in the upper tiers, who claimed this raised their rates and was not in keeping with existing subscriber agreements. Blue Shield settled without admitting guilt and, indeed, felt the charges were defensible. The plaintiff felt its legal assertions had merit. Both sides agreed to settle rather than to go through the time and expense of legal proceedings.

I looked up Blue Shield's Annual Report for 2006. Its administrative expense as a percentage of revenues was 11.8% - not the 15-20% cited by Dr. Snook. Approximately one third of this goes to insurance brokers, the people we turn to when we purchase insurance products. About 2-4% of the premium goes toward the cost of sending out membership cards, membership information and processing claims. Blue Shield also contributed \$30 million from profits to its Foundation for community support. Grants were awarded from this pool to help fund the Healthy Family Program, free clinics and domestic violence programs

Dr. Snook states that doctor charges do not increase costs of health care. In general, he is correct. However, our behavior does indeed affect costs. Unnecessary testing certainly plays a role. As an example, abdominal CT scans are typically ordered before a surgeon sees a patient, even when there is a strong clinical suspicion of appendicitis. This test carries a false negative rate of upwards of 25%. There are recent reports that the resultant delay in providing surgical management results in a subset of patients experiencing a ruptured appendix. (Indeed, some old timers feel many younger physicians have lost their diagnostic acumen, failing to rely on history and physical examination skills, and instead using advanced radiographic imaging as an extension of the physical exam.) While the treating physician may not receive more money, there are certainly increased costs and payments to other parts of the delivery system - costs ultimately borne by employers and all consumers.

Where services are performed also can be significant. I recently had a trans-esophageal echocardiogram, done on an outpatient basis at Mercy General Hospital. I was shocked to see the charge for the technical component was over \$2,000. The allowed amount was 90% of the gross charge. I looked up the CMS allowance for the procedure and found it

was in the range of \$270. I paid more with my co-insurance than if the procedure were performed in a non-hospital-owned free-standing facility, and if I paid for 100% of the technical component - even at 180% of the CMS allowance!

Finally, if we believe that we don't directly contribute to the cost of care, I suggest reading "Coronary, A True Story of Medicine Gone Awry", by Stephen Klaidman. It is a book outlining what took place in a hospital system in Northern California several years ago. (Editor's note: read book review in this issue.)

- Frank Apgar, MD

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