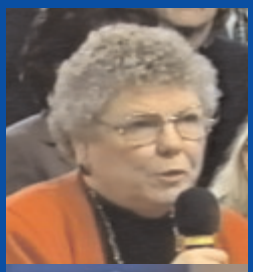

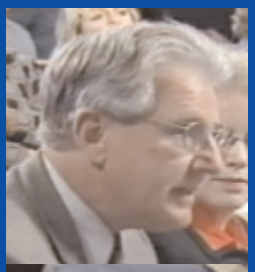

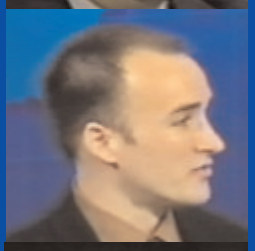

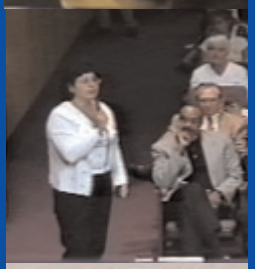
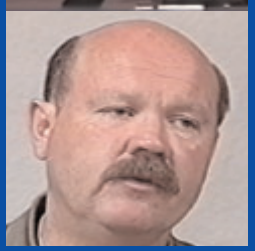

# Crisis and Opportunity

## *Forging a Universal Health Care Consensus*

★ ★ ★ ★ ★

California Health Consensus

THE FOUNDATION FOR TAXPAYER AND CONSUMER RIGHTS

# Crisis and Opportunity

## *Forging a Universal Health Care Consensus*

★ ★ ★ ★ ★

Jerry Flanagan
The Foundation For Taxpayer and Consumer Rights

March 2004

For more information about the Foundation for Taxpayer and Consumer Rights or the California Health Consensus Project please visit us on the web at www.calhealthconsenus.org or www.consumerwatchdog.org

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Cover photos, clockwise from top right corner: Steve Thompson, V.P. of Government Relations, California Medical Association; State Senator Liz Figueroa (D-Fremont); Charlie Woo, CEO, MegaToys; Daniel Zingale, former Director, Department of Managed Health Care; Felicia Wilson, uninsured patient; Irma Cota, CEO, North County Health Services; Ken Wuchner, paramedic; San Francisco Town Hall; Richard Ledford, President of the Board, San Diego County Chamber of Commerce; Lee Blitch, President & CEO, San Francisco Chamber of Commerce; State Assembly Member Keith Richman (R-Northridge); Maria Ortiz, Community Organizer, Bi-National Border Health Program; Sara Nichols, former Legislative Advocate, California Nurses Association; Jim Lott, Exec. V.P. for Policy Development and Communications, Healthcare Association of Southern California; Kay McVay, President, California Nurses Association; Los Angeles Town Hall.

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# Executive Summary

This report, *Crisis & Opportunity: Forging a Universal Health Care Consensus*, provides a first-hand account of the health care system in the words of the doctors, patients, employers, nurses, hospital administrators, clinic directors and health insurance executives that navigate it. The statements and stories reported here were collected from five broadcast town halls, two public television programs produced by California Connected, and more than 50 individual interviews and work groups that took place between February 2002 and January 2004. The goal of this on-going process is to forge a consensus on a cost-effective universal health care plan.

The purpose of this report is to provide policymakers and opinion leaders the personal testimonies of patients and prominent stakeholders about problems with, and solutions to the health care system. From the input of hundreds of participants, we have developed three model cost-control laws and a model universal health care solution (see Section VI & VII).

Not everyone agreed on every issue; however, it is clear from these discussions that affordability is the key to health care reform. This year, several cost-saving measures have been introduced in the state Legislature. These measures compliment legislation passed in 2003 that provides access to health care for 1 million uninsured working Californians through an expansion of employer-sponsored health care.

If the Legislature fails to provide the necessary reforms, the Foundation for Taxpayer and Consumer Rights will propose a ballot initiative to allow California patients to have the final say in the policy debate.

Four consensus themes were culled from stakeholder discussions (see Section II):

- ◆The market-based system is devastating all stakeholders except health insurers and drug companies.
- ◆There is enough money in the health care system to insure everyone, but it is being mismanaged.
- ◆Access to care for all patients is threatened due to a lack of coordination between the public and private health care delivery systems.
- ◆More public control is necessary to create a rational decision-making process and to provide greater cost efficiency.

Participants from across the political and ideological spectrum also agreed on several key tenets of a universal health care plan (see Section V), including:

## Universal Access

Almost without exception, participants said they support a system that provides universal access to health care, though there was much disagreement about how to achieve it. Many believe there is enough money in the system to provide care for all Californians, but it is being spent in inappropriate ways.

> *"Let's recognize that ... we do intend to provide care to people when they truly need it. And let's do it in a more cost-efficient way."*
> Daniel Zingale, former Director of the Department of Managed Health Care and former Governor Gray Davis' Chief of Staff[1]

Some think the key to universal coverage lies in regulating the health care system, as California once did for the telephone and electricity systems.

> *"I can remember the old days when there was one Bell system. And our goal at that point, we had two words, 'universal service.' And we dealt with this through the -- through the private industry to do this."*
> Lee Blitch, President & C.E.O., San Francisco Chamber of Commerce[2]

Still others believe that more money is necessary in order to stabilize the health care system and provide insurance coverage for all Californians.

> *"We have not been willing as a society to put enough of our ... tax dollars in the pot to make sure that the trauma centers are okay ... that the emergency rooms are okay; that the uninsured have insurance."* Walter Zelman, former President & C.E.O. of the California Association of Health Plans[3]

## Affordability

Affordability means different things to different people, but all agree that it is lacking. For consumers, and the growing number of middle-class Californians struggling to pay for their coverage, affordability means controlling premium increases and out-of-pocket costs.

> *"Individual policyholders have no leverage; we need all the help we can get. My family and I have been victims of bait and switch tactics and frequent, exorbitant cost increases. We need limits imposed, including on the number and percentage of rate increases."*
> Jon Pastoria, self-employed, Studio City, California[4]

For business owners, affordability means holding down overall costs, limiting coverage, or passing on costs to employees in the form of out-of-pocket costs like co-pays and deductibles.

> *"When you look at the average business, labor costs are among the most significant portion of their total cost of doing business. And the portion of labor cost that's rising fastest is health care..."* Rusty Hammer, President & C.E.O., Los Angeles Chamber of Commerce[5]

Health insurers say that high medical costs and spiraling prescription drug utilization are triggering annual premium increases of 20-40% or more in some cases. According to health plans, affordability for the consumer is available in the market if he or she is willing to look.

> *"I would tell you to get an insurance agent and shop the market... there are many, many quality choices for both individuals and employers..."*
> D. Mark Weinberg, Exec. V.P. and Chief Development Officer, WellPoint[6]

Doctors, nurses and hospital systems are each impacted by inadequate government reimbursements and budgets squeezed by overhead and profit needs. Many say the current crisis is the worst they have seen in more than a decade, if ever.

> *"Our insurance industry needs to be re-regulated so that the premiums they charge people are based upon the medical needs of those people, not upon market rates. That money must be held in trust, and then paid out when we need it, to hospitals, doctors, and nurses. We need to re-regulate."* Dr. Brian Johnston, emergency room physician, former president of the Los Angeles County Medical Association[7]

## Public Decision-making Process

While these discussions found a broad-based level of support for universal health care, many remarked on the lack of political will to achieve a solution.

> *"What is preventing the health care system from delivering something that is so fundamental to every American?"* Steve Thompson, V.P. of Government Relations, California Medical Association[8]

Currently, there is no integration of disparate state-decision making bodies. As a result, changes in the health care market are often brought about by market forces alone that rarely reflect the needs of individuals or the needs of the system as a whole.

> *" ...public health is not a quarterly commitment..."*
> Wade Rose, V.P. of Policy and Planning, Catholic Healthcare West

Participants felt that giving the authority to an independent body that does not have an economic stake in policy outcomes is the key to achieving a rational, system-wide approach.

> *"...an independent commission that would monitor and have... control over cost increases."* Art Letter, retired member of health oversight commission, San Diego[9]

By doing so, the public would have a say in determining health care priorities.

> *"...the key ... is public control over how the money is spent."*
> Dr. Michael Cousineau, Associate Professor of Clinical Medicine, Keck School of Medicine, USC[10]

The California Health Consensus Project's model universal health care law includes policy elements to address each of these concerns (see Section V & Section VI):

1) Hospital and medical group rate stabilization;
2) Health insurer premium control and bulk purchasing;
3) Universal access to a comprehensive health benefits package;
4) A public decision making process.

## Cost Controls Are The Next Phase of Reform

During the course of the town hall process, many of the stakeholder groups supported "pay or play" legislation, SB 2, designed to expand employer-sponsored health care by requiring

employers with 50 or more workers to provide coverage beginning in 2006. Though SB 2 eventually passed, it did not contain cost control mechanisms.

The next phase of health care reform will be to make health care affordable to millions of working families and business owners. The majority of stakeholders at the town halls agreed that California should implement three immediate cost control strategies (see Section VII):

### 1) Prescription drug bulk purchasing

Canada and the U.S. Department of Veteran Affairs (DVA) receive discounts of 30-60% off U.S. made drugs as a result of negotiated bulk purchasing discounts. The California Public Employees Retirement System (CalPERS) bulk purchasing pool should be expanded to provide patients and businesses access to the same discount prescription drug rates that state employees, legislators, and the Governor currently receive.

### 2) Hospital Market Stabilization

There were deep concerns voiced in town hall discussions about the stability of the hospital system. Long waits in emergency rooms and financing inequities were of particular concern. Tenet Healthcare Corporation's recent announcement that it intends to sell 19 California hospitals brings to the fore several key failures of the hospital market. Independent oversight of finances is necessary to allow for the kind of long-range planning needed to ensure that our hospitals are safe and to stabilize access to emergency care. The state of Maryland has used a similar model to effectively control costs since 1971.

### 3) Health Care Premium Regulation

Since 1988, California consumers have saved more than $23 billion dollars on their auto insurance rates as a result of voter-approved Proposition 103, which requires auto insures to get approval before raising rates. Health insurers should be required to abide by similar oversight and to justify their administrative costs and profits.

Other cost control policies proposed by California Health Consensus Project participants include both market-based and regulatory solutions:

Table 1: Cost-Control Policy Options

| Cost centers | Market-based | Regulatory |
|---|---|---|
| Prescription Drugs | ◆Bulk Purchasing<br>◆Re-importation from Canada<br>◆Information about the relative effectiveness of new, costly drugs | ◆Restrictions on advertising and direct marketing<br>◆Price setting: Canadian rate, Federal Supply Schedule, etc.<br>◆Ban gifts from pharmaceutical companies to physicians |
| Health Insurers | ◆Allow more group purchasing | ◆Provide greater transparency of how premium dollars are spent |
| Hospitals | ◆Disclosure of rates | ◆All-payer rate setting similar to a system in place in Maryland since 1971 |
| Physicians/Medical Groups | ◆Disclosure of fees | ◆Fee regulation & anti-trust actions<br>◆Knox-Keane licensure |
| Regulatory Complexity | ◆Consolidation of oversight | ◆Elected health commission |

# Section I.
# Introduction: Why We Brought Together the Voices of Health Care

Beginning in 2000, our consumer group experienced a dramatic increase in phone calls and emails from working Californians struggling to pay for their health insurance. Worried parents wanted to know if there were options for lower-cost care. Some were making the tough decision to limit their family's health insurance to only catastrophic coverage. All faced the frightening reality that health insurance might soon become unaffordable.

At the same time, we knew from colleagues and others who have a stake in the system—doctors, nurses, employers, hospital executives, clinic administrators, and insurance executives—that cost increases, coupled with a slowing economy, were creating a nearly universal crisis. What we were hearing appeared to be a commonality of experience among a surprisingly broad set of stakeholders, including growing outrage from the politically important business owner contingent—an historic appearance of that group among the ranks of the health care system's disenfranchised.

We wondered if it was time to talk seriously about a cost-effective system to provide care to all Californians, because everyone saves money when everyone is insured. Knowing that common problems can sometimes inspire common solutions if carefully nurtured, we launched the California Health Consensus Project to provide forums for dialogue.

The objective of these discussions was to temporarily suspend the day-to-day frictions that have kept these groups apart in order to ask the question: "Are there areas where we all can agree? Are there common solutions that we all can support that will lead to a cost-effective universal health care system? If so, what are they?"

To answer these questions, we invited the leaders of the most powerful stakeholder groups to meet with those struggling to hold onto their health coverage and those with no coverage whatsoever. These meetings brought together groups of people who are rarely in the same room together, let alone for a common purpose.

Agreement among this broad group, we hoped, could give rise to politically relevant solutions, not merely theoretical machinations. Since February 20, 2002 the Project has held town halls with over 700 participants, conducted more than 50 point-of-view interviews and has convened or participated in dozens of working groups and informal meetings among stakeholders.

We knew that if the answers to our questions were as promising as we hoped, we would have to make them available to the public and policy makers. Hence the town halls were televised and broadcast, interviews made public, certified transcripts prepared.

Not everyone agreed on every issue, and though we encouraged participants to put aside their differences and look for solutions, there was often loud disagreement. For the purposes of this report, "consensus" means that at least 2/3 of town hall participants concurred. Admittedly, molding the disparate perspectives into a finite set of consensus themes and policy elements is an inherently subjective process.

First we will summarize the major complaints from each of the major stakeholder groups—answering the question, "What is the major problem in the health care system from your perspective?" Following this brief overview, we provide a detailed vetting of the consensus themes and solutions, present a model universal health care law, and offer immediate policy solutions to the cost epidemic.

## High Costs Impact All Stakeholders

Without dispute, the health care system is burdened by high costs that are expected to double within the decade:

- ◆In 2002, health care spending increased 9%—the largest increase in 11 years. The nation now spends $1.6 trillion every year on health care—or $5,440 per person. Health spending is projected to double in the next 8 years.[11]
- ◆Health care premiums are growing even faster than medical costs. Premiums rose 13.9% in 2003—the biggest annual jump since 1990—and employers shifted more and more costs to workers. Over the past three years, the amount typically paid by employees for family coverage has increased by more than 50%.[12]
- ◆Health care cost increases in excess of growth in wages or the economy as a whole is projected to continue for the rest of this decade.[13]

There is of course disagreement over the cause of these increases, but the majority of stakeholders agree that system-wide administrative costs, advertising costs, and excessive profits are diverting tens of billions of dollars away from patient care. Thus, all purchasers pay more for less care. The resulting cost increases impact consumers, nurses, doctors, employers, hospitals, clinics and health insurers in different ways:

### *Consumers*

Among those insured with employer-based coverage, 1 of 4 reported that they did not get needed medical care due to high costs. Middle-class families are being forced to limit coverage or go without because they cannot afford their share of premiums and out-of-pocket costs. Millions of individually insured Californians and pre-Medicare retirees without health care benefits pay the highest price for health insurance. For California's 5.3 million working uninsured, increasing costs present an ever-growing roadblock to coverage.

### *Employers*

Annual premium increases of 20-30% and higher result in increased uninsured rates as businesses limit coverage, raise workers' share of premium costs and increase out-of-pocket requirements. California employers that provide health care benefits effectively pay two premiums for care because they are also required by law to provide workers' compensation insurance for on-the-job injuries.

### *Uninsured*

Perhaps the most perplexing aspect of the dysfunctional system is that preventive care is often denied to the uninsured, requiring those without health insurance or government sponsored care to reach a critical need before being treated. The state's 6.5 million uninsured are often treated in hospital emergency rooms, where care is more expensive and space and resources are in short supply. Overcrowded emergency rooms lead to diversions of all patients to other hospitals, delaying care when care is needed most.

### *Community Clinics*

Community health clinics often provide a critical bridge to care for the uninsured, and could play an even larger role in providing preventive care. In 2003, 55% of all community clinic visits were made by the uninsured. However, roughly 12% of all visits were not compensated.[14]

### *Hospitals*

For most hospitals, the lack of a system-wide plan has resulted in budget shortfalls due to uncompensated care for the uninsured. Meanwhile, some hospitals have achieved excessive profit margins by gaming the system and defrauding public programs.

### *Nurses*

Nurses face continued work force threats, thus removing the front line of caregivers from the patients who need them most. More must be done to retain and expand the number of nurses in the state and to recruit new nurses to the profession.

### *Physicians*

While some individual doctors and physician groups have learned to thrive in a market void of regulation, more than one hundred groups in California have closed their doors in recent years because payments from insurers and government reimbursements failed to meet overhead needs and profit demands. Many physicians have left the state or the profession altogether.

### *HMOs and Health Insurers*

Health insurance executives cite increasing physician and hospital costs, new technologies, over regulation of the market, and ballooning prescription drug utilization as the key factors forcing premium and out-of-pocket increases for consumers and business owners. Some say that inadequate government payments for those patients enrolled in public programs force them to shift costs to other consumers.

### *State of California*

The California Public Employees' Retirement System (CalPERS), which purchases health care coverage for almost 2 million people in California and is the second largest purchaser of health care benefits in the country after the federal government, experienced double-digit premium increases since 1999 and upwards of a 25.1% increase in 2003. The State of California also faces significant cost increases in public programs providing care to the uninsured.[15]

### *Regulators*

Regulators feel they do not have the right tools to ensure that consumers, employers, doctors, nurses, hospitals and others are adequately protected. No state agency has the authority to coordinate the entire health care system. Very little is done currently to ensure that the prices paid for care are equal to the benefit provided.

As a result of the confluence of these and other forces, four consensus problem themes emerged from the town hall meetings and interviews:

- ◆The market-based system is devastating all stakeholders except health insurers and drug companies.
- ◆There is enough money in the health care system to insure everyone, but it is being mismanaged.
- ◆Access to care for all patients is threatened due to a lack of coordination between the public and private health care delivery systems.
- ◆More public control is necessary to create a rational decision-making process and to provide greater cost efficiency.

## Chart 1: Common Problems

| | *Systemic Waste, Profiteering & Inefficiency* | *Access to Quality Care* | *Lack of System-wide Planning & Oversight* |
|---|---|---|---|
| Patients | ◆Systemic waste and profiteering are diverting tens of billions of dollars away from care. Therefore, all purchasers pay more for less care.<br><br>◆Consumers and patients are often overwhelmed by the complex and often bureaucratic health care system. | ◆There is a lack of transparency due to inconsistent and confusing quality indicators.<br><br>◆82% of California's uninsured are working families & must choose between health care and food. | ◆Increasing costs, without accountability.<br><br>◆Inadequate independent oversight of cost increases.<br><br>◆No public process for decision-making. |
| Employers | ◆Employers pass on premium increases to employees in the form of co-pays, deductibles and other out-of-pocket costs. | ◆In a recent poll, business said that although the cost of care was increasing, 42% felt that the quality of care was decreasing.[16] | ◆Many workers are eligible for government-sponsored programs but are either unaware or unwilling to enroll due to social stigmas. |
| Doctors | ◆Less time and money for hands-on cautious care for patients.<br><br>◆Falling rates for insured patients mean higher costs for the uninsured. | ◆Reimbursement rates for state and federal health care programs are too low to cover the cost of providing care.<br><br>◆Physicians leave the state or the profession altogether due to falling reimbursement rates and displeasure with managed care practices. | ◆Too much money spent on administration, too little on patient care and adequate staff-to-patient ratios.<br><br>◆No public process for decision-making. |
| Nurses | ◆Complex and time consuming administrative tasks keep nurses from serving the patients that need them.<br><br>◆Some hospitals would rather increase profit than provide adequate nurse-to-patient ratios. | ◆Falling staffing ratios and increasing patient loads.<br><br>◆Nursing schools are reporting falling attendance as demand for new nurses is expected to increase dramatically over the next ten years. | ◆Too much money spent on administration, too little on patient care.<br><br>◆No public process for decision-making. |

## Chart 1: Common Problems continued

| | *Systemic Waste, Profiteering & Inefficiency* | *Access to Quality Care* | *Lack of System-wide Planning & Oversight* |
|---|---|---|---|
| Hospitals & Emergency Rooms (ERs) | ◆Facilities are forced to close.<br><br>◆No stability for long range budgeting.<br><br>◆Uninsured access care in ER's where care is more costly and resources scarce for all patients. | ◆Overcrowded ERs must take all-comers.<br><br>◆Staff cutbacks, fewer on-call specialists and longer ER waits.<br><br>◆Falling reimbursement rates remove needed resources. | ◆Increasing uncertainty for facility budgets.<br><br>◆Huge losses from uncompensated care.<br><br>◆No public process for decision-making. |
| Community Clinics | ◆Increasing administrative costs of health plans administering government-sponsored programs means there is less money available to fund community clinics where care is often more cost-effective. | ◆12% of clinic visits are not compensated.[17]<br><br>◆Clinics are forced to lay-off outreach staff leaving the uninsured to rely on ERs for their health care. | ◆Clinics are not integrated into an effective community-based system to provide life-saving and cost-effective preventive care to the uninsured.<br><br>◆No public process for decision-making. |
| Health Insurers | ◆Health plans blame increasing RX utilization, hospital and physician rates, and new technologies for 20-40% and higher premium increases. | ◆Health insurers say that providing health care to all those who need it will require dramatic increases in health care funding. | ◆No state regulators have authority over excessive RX costs.<br><br>◆No state regulator has the authority to determine whether physician and hospital expenses are adequate or excessive. |
| Regulators | ◆Many regulators are aware of waste, profiteering and inefficiency but are frustrated by their lack of authority to address these problems. | ◆Public programs providing care to the uninsured have been dramatically cut back as a result of budget shortfalls.<br>◆Despite some progress, regulators still do not have the authority they need to protect patients from denials of necessary care. | ◆There is no system-wide coordination of the health care system.<br><br>◆No regulator has the authority to oversee rate increases or to ensure that cost of care is equal to the value of care. |

# Section II. Common Problems: Town Hall Consensus Themes

Town Hall Consensus Theme:
**"The market-based system is devastating all stakeholders except health insurers and drug companies."**

The state's health care crisis has affected perhaps none more than small business owners, their employees, and other consumers who are struggling to afford skyrocketing cost increases with little margin for error.

While many business owners want to provide health care benefits to their employees, all are faced with dramatic cost increases. A poll of business executives conducted by the California Health Consensus Project found much area for agreement with other stakeholders, including the fact that a majority supported universal health care coverage:

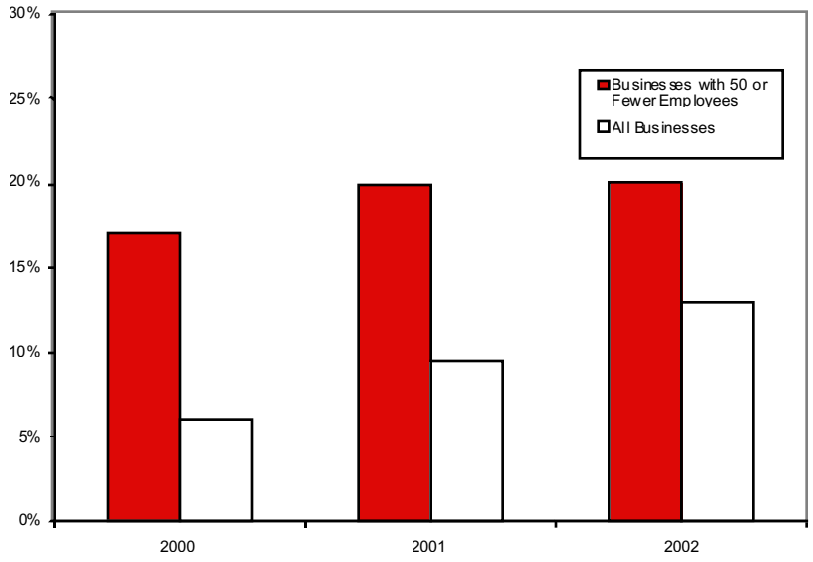
- 83% of those responding to the poll provide health benefits to their employees;
- 78% provide coverage to an employee's family;
- 58% support universal access to health care regardless of an individual's employment status or ability to pay for services;
- 45% support policies requiring businesses to help pay the cost of private health insurance;
- 70% would support paying into a state insurance pool to provide universal health care coverage if costs would not increase.

## Many Businesses Cut Back on Coverage

California small businesses with 50 or fewer employees experienced an average increase in health insurance premiums of 20% in 2003, 2002 and 2001.[18] As the chart shows, small employers have experienced higher premium increases than large employers, partly due to a lack of purchasing clout. Simply, those with more employees can negotiate lower per-employee rates.

The economic impact of such cost increases has statewide implications, because small businesses of 100 and fewer employees comprise nearly 98% (or 2.5 million) of all businesses in the state and

Graph 1: Average Health Care Premiums, 1999-2002[19]




Source: MCOL and Kaiser Family Foundation, 2003

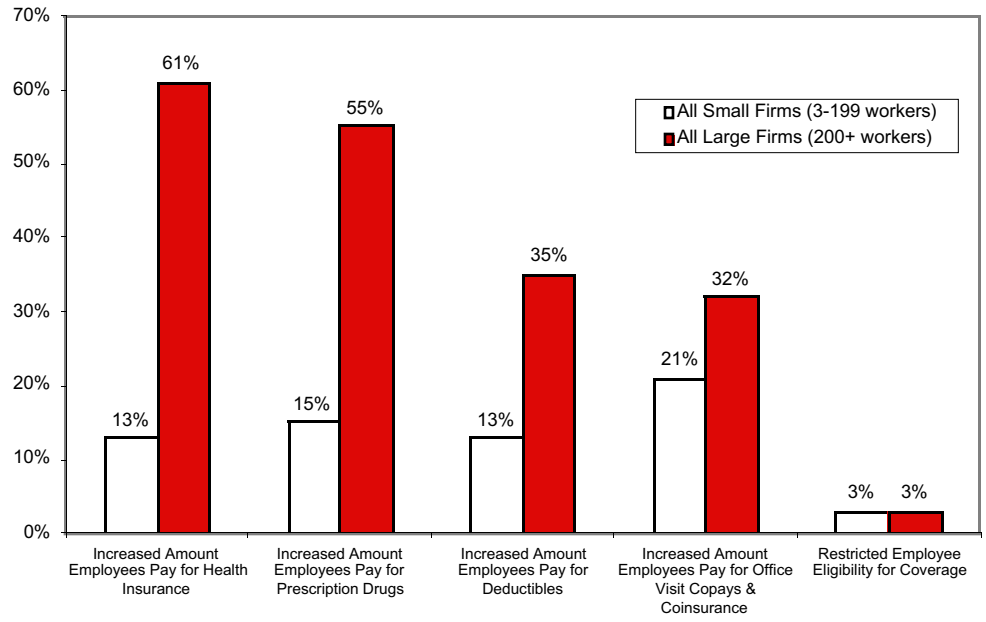
employ more than 50%, or 7.5 million, of the state's work force. They generate more than half the state's gross domestic product.[20]

Many employers who do not currently offer health care to workers cite high costs as a permanent barrier to benefits. Other employers have been forced to cut back on health care benefits, increase co-pays and deductibles to employees, or drop coverage altogether. Currently, more than 80% of the 6.5 million uninsured Californians are members of working families.[21]

**"I think we're close to a meltdown."**

*"Businesses, especially the small businesses that I represent, are having to reduce the health care because they can no longer afford the hundred-plus percent increases that they're getting hit with to keep with the costs. I think we're close to a meltdown...I would look possibly to the state to do something."*
Lee Blitch, President & C.E.O., San Francisco Chamber of Commerce[22]

Graph 2: Percentage of CA Firms Reporting Changes in Health Benefits, 2002[23]




Source: Kaiser Family Foundation, 2003

A look at the Mill Yard, a lumber mill in Arcata, California, illustrates how this paradigm brings stress to employee and employer alike.

Stan Smith, an insurance broker with the Ming Tree Group for the Mill Yard, sees first-hand the impact of skyrocketing premium increases:

**"Maybe it's time to drop general insurance."**

*"Every business that I insure is having a very, very difficult time... Now we're looking at 20 to 30 to 40%. I have one large group that they're asking 51%... [I]t's my opinion that the health insurance company bumped it to 51% because it was one way that they can probably get rid of the group. That's a nice way to do business, huh?"*

Laurie Mark, owner of the Mill Yard, has been forced to ask her employees, like Kirk Wayman, to share the costs for their own health insurance. Wayman cannot afford to go without health insurance because his son was born with a serious heart problem.

> Kirk Wayman describes his family's health care needs: *"He [his son Ben] had his first open-heart surgery when he was 3 days old. He was in the hospital for about 3 weeks. That's when they discovered he had a second problem, which is a fairly large hole in his heart. I'll need insurance until Ben is either out of my care, or dies; one of the two. You know, hopefully he'll outlive this disease. That's a definite possibility."*
>
> Laurie Mark was shocked to hear the news of the Mill Yard's 30% health care cost increase:
> *"I don't know what to say. I wasn't anticipating anything near this much. Nothing this big. And I've got two people with babies due. I've got, of course, Kirk's son. I mean, I—you know, I—I can't just go to less. That's not an option. Maybe it's time to drop general insurance. Maybe we can't provide everything."*
>
> Kirk Wayman: *"I can't say, 'Let's eat out once a week less. Let's go see less movies... Let's not go on vacation this year.' I've already taken those things out of the budget."*
>
> Laurie Mark: *"There's going to have to be some big uprising to put a stop to all of this. Yes, that's what I really feel. That somehow we have to start something—we being the people, being the business owners, being the employees. And if we don't bring it back in control, there won't be businesses in the state of California."*[24]

Laurie Mark is not the only small businesswoman to face unpalatable choices. The business community throughout the state, large and small, is anxious about the rising cost of health care.

The Los Angeles Chamber of Commerce (LACC) acknowledges that the County of Los Angeles is facing a health care crisis. An estimated 2.7 million people have no health insurance. Approximately two million of the uninsured are adults between the ages of 18 and 64. There are an estimated 700,000 uninsured children in the county representing one-fourth of all children below 18.

After seven years as president and CEO of the Sacramento Metropolitan Chamber of Commerce, Rusty Hammer has taken the helm of the Los Angeles Chamber of Commerce and acknowledges the severity of the affordability crisis.

> *"When you look at the average business, labor costs are among the most significant portion of their total cost of doing business. And the portion of labor cost that's rising fastest is health care...*

*"Business wants its workers healthy, and business wants to be able to cover workers. And while, as we sit here today, people have different answers for why the system is the way it is, the one thing we can all agree on is that costs are doing nothing but going up. And that is one of the major impacts on business...*

*"[I]t's not a case of that small business does not want to cover their workers; they just don't have the money to be able to do it. And so we need to find a way to deal with what has been the fastest growing cost on business today."*
Rusty Hammer, President & C.E.O., Los Angeles Chamber of Commerce[25]

**"[T]he portion of labor cost that's rising fastest is health care."**

The LACC says it has sought to identify specific issues and legislation where the Chamber can influence policy that will result in a more responsible response to the lack of quality health care in Los Angeles County and surrounding counties while also maintaining costs for business. Many small and medium-sized business—80% of the Chamber's membership—cannot offer employees health care without an enormous burden on their bottom line. The LACC says it is committed to identifying ways to keep health care costs down so that employers can offer coverage as a benefit to their employees.

## Business Cares but is Constrained

Business owners, managers and executives describe the health care system in near catastrophic terms once reserved for low-income consumers.

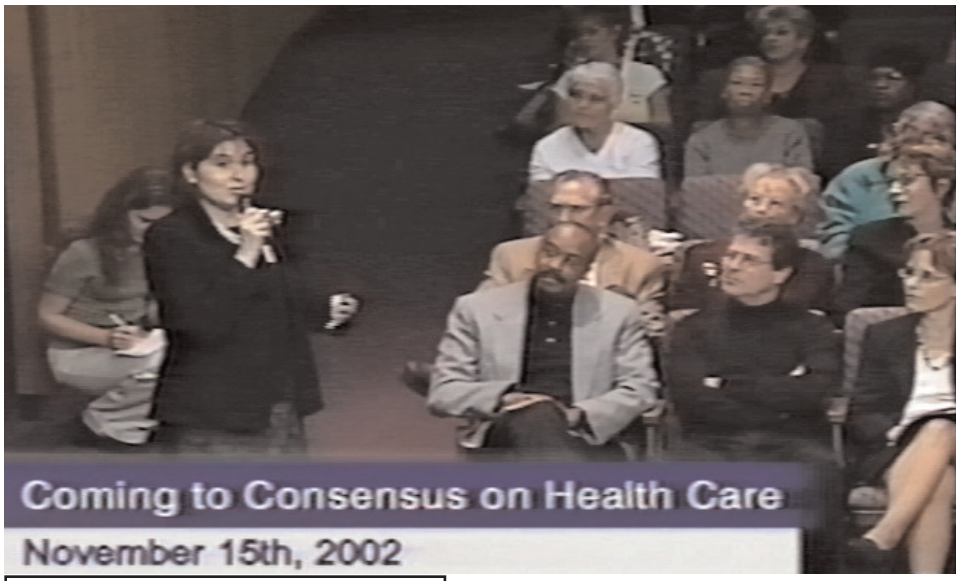
Compared to some other Kaiser subscribers, the premium increase facing Sharon Fowler and her husband on Jan. 1 was modest–'only' 10%, from $515 to $565. Many Kaiser patients saw fees jump by 40, 50, even, in some cases, 70%. But the fact that the boost barely made double digits did not make them feel a whole lot better.

**"The timing could hardly have been worse for me."**

*"We were expecting the increase, but not the cut in benefits. There is a new $200 a day hospital fee, up from zero last year. There is a $250 deductible on brand name drugs, also a new charge. CAT scans and MRIs, which had been free, are $50. The out-of-pocket maximum is $500 per family, up from $300.*

*"The timing could hardly have been worse for me. My small business is about to shut down temporarily because of the Southern California grocers' strike. I provide glass vases to floral departments at Ralphs supermarket, and am about to close for a couple of weeks, putting myself and my two employees out of work at the holiday season."*
Sharon Fowler, small business owner, San Diego[26]

In addition to being President of the Board of the Hispanic Chamber of Commerce, Elizabeth Bustos is also a small business owner and a member of the Board of Directors for the Latino Health Council.




**"It really is crisis mode."**

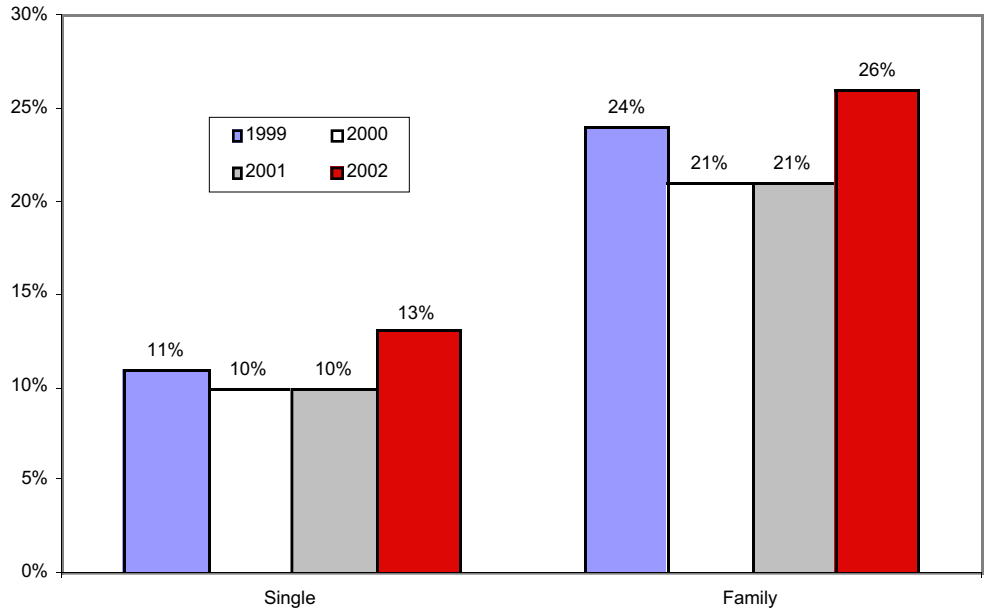
*"I myself am a business owner. And the issue is not that we do not want coverage... The issue is that we cannot afford the coverage.*

*"[Business owners] would love to be able to insure their employees, except for one thing, they can't even afford to ... insure themselves and their children. It really is crisis mode."*
Elizabeth Bustos, former President, San Diego County Hispanic Chamber of Commerce[27]

There was a time when Elizabeth Bustos believed that if a small business owner did not provide health benefits to their employees they were being socially irresponsible. Now, she says, small business owners are having a hard enough time paying for their own family's health care. "Small businesses are being priced out of the market," says Elizabeth Bustos.

Charlie Woo, the CEO of Mega Toys in Los Angeles, was the past Chairman of the Los Angeles Chamber of Commerce. "The government has screwed up a lot of things. They are inefficient and sooner or later they are going to raise the price," says Charlie Woo.

Graph 3: Percentage of Premiums Paid by Workers in California, 1999-2002[28]




Source: Kaiser Family Foundation, 2003

Yet he also affirmed that employers are most concerned about cost and, if the benefit government provided was efficiency, he would support it. Charlie Woo's company employs 50-60 people; health care coverage is provided to all full-time employees.

*"What business needs is something basic, something low cost that, you know, when things get tough, when the margin gets squeezed, we still can take care of our workers. And that is really urgent."*
Charlie Woo, CEO, Mega Toys[29]

**"What business needs is something basic, something low cost."**

## Work Force Threatened

Without exception, each town hall challenged deep-seated paradigms held by different groups about their peers. This cathartic process broke down barriers in some cases and led to deeper understanding and agreement in others. There is perhaps no more powerful a myth than the one that holds that employers do not care whether or not their employees have health coverage. The employers cited here cared enough about health care to attend our events; some care very deeply. Most are challenged by high costs, and all want solutions.

*"[T]he number one reason that small business in California would provide insurance is, guess what, not if they're provided subsidies, it's because they want to. Because those of us in small business... have a concern about the people we spend more time with than our families. We don't want them sick, not because we're going to lose productivity; we don't want them sick because they're our friends. It's pretty simple."* Richard Ledford, President, Board of Directors, San Diego Regional Chamber of Commerce[30]

**"[We] have a concern about the people we spend more time with than our families."**

Richard Ledford of the San Diego Regional Chamber of Commerce is a long-time leader in San Diego's experiment with business and community partnerships united to provide access to care for all residents.

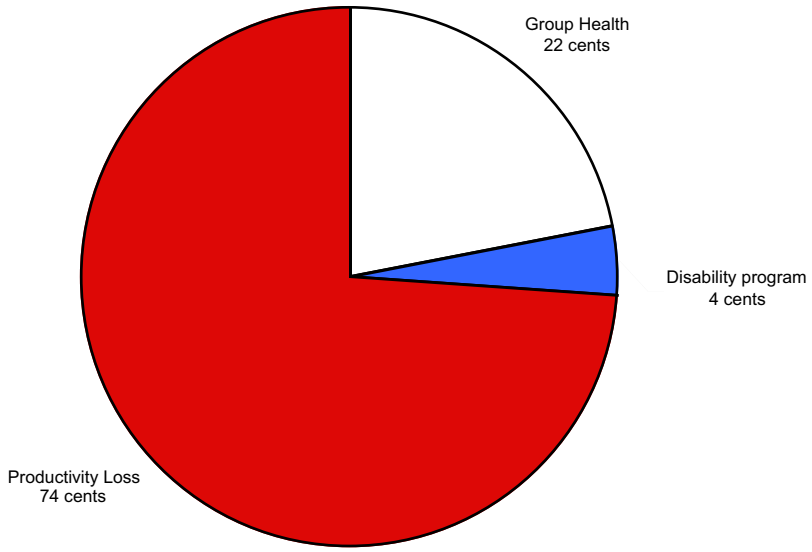
The mission statement of Richard Ledford's Healthcare Committee underscores the solutions-oriented approach taken by many business groups: to promote through education, advocacy and leadership, a high quality, affordable health care environment in San Diego County that is accessible to businesses and their employees.

Richard Ledford's sentiment that business owners want to provide health benefits because they care about their employees is one for which we found broad support. There is another reason that business cares: productivity and staff retention.

Without a healthy work force, businesses cannot provide their services or manufacture their products. Without benefits as employment incentives, health care being the most important, businesses have trouble retaining and attracting the best employees and candidates.

However, most employers do not quantify the magnitude of lost productivity associated with worker absence due to illness or injury. As a result, most employers think about only the direct health care premium costs when making decisions about whether or not their business can afford to offer coverage. When considered together with lost productivity revenue resulting from absent workers, health care and workers' compensation premiums combined make up as little as one-quarter of total costs.

Graph 4: Productivity Loss Vs. Health and Workers' Compensation Costs[31]




Source: Integrated Benefits Institute, 2003

## Common Problem, Uncommon Solution

John Hughes co-owns a Hollywood animation company, Rhythm and Hues, that employs 300 permanent employees and up to 500 employees when large projects arise. Hughes spends about $10,000 per employee, per year to give his workers the best health care benefits available. He "self-funds" the plan, bypassing insurers to simply pay all claims, and adds benefits whenever an employee's needs arise, such as dental, vision, or a special surgery.

For Hughes, providing health care to his employees is a matter of principle. Even though Hollywood tends to be generous with its workers, Rhythm & Hues was criticized by some following a newspaper article describing the richness of the company's benefits package.

*"We received a phone call from a high level executive with one of our clients complaining about our health care package, that we were spending too much on our employees, and that's why our prices were high. We didn't lose the business, but you know, there's still fallout from that article. There are still clients complaining about our benefit package.*

**"I've decided to put the money back to the employees and their health care..."**

*And you know, what's hypocritical is that these clients typically have million dollar houses and drive Mercedes and BMW's and Jaguars... I live in a small town house and I drive a Honda Civic. So, instead of living in a million dollar house, I've decided to put the money back to the employees and their health care.... they consider that as a bad business practice and they're angry at me for doing that."*

John Hughes, President & Founder, Rhythm and Hues[31]

## All but the Wealthiest Consumers Feel Pain

As crippling as rising premiums are to employers, they create bigger roadblocks to care for consumers from all economic strata except multi-millionaires.

*"[I]n the next 10 to 15 years this system, the way it is, if we don't do some fundamental overhaul, is going to implode on itself, and health care*

**"...health care will be a privilege that only the very richest people...are allowed to have.."**

*will be a privilege that only the very richest people in this state are allowed to have, and the rest of us are going to be darn out of luck."*
Gerry Jenkins, R.N., UCSD Medical Center, Board of California Nurses Association, Region 2[33]

Sustained unemployment has resulted in rising uninsured rates among middle class Californians for the first time in a decade. A U.S. Census Bureau Report found that the greatest increase in uninsured rates for 2002 occurred in families with annual incomes between $25,000 and $49,999.[34]

Table 2: Uninsured Rates of the Middle-Class[35]

| *Income* | *Increase in Uninsured Rates: 2001 -2002* |
|---|---|
| Less than $25,000 | .2% |
| $25,000—$49,999 | 1.5% |
| $50,000—$74,999 | .4% |
| $75,000 or more | .5% |

The uninsured are people at all income levels who cannot afford to buy coverage or cannot get it at any price because of pre-existing health problems. While people with low and moderate income levels are most likely to be uninsured, fourteen million uninsured Americans have incomes in excess of $50,000 and seven million have incomes in excess of $75,000.[36]

For the newly unemployed, a federal law, COBRA,[37] allows individuals and families to keep the coverage they had for a limited period of time but allows insurers to increase their rates at will. Through COBRA, the unemployed worker and spouse can keep coverage for up to 18 months. After a divorce or death, the worker's spouse or child can be covered through COBRA for 36 months. A child who no longer qualifies as a dependent can also receive COBRA coverage for up to 36 months.

*"I got laid off by a dot-com. And then the dot-com went out of business, and then the COBRA disappeared. And then, since I have pre-existing conditions of cholesterol and high blood pressure, I had to go, you know, looking around, 'How am I going to get insurance?' You know, I was getting turned down by insurance companies."*
Clifford Figalio, San Francisco, California[38]

**"...and then the COBRA disappeared."**

Rising health care costs have made far too many consumers fear the future. "I think there should be universal health care," says Karen Locke. Karen and her husband, self-employed small business owners who are over 50, have contemplated dropping health insurance because of dramatically rising costs.[39]

Health care consumers blame insurers for many problems in the health care system: skyrocketing premiums, higher deductibles and co-pays, cutbacks in corollary coverage like prescription drugs and vision and dental care. For all of them it is a struggle, and they adapt and survive in different ways. Some, like the poor who go to clinics, cut back on treatment, some abandon it altogether.

A study in the New England Journal of Medicine found that nearly half of all American patients do not receive the accepted standard of care:

- ◆Only 24.7% of patients with atrial fibrillations, 22.8% of those with hip fractures, and 10.8% of those with alcohol dependence receive the accepted standard of care.
- ◆Twenty-four percent of breast cancer patients receive substandard care, as do 35% of patients with high blood pressure, 45% of those with asthma, and 61% of those with pneumonia.[40]
- ◆Appropriate, timely medical intervention can save lives. For example, access to clot-dissolving drugs has been shown to reduce disability and death by 55%,[41] but only 3% of patients receive needed treatment.[42]

## Families On the Edge

Roughly 1.5 million self-employed Californians either provide for their own health coverage by purchasing individual insurance coverage, or go without coverage. Some of these people are hired as outside contractors so an employer can avoid paying benefits, some own their own one-person businesses. These individually insured consumers have absolutely no leverage, no market clout, not even the small bulk purchasing power that a business with a few employees might provide.

These families often must make difficult decisions to cut back on care. In the U.S. health care costs have a dramatic impact on family budgets.

Nearly 600,000 families a year declare bankruptcy due to high medical costs.[43] More than 9 million families spend more than one fifth of their total income on medical costs.[44]

The Browns of Healdsburg, California are one such family struggling to afford health insurance. The Browns say it is getting more difficult with every increase, and the relentless rise in costs—the most recent was 45%—is depleting not only their bank account but also their faith in the system.

*"You have to stay positive, but we are both cynical as hell. Blue Cross's attitude is, pay it or don't; they'd love to have you fall off."*
Brad Brown, self-employed, Healdsburg, California[45]

Brad Brown has reason to be cynical. A 49-year-old licensing agent, he is individually insured. He signed on with Blue Cross, a PPO account for himself, his wife and his two grade-school-aged children.

He has watched his rates climb steadily. In 2003, the deductible shot from $2,000 per person, per year to $2,500 per person. As the deductible increased, the coverage lessened, and Blue Cross required the Browns to pay more out-of-pocket for their health care.

In addition, the premium went from $356 bi-monthly for all four to $498—a 45% jump that tacks on $852 to the yearly bill.

It would be an understatement to say that Brad was angry. But with an active family, he felt he had to maintain coverage in case of catastrophe. "I have two young boys who like to throw themselves off things," he jokes. "I can afford to pay $2,500; I can't afford to pay $25,000" for a major injury or illness.

Brad may have to hold on to coverage, but he doesn't have to like it, and he wants to see changes made. He sees the health care industry ripping off consumers in numerous ways.

For one thing, says Brad, the cost increases have nothing to do with his family's actual use of health care. "We have not had any major surgeries or large claims." To Brad—and many others—it looks as though they are paying for services not rendered.

The amount of the increases as well as their frequency also needs to be checked, he says. "You just get clobbered," he says. And nobody stops these insurers. "Why do they do this? Because they can," he says.

"Health insurance needs to be regulated," Brad says. "You can't trust private industry to regulate itself. You can't give Enron the keys to the building and say, 'don't steal anything.'"

Brad would like to see the government conduct a cost analysis that would regulate coverage as well as the cost of premiums and other medical expenses, such as deductible. "They're trying to get everything they can," he says, and "until the government steps in" they will continue to do so.

"We paid our dues for the American dream," Brad says, "and we're getting hosed. What the hell happened?"[46]

It is not uncommon for these individually insured consumers to face 20%, 30% 40% or more annual premium increases, not to mention sizable jumps in co-pays, deductibles and co-insurance costs.

*"I am a self-employed contractor and own an advertising business. I received a notice from Kaiser for coverage in the upcoming year. I was sure that the news was bad, I waited a couple of days before opening it. I didn't want to ruin my weekend.*
*My monthly premium shot from $295 to $493. My hospitalization costs went from nothing to $200 a day, and my co-pay increased. I was stunned. Shocked. I thought, this has to be a mistake.*

*Double digit annual increases are too onerous a burden for me. Please help."* Gail Saivar, self-employed, San Diego, California[47]

**"Please help."**

## Holes in the Safety Net

Town hall testimonies made it clear that being uninsured is no longer about being poor or being a member of a particular social group or minority population. Sudden changes in employment or the constant barrage of premium increases can mean any consumer may have to go without health coverage.

Seamstress Peggy McPhee has found herself in just that situation. Peggy has worked at a Santa Rosa bridal shop for 20 years and has a good relationship with her boss who, like many small business people, simply can't afford to pay for Peggy's health insurance. So Peggy, 51, has fended for herself.[48]

Until now, she has always gotten by. It was easier back in the early 1980s when her husband worked at Sonoma State University, which covered their health needs. When they divorced, she went on to a Kaiser conversion plan. She was able to make the payments. "Kaiser was easy to deal with. They were pretty easygoing back then," says Peggy.

But rates began to creep up, and this year it was no longer a creep: it was a full gallop. Her premium jumped from $300 a month to $490, her co-pays escalated, hospital rates climbed. It was a devastating blow to someone who, like Peggy, has to watch every penny.

"I was very angry," she says. She went to Kaiser's health plan office, which said there was no mistake about the rates. She does not qualify for Medi-Cal. Other plans are out of the question because she has pre-existing conditions.

She doesn't know where she can cut back this time. She canceled her cell phone last year, and endured the winter without turning on the heater. "I bit the bullet," Peggy says. "But now, it's just out of reach. I can't afford this now. I don't know where the $190 is going to come from."

Ironically, the added financial pressure has worsened her physical condition by giving her irregular heartbeats. That's not the worst of it, though: it is the discouragement. "It's gotten me depressed," Peggy says.

*"If you bought health care at minimum wage, it would consume your entire salary."*
Dr. Jack Lewin, C.E.O., California Medical Association

In addition to the growing number of working middle class families who can no longer afford health coverage, and the newly uninsured struggling to keep up with COBRA payments, others have simply fallen through the cracks of the health care system's safety net. As state and federal funding evaporates, even those at or below the poverty level no longer qualify for government-sponsored health care coverage.

*"...when you hear something like a community clinic having 90% of their uninsured patients being at or around the poverty line, that is a fundamental failure of government. It is an absurdity that we have something called a "Medicaid program" and that there are people at the poverty line who are nowhere near eligible for that.*

**"....a fundamental failure of government."**

*"That's a national travesty. If we have to raise taxes, whatever we have to do, we need to take care of our neediest citizens, and we are not."*
Dr. Robert Hertzka, President, California Medical Association[49]

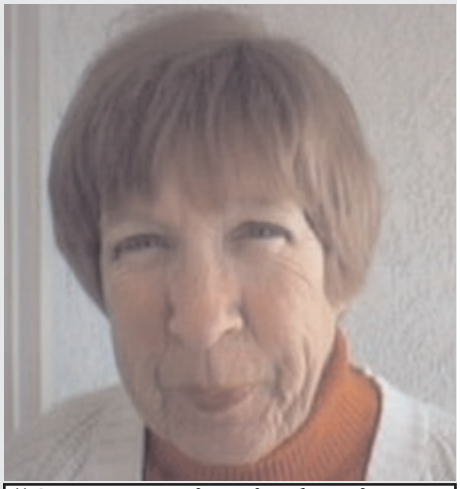
With incomes too high to qualify for public programs, but unable to afford comprehensive coverage, these people exist in a gray area of health care. Their impossible circumstances are even more heartbreaking considering the failures of a system to help those that need help the most.

For Susan Walker of Granada Hills, health care coverage is not something abstract, an optional expense that she can take or leave. For Susan it is, literally, a matter of life and death. She has had bad luck medically, with heart problems, cancer and other ailments. She has had seven surgeries.

So when she opened her mail in early December and saw the new 2004 rates from Kaiser Permanente, she panicked.

Susan's premium will shoot from $319 to $493. Worse, in her eyes, is the jump in hospital stay to $200 a day. It had been free.

> *"I don't understand why they did this. The last [premium increase] was from $249 to $319, so I thought it would go up a little, but not like this. Coverage is vital. It's my safety net, my security blanket. I feel as though it's been completely ripped from me now."*
> Susan Walker, employed part-time, cancer survivor[50]



**"Coverage is vital. It's my safety net, my security blanket."**

The only moderately good news on her health care premium front this holiday season is the fact that the increases don't affect her children. Her adult daughter is covered through her place of employment and her son, a 17-year-old high school senior, is covered by her ex-husband's plan.

Susan, who is 61, grew up in San Marino and has spent most of her life in southern California. Her health was not an issue until 1986, when she contracted cancer. She beat it, but like all cancer survivors she has had to be cautious; that caution requires constant medical monitoring. She also has had heart problems.

"The hospital fee is really frightening," Susan says. "I've had seven surgeries."

Susan looks around her and does not see any help forthcoming. Because she is not strong enough, she cannot work full time. An administrative assistant, she works 25 hours a week, not enough to qualify under her company's plan.

The cancer and the heart problems give her pre-existing conditions, making a move to a different insurer all but impossible. "I don't know what else to try," Susan says.

The premium increase, along with her general health problems, also has affected her mental health. "I was so distraught, I wanted to get some counseling," Susan says. Then she learned that the co-pay for counseling also is going up, making that, too, unaffordable.

Like the many other patients over 50 who are receiving similar notices from Kaiser Permanente this month, Susan believes the health care giant is attempting to jettison people as they age. "The older you are, the more you're going to cost them. It's age-ism. It's total discrimination," she says. "You're penalized for being older."

It's more than discrimination: it's also cruel. "We need it (health care) the most," she says. And the entire issue of health is "more nerve-wracking when you get older."

Until now, Susan has remained politically unsophisticated, but that may change. She is not just depressed and worried, she is angry. She cannot understand how Kaiser or any

other health care insurer can raise rates arbitrarily. "They're not accountable to their clients?" she asks.

"We need some kind of cap" and other state regulation, Susan says. Without someone keeping insurers in line, "it's only going to get worse."

"If you want me to carry a banner, I'm ready," says this suburban Mom. "I'm ready to start a riot."

As more and more Californians find themselves on the edge of coverage like Susan Walker and Peggy McPhee, those that provide care to the uninsured and underinsured continue to face evaporating budgets.

Founded in 1973, North County Health Services (NCHS), a non-profit health care corporation, was organized by a team of nurses to provide care to uninsured residents of north San Diego County using a mobile clinic. In 1973, North San Diego County was rural. There were barriers to access and utilization of health care services, the region did not have a health care provider, and many residents lacked transportation. These nurses were the only medical providers serving the rural residents of the North County and they were committed to bringing health care into these underserved areas.

Today, the profile of North San Diego County has changed, but the challenges remain the same. It is less rural, yet access to health care remains problematic.

*"Ninety percent of our patients are—are below the 100% poverty level. What we're finding is that the patients are now making major decisions about very minor resources that they have, and they're making decisions to stay away from health care.*

*"Because they make those decisions, the conditions that they have will be exacerbated and [they] will end up going to the emergency room, or they will not have the money to pay for their treatment.*

**"They're making decisions to stay away from health care."**

*"We're also finding that the health—the Healthy Families insurance is also going down among our population because patients are opting not to continue the health insurance for their children or opting to cover only some children and not others."* Irma Cota, CEO, North County Health Services[51]

Increasing premiums and pending state budget cuts for public health care programs could mean higher costs in the long run by increasing the number of uninsured in state and thereby forcing more to receive routine care in emergency rooms. This year, public health programs that provide care to lowest income Californians are facing budget cuts

of $3 billion or more. Health care advocates estimate that changes in the income eligibility limits for Medi-Cal and Healthy Families programs could mean 350,000 new uninsured in the next several years.

> *"There are not direct rate cuts to hospitals, but this will impact hospitals. We will have trouble finding doctors to serve on-call at the emergency rooms, and we will have a very hard time finding specialists that we need."*
> Barbara Glaser, California Healthcare Association[52]

Governor Schwarzenegger's proposed 2004 budget would cut more than $1 billion dollars from Medi-Cal. In 2005, the plan will further reduce services, require patients to share in the cost of coverage, and require more to enroll in private health care plans.

Many experts agree that the more than 6.5 million uninsured in the state of California, who represent over 20% of the state's population under the age of 65, will continue to increase in number over the next decade unless the state acts to control costs.

## Minority Populations Face Additional Challenges

Large numbers of people in all racial/ethnic groups are uninsured, but minority groups often suffer the most. In the U.S. one in ten non-Hispanic whites are uninsured, one in five African Americans are uninsured, and one in three Hispanics are uninsured.[53]

Table 3: Uninsured Rates of Minority Groups—U.S. & California[54]

| U.S. | Percentage |
|---|---|
| White | 12% |
| Black | 20% |
| Hispanic | 35% |
| Other | 21% |

| California | Percentage |
|---|---|
| White | 12% |
| Black | 17% |
| Hispanic | 34% |
| Other | 19% |

In California, minority groups face uninsured rates of 1.5 to 3 times that of whites.[55]

> *"I think this problem is bigger in minority populations. It's a big problem, because they don't feel free to go look for health care...."*
> Maria Ortiz, community organizer, Los Angeles County Department of Health Services[56]

Many participants cited language and cultural barriers as well as social stigmas associated with public programs as reasons for the differences in uninsured rates.

**"...this problem is bigger in minority populations."**

*"I think it's about cultural and language barriers, um, that make it very difficult for both the provider and the patient to be able to communicate what the patient needs."*
Denny Martin, President & C.E.O., California Association of Public Hospitals and Health Systems[57]

**"...communicate what the patient needs."**

All of the state's uninsured face fewer options for care as community clinics and emergency rooms shut their doors. Twenty million uninsured Americans a year postpone seeking care because of cost; nineteen million need care but did not receive it; sixteen million did not fill a prescription because of cost; and 15 million skipped a treatment recommended by their doctor because of cost.[58]

*"I believe it's not only the culture or language barrier. What actually it is that since the county is closing all these many clinics, we don't have access, nowhere we can go. We are sick. We have sick kids and sick mothers."*
Maria Andrade, uninsured[59]

**"...we don't have access, nowhere we can go."**

## Retirement Nightmare

Murray Axelrod's story represents the untold millions of pre-Medicare retirees with limited or no employer-sponsored retirement benefit. These seniors must purchase some of the state's most expensive health insurance on limited budgets.

Murray, 64, is a retired grocery clerk. His union, Local 770 of the Retail Clerks, took care of his coverage originally, and he had no complaints. His provider since he was 20 years old has been Kaiser. He has been a conversion plan member for 34 years.

On Christmas Eve 2002, Kaiser told him that he would face a 77% increase in his monthly premiums beginning in January, from $237 to $421. His premiums, which were $2,844 annually in 2002, were about to go to $5,052—an increase of $2,208.

Murray was flabbergasted. He contacted Kaiser and asked them why his rates were increasing so dramatically. They told him it was because he had a zip code in western Ventura County, which Kaiser had declared an "expansion zone." People in expansion zones were going to pay more.

Well, Murray thought, I could go to another insurer. But Murray had a heart attack 10 years ago, which means he has a pre-existing condition. Most plans would either reject him or make him pay exorbitant prices.

There was another way out, and he took it: He moved to Los Angeles County. He had been using the Woodland Hills Kaiser facility anyway, so it made sense, at least in terms of affording health coverage. His rates still jumped by $984 a year, which was not good, but was better than the $2,208 he was facing in Ventura County.

But this begs the question: Should an individual have to move in order to receive the health care he needs?

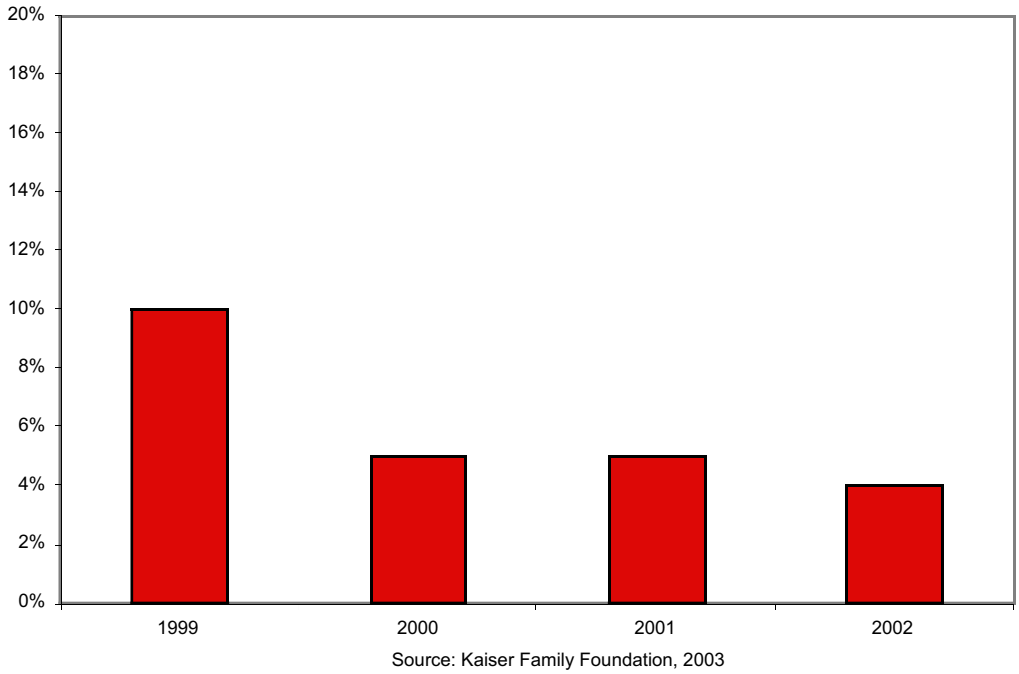
Murray believes the answer is no. "It's bull....!" Murray fumes. "It's corporate greed. They've become more of a business and less patient-oriented."

The increased costs and the uncertainty create especially heavy anxiety for people in his age bracket, Murray notes. "It's created a nightmare. I'm on a fixed income, and along with large losses in my retirement IRA I am deeply worried about my future." He says people in his situation seemingly are being forced to choose between moving and giving up their health coverage.

"How can Kaiser get away with such practices?" Murray asks. He would like to see health care providers come under regulation.

As Graph 5 shows, the problems facing retirees like Murray will increase exponentially in the future as fewer firms offer retiree benefits to new hires.

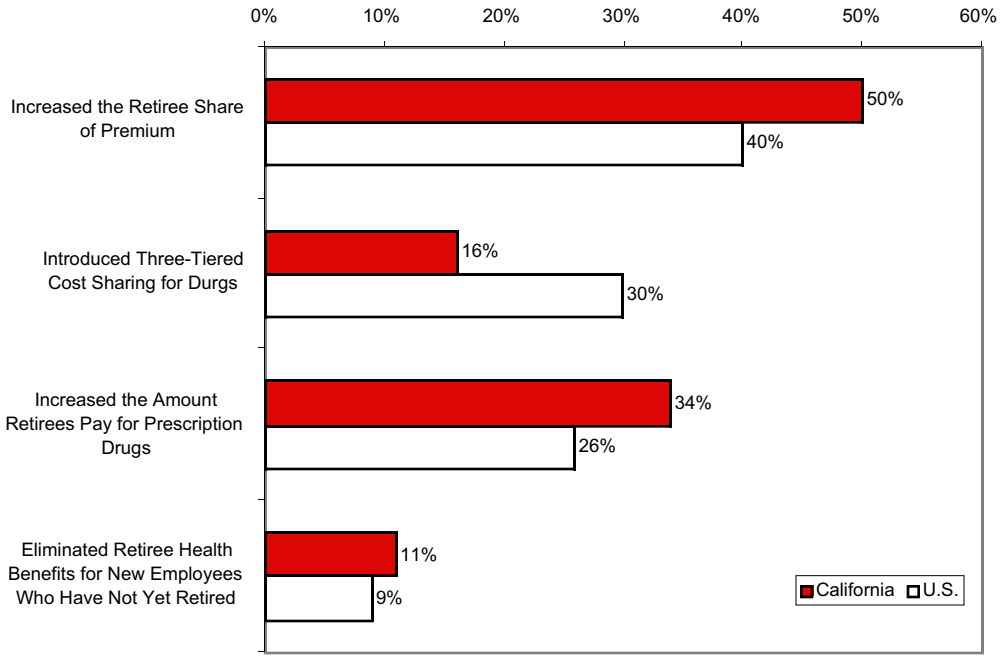
Graph 5: Percentage of Firms that Offer Retiree Health Benefits, 1999-2002[60]




Source: Kaiser Family Foundation, 2003

As Graph 6 shows, those companies that continue to offer health benefits for new retirees require recipients to pay a greater portion of the cost of coverage or make changes to benefit packages.

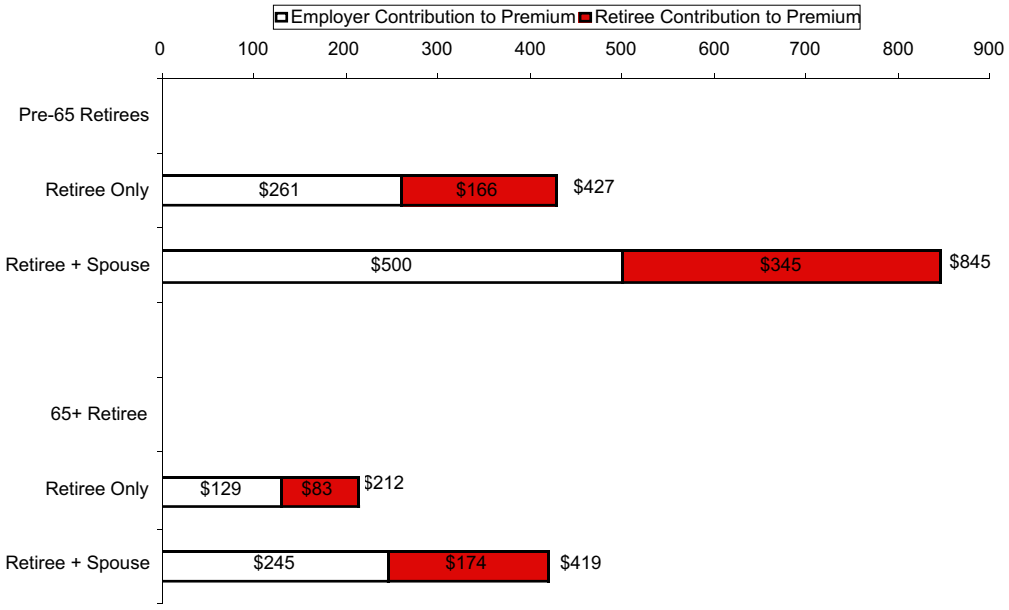
## Graph 6: Percentage of Large Firms Reporting Changes in Retiree Health Benefits[61]




Source: Kaiser Family Foundation, 2003

As Graph 7 indicates, retirees, many of whom survive on limited incomes, already pay more than 1/3 the cost of benefits.

## Graph 7: Average Monthly Premiums for Those Retiring in 2003[62]




Source: Kaiser/Hewitt, 2004

In fact, seniors face some of the biggest cost increases of any consumers. Some feel that they are being unfairly targeted simply because they are older, not because they are sick or have a history of illness. Nearly universally they want the government to step in.

> *"We have lived in Orange for 27 years, and are semi-retired. Dave was let go from his job at a small electronics sales firm in October 2001. We have been on COBRA since then. Dave had open-heart surgery in November 2002, the first time either of us had incurred major medical expenses.*
>
> *"This year Blue Cross increased our health insurance premium by 38%—from $673 to $941. At first we thought Blue Cross had made a mistake, or the rise was tied to Dave's open-heart surgery. Neither proved to be the case. A Blue Cross employee told us that there is no year-to-year contract and that rates can and do go up arbitrarily. "The health insurance industry preys on those that are especially weak—the unemployed and retirees—who are already struggling to maintain their medical insurance on limited incomes, trying not to dip into retirement accounts or Social Security. Health insurers should have to justify their premium increases to the state and the public should have a right to contest unfair increases."*[63]
> Pat & Dave Parker, Orange, California.

Like many health care subscribers who have been with one provider for many years, Michael Fry, a former electronics engineer, thought he had some minimal security from his health plan. He doesn't think that anymore. Just after turning 60, he received a notice from Kaiser that pushes his monthly premium up by 73%, to $961, beginning January 1 of this year.

The increase is $406 a month and means he and his wife will have to pay $11,532 a year. There is also a new $200 daily hospital co-pay, and a regular office co-pay increase to $25.

**"Health insurers should have to justify their premium increases..."**

Fry, who has spent days on the Internet researching health care since his notice arrived, says he and his wife can weather the storm—in the short term. "We could ride through a year of this," he said. But after that they would be in trouble.

And not just financial trouble: this price gouging takes away something that you can't put a dollar value on: security and a sense of well-being and optimism about the future. "Now you think, what if I had to go to the hospital for a month?"

"Its a real violation of security," Fry says. "You think that you're under a nice umbrella. It's a fatal event in what's become a dysfunctional relationship."

This is the second straight increase. "Last year was quite a shock," Fry says. His premium went from $450 to $550. But when he opened the envelope this year, "the world became a dark place."

As bad as it is for he and his wife, Fry worries about those who are even less able to pay for health care coverage. "The whole bottom third is going to fall off the charts," he says. "They're low-income people and they're going to do without. They're going to die quietly, at home or in emergency rooms."

## Policy Makers and Regulators are Frustrated

Daniel Zingale was appointed to head the Department of Managed Health Care (DMHC) by Governor Davis when the Department was created as a result of the 1999 passage of the Patients' Bill of Rights. The DMHC regulates some aspects of the managed care market. However, no government agency has the authority to question whether health care premiums equate to the coverage provided or to investigate health insurer finances, including overhead costs, advertising, and profit.

*"It's bad enough ... that we have seven million Californians without health insurance. It's even worse that many of us who are fortunate enough to have insurance have to wonder whether the premium dollars we invest or our employers invest will actually provide health care for us when we need it or when our loved ones need it"*

Daniel Zingale, former Director of the DMHC and former Governor Gray Davis' Chief of Staff[64]

Some legislators are aware of the problem and have pledged to investigate the root causes of skyrocketing costs.

*"Controlling rising HMO premiums and improving the declining quality of health care will be my top priority as chair of the Health Committee."*

Assembly Member Dario Frommer (D- Glendale), Chair of the State Assembly Health Committee[65]

**"Controlling ...rising HMO premiums and improving the declining quality of health care will be my top priority..."**

A lack of statewide solutions has forced county officials to look locally. In November 2002, shortly after the California Health Consensus Project's Los Angeles town hall, Los Angeles County voters approved by a 73%-27% margin Los Angeles County Supervisor Zev Yaroslavsky's proposal to enact a 3 cents/sq.ft. parcel tax on building improvements to fund trauma and emergency services and bio-terrorism preparedness efforts.

The special tax, however, will raise only $175 million of the county's $750 billion health care deficit. The effects of the shortfalls will be felt system-wide, many policy makers say, because the health of the system affects the delivery of care for all consumers.

**"[the deficit] affects ...not just the uninsured; it affects every man, woman, and child."**

*"...[the deficit] affects the poor, not just the uninsured; it affects every man, woman, and child. Because we are all, each and every one of us, a drunk [driver] away or a gunshot away from needing a trauma, or we're a stroke away or a heart attack away from needing an emergency room. So this is for those who have all called and said, 'Oh, this is just about the uninsured.' Guess again. This is about you, my friend. This is about your neighbor, on both sides of you, because our system is not in isolation. It's part of an integrated system that involves all the hospitals and emergency rooms in the region."*
Zev Yaroslavsky, Supervisor, Los Angeles County[66]

Some observers say that simply cutting budgets is not the right move, but that policy makers should first look for other resources. Admittedly, this would require a systematic review of the state's health care system, for which no forum currently exists.

**"There is money in the health care system..."**

*"There is money in the health care system... and there is money in this state. And there is money in this country that ought to protect this system from collapsing. Because if the L.A. County health care system collapses, you can bet the rest of the system in the state is going to be coming down behind it."*
Robert Leonard, Service Employees International Union (SEIU), Local 660[67]

## Physicians Feel the Pinch

For most health care providers, systemic inefficiencies mean more money is diverted away from hands-on care and starving hospital budgets. The crisis affects every corner of California and providers of every description.

The story is no different for physicians. To reduce risk and ensure their own profit, many California health insurers have made extensive use of capitation, paying providers a fixed amount per-member-per-month to provide all care or certain services to enrollees who select those providers.

In the late 1990s, many physician groups went out of business as a result of aggressive pricing, falling reimbursement rates and increasing medical costs.[68]

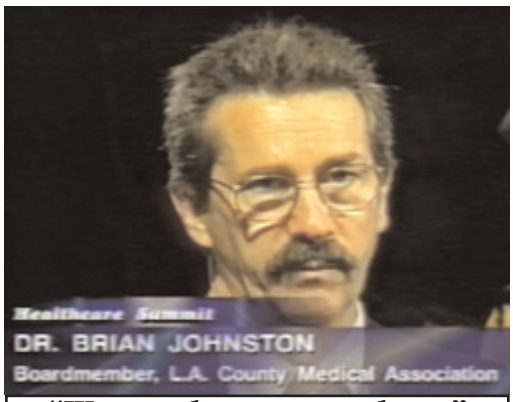
**"Physicians... are very unhappy."**

*"I don't think anyone in this room would deny the fact that the physicians they know are very unhappy. Mostly because, in addition to not being reimbursed the way they feel they should for care... physicians don't have a lot of autonomy. They have medical training and medical judgment, and they try to do what's best for their patients, and many times they're unable to do that."*
Dr. Marie Kuffner, former president of the California Medical Association[69]

In California, capitation is usually coupled with delegation. Under the "delegation model," the health plan delegates significant functions to the provider organization, including credentialing of physicians, payment of claims, and collection of data. There is little active independent oversight to ensure that capitated rates are adequate to compensate for the care provided or to cover necessary administrative costs.[70]

Some physician groups have thrived in a market void of rate regulation, if they amass sufficient bargaining clout with health insurers. However, most physicians feel pressure to accept lower reimbursements from health insurers. All feel that government reimbursement for providing care to those patients enrolled in public programs is inadequate.

Emergency rooms live with the consequences as much as anyone. The doctors who work in the front lines, and see the effects first hand, say there is only one cure.

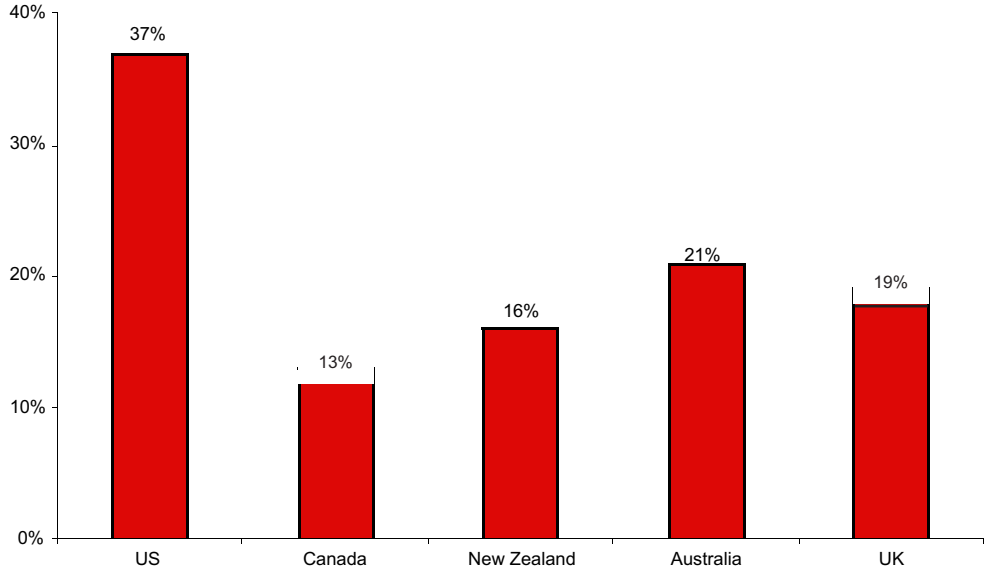


**"We need to re-regulate."**

*"Our insurance industry needs to be re-regulated so that the premiums they charge people are based upon the medical needs of those people, not upon market rates. That money must be held in trust, and then paid out when we need it, to hospitals, doctors, and nurses. We need to re-regulate."*
Dr. Brian Johnston, emergency room physician and former President of the Los Angeles County Medical Society[71]

Dr. Johnston points to a clear inconsistency in the way California manages health care. In California, home and auto insurance rates are regulated, and 26 other states require some type of approval process for health insurance rates. In California, no such rules apply to health insurer, physician, or hospital rates.

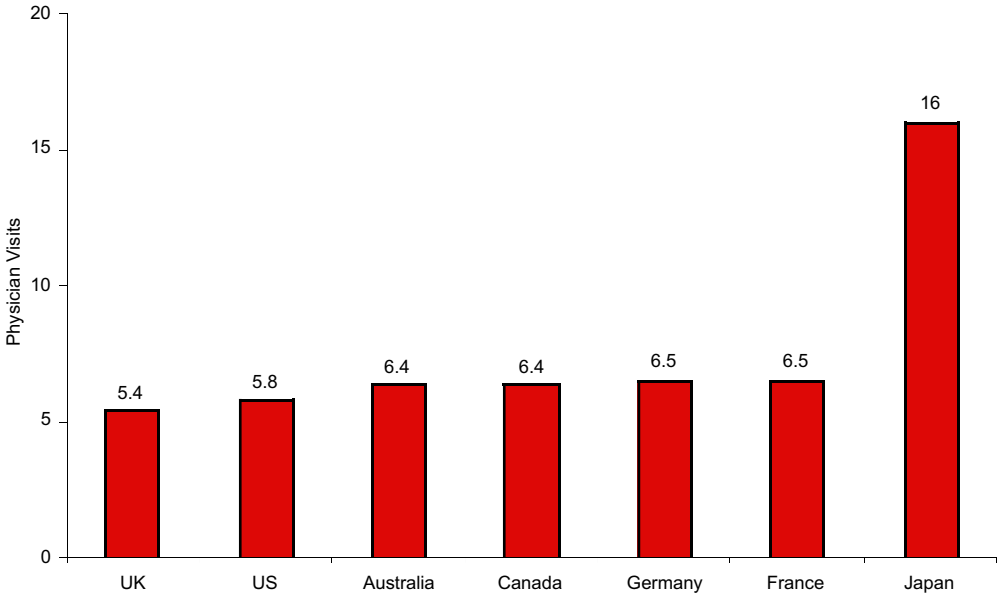
Graph 8: Percentage of U.S. Physicians Reporting Outside Review to Control Costs is a Major Problem in Their Practice[72]




Source: Health Affairs, 2001

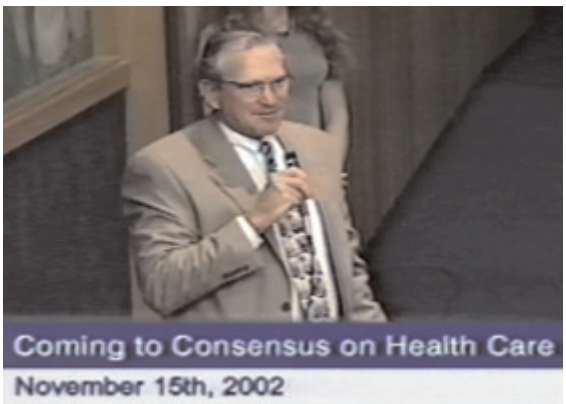
As a result of inadequate financing many physicians are leaving the state; others are leaving the profession altogether. In fact, the U.S. has the fewest doctors per capita than many countries—even those with government-run systems like France, Germany and Canada.

Graph 9: Physician Visits Per Capita, 2000[73]




Source: OECD, 2002

Dr. Tom Cummings of San Diego worked in joint and private and practices for 25 years until he decided to leave the profession for good at a relatively young age. In the last decade Dr. Cummings has become increasingly distrustful of managed care organizations as the result of a series of patient care denials and mistreatment by health insurers.




**"...the hassle factor is increasing markedly..."**

> *"I've just had to [be] overwhelmed by diminishing returns on the tangible, for I made half as much money in 2001 as in 1989. And then the hassle factor is increasing markedly: the feeling that I was working for the insurance company rather than patients, and that being a source of conflict of interests."*
> Dr. Tom Cummings, former family care physician, San Diego, California[74]

Many physicians cite insufficient government reimbursement for the failure of the public to provide care to those who need it.

**"If I put out a shingle tomorrow that says I take Medi-Cal patients...I will be bankrupt..."**

> *"If I put out a shingle tomorrow that says I take Medi-Cal patients, my office will be inundated overnight, and I will be bankrupt, so it's kind of a balance. I believe the doctors should do it. Some of us do more than others. If they're not doing anything—not doing any of that work—then I sincerely have a problem with that."*
> Dr. Robert del Junco, Orange County, California[75]

One physician might have hit on a successful model to cut overhead costs with the use of computerized records and shared resources and run a successful practice with a majority of Medicare and MediCal patients. Dr. Doug Roberts of Sacramento is a rheumatologist specializing in arthritis and diseases involving abnormally regulated immune systems, such as lupus. He worked for a large group practice in Arizona, was transferred here in the mid-1990s, and tried to hold on to some professional stability as the ownership of his medical group changed three times.

He noticed a fundamental problem in medical care delivery during these financial comings and goings: "a basic lack of commitment or feeling of responsibility for patients as being your own. In a big group, you're serving two masters."

"You want to know the patient," he said. Dr. Robert found that was difficult in the "factory-like" HMOs.

In Sacramento, a large group of cardiologists bought a building, and had extra space. Roberts and a couple of internists went in on a piece of it.

By sharing, they cut costs, which allowed them to provide better treatment and, incidentally, make their own lives more fulfilled, which in turn leads to better medical care.

Their office, Roberts says, is "like a barber shop, where you rent a chair," or the medical equivalent thereof. The doctors share staff, and that staff is minimal: one receptionist-scheduler.

There is one exam room. The doctors use a computer for medical records, which eliminates filing and "saves the need for another room to store charts."

"The technology has allowed me to go back" to the days when doctors focused on patients and not paperwork and bureaucracy. "I take an hour with each new patient, half an hour with everyone else." Roberts estimates that he has reduced overhead by as much as 70%.

Most of his patients, Roberts says, are from Medicare, which he describes as "a single-payer system for seniors." Others have PPOs, some are insured through their employers, some are self-insured.

The key, he says is "to remove the for-profit" aspect of medical care. This is do-able if you have the right model. I'd like to see the formation of a non-profit plan."

"This," Roberts says, "is the way I want to practice. I didn't want to (struggle) with HMOs, getting approval of tests that have to be done."

He stresses that a happy doctor is good for the system. "I get a lot of enjoyment," he says. That includes working three long days and taking off the other two, so he can spend more time with his children, who are 3, 5, and 9. "I can't tell you how nice it is to stay at home two days." The doctors cover for one another when the situation calls for it.

"Job satisfaction," Roberts says, "is better for everybody."

## Consensus on Nursing Shortage

Employers, employees, consumers, brokers, doctors, rural, urban and suburban health care providers—all are casualties of this broken system. So, too, are the people who battle on the front lines every day: nurses. They are reeling, and the profession itself is in danger. Growing research points to dire consequences for the quality of patient care when fewer nurses are available in the state's emergency rooms and hospitals.

*"I have no idea how many patients I see on a given day. It just depends. If I have a really sick patient, then I might be just doing one-on-one care with that patient... And then the other nurses will kind of pick up, you know, the other ones that I can't see.*

**"People that are less critical can be waiting for a long time."**

*"But sometimes, I see patients—I'm just, like, getting them in and out super fast, so I could see as many as, like, 15 or 20. It just depends. And I never really count how many I see. I just...you*

*know, kind of do my job and get them in as fast as I can and get them out as fast as I can... [P]eople that are less critical can be waiting for a long time."*
Kristen Craven, nurse, Roseville Medical Center[76]

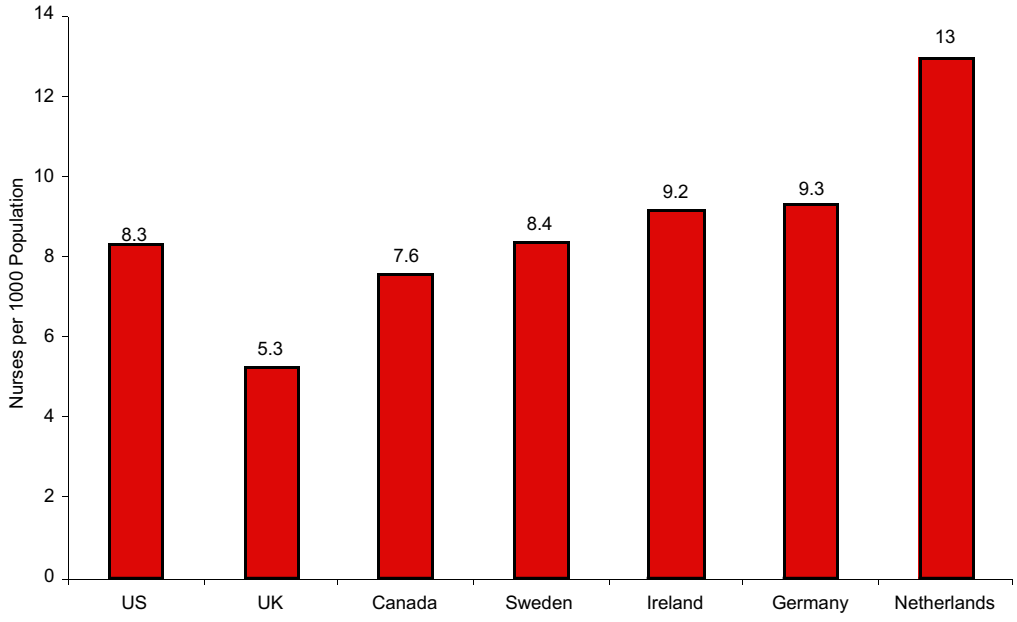
California's new nurse-staffing ratio law sets specific nurse-to-patient staffing requirements for California hospitals. The state's multi-billion dollar hospital industry is continuing its campaign for a major overhaul arguing that it in effect limits the load of patients a hospital can take in to the number of nurses working at any given time.[77]

The California Hospital Association (CHA) filed a lawsuit hours before the regulations were to go into effect on January 1. The CHA is rumored to be on the verge of filing a second lawsuit designed to suspend the rules until they are weakened. The new lawsuit is reported to target nurse-to-patient requirements for Emergency Rooms that the hospitals claim are keeping them from treating critical care patients.

Though there is disagreement over the structure of the nurse-to-staff ratios, nearly all participants agreed that the greatest nursing shortage may be yet to come, when an aging nursing work force, declining numbers of nursing students, an aging population, and sicker patients collide. U.S. nursing schools are experiencing declining attendance as fewer college students are choosing nursing as a career.

It is estimated that by 2010, an additional 74,000 registered nurses will be required for the state of California alone. According to the Bureau of Labor Statistics, employment demand for registered nurses will grow faster than the average for all occupations through 2006, largely due to growing need in settings such as health maintenance organizations, community health centers, home care and long-term care.

Graph 10: Number of Nurses per 1,000 Population, 2001[78]




Source: OECD, 2002

In California the majority of working nurses are over 45. About half of the nation's nurses will reach retirement age within 15 years—just as "baby boomers" present new challenges to the health care system.

By 2020, one out of every four working adults will be 65 or older, and the fastest growing age groups will be those between 85 and 100 years of age. At current growth rates, the registered nurse shortage in the nation is expected to reach nearly 500,000 positions. That may even be too optimistic. The Department of Health and Human Services expects by 2020 a nursing shortfall in the U.S. of 635,000 to 1,754,000 nurses.[79]

Even hospital administrators like Arrowhead regional Health Care Center's C.E.O. Mark Uffer agree that hospitals need more nurses to adequately address patient needs.

*"The nursing shortage is probably one of the most acute issues that's gonna face all hospitals, especially in California. And you have to ask yourself, how did it happen? Why don't people wanna be nurses? And it's really very simple. You have these nurses that are working long hours, 12-hour shifts, they're taking care of too many patients, there's not enough nursing assistants or resources to help them. They get tired, they get angry. They feel that they're doing something that potentially could jeopardize a patient's life, and they just say, you know what? It's no longer fun to do this. It's no longer safe to do this. I'm gonna do something else. And they leave."*

**"The nursing shortage is probably one of the most acute issues that's gonna face all hospitals, especially in California."**

Mark Uffer, C.E.O. of the Arrowhead Regional Health Care Center[80]

## Many Hospitals Fight for Survival

As managed care plans gained economic strength in the 1990s, hospitals sought to compete through growth. Hospitals consolidated organizations into a small number of systems. Joint contracting strategies have in some cases enabled them to secure better payments and contract terms.

Some prominent hospital systems, such as Sutter, Scripps, and Catholic Healthcare West have insisted on ending some of their risk contracts. In general, hospitals are able to stand up to health plans better than physicians are. Although they are also facing financial pressures, most hospital systems have significant reserves to cushion the loss of revenues from terminating an HMO contract. Few physician organizations maintain a level of reserves that would allow them to weather the loss of a major contract.

Despite their market clout, many hospitals across the state continue to endure a precarious existence. Between 1995 and 2000, 23 acute care hospitals closed, 11 of which were for-profit.[81] In the last ten years nearly 60 emergency departments in

California have shut their doors. Many of those that remain open are often "on diversion"—meaning they must refuse to accept ambulances because there are no more beds. Last November, the California Medical Association reported that more than 82% of California's emergency rooms are losing money.[82]

Those who work for and with hospitals consider the crisis ruinous.

*"It's a misnomer to call this a 'system.' It sort of suggests like we're all working together. We've got the best non-healthcare system in the United States, and particularly here in—in California. And to call it 'managed care' is another misnomer. It's more like mangled care."*
Jim Lott, Exec. V.P. for Policy Development and Communications, Healthcare Association of Southern California[83]

**"...mangled care."**

In each stakeholder group there are bad actors. Tenet Hospitals are renowned for their system gaming, which has earned them excessive profit margins and an FBI investigation of unnecessary surgeries. Due to regional monopolies and limited disclosures, some hospitals and physicians can charge widely varying rates for the same treatments.

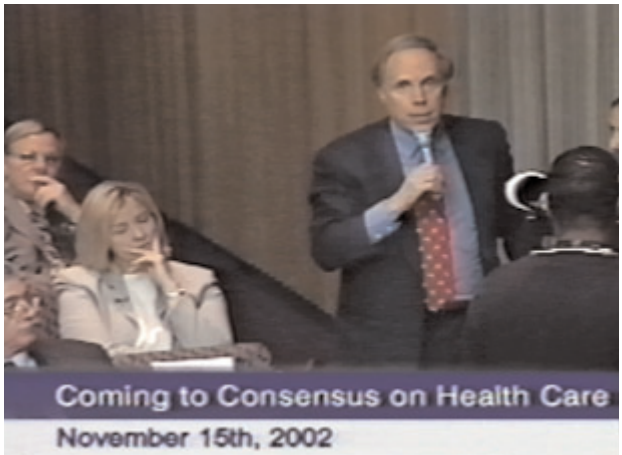
Many Hospitals in California are in trouble, as they face a violent squeeze between the influx of Medi-Cal patients and a near shutdown of public funding.

Due to budget shortfalls, in July of 2002 the Los Angeles Board of Supervisors voted to close 11 clinics and High Desert Hospital in the Antelope Valley. The move was made to slash $150 million from the County Health Department's $2.9 billion budget, but supervisors warn they may have to close down two more hospitals and make other cuts unless the county receives new financial assistance.[84]

All hospitals administrators feel the squeeze:

*"We are in crisis as a—as an institution that's 50% reliant on Medi-Cal. The State of California is either 49th or 48th or 50th, depending on which one you read, of level of funding in the 50 states. That's partly why it is a federal solution...*

*"Our emergency room...was built for 25,000 visits; we're now at 62,000 visits. Too often a child has to wait, who is not urgent, for four or five hours at Children's Hospital."*
Blair Sadler, CEO, Children's Hospital, San Diego, California[85]



**"Too often a child has to wait..."**

A recent Kaiser Family Foundation study, published in the journal Health Affairs, estimates that uninsured people in the US received $35 billion in uncompensated care in 2001. While the federal and state governments, hospitals, and doctors face this $35 billion loss, ultimately other health insurance purchasers end up paying the costs.

Some hospital executives say the current crisis is the worst the industry has faced in over a decade.

*"Ten years ago we faced a national health care crisis. At that time, though, there was not a political will to address the primary drivers of that crisis... We have that problem again today. It's more severe."*
Steve Escoboza, President & CEO, Healthcare Association of San Diego and Imperial County[86]

**"...there was not a political will to address the primary drivers of that crisis..."**

Consensus Town Hall Theme:
**"There is enough money in the health care system to insure everyone, but it is being mismanaged."**

Increasingly, consumers experience the health care system as one in which sudden and unexpected changes in their employment can quickly lead to a loss of coverage. Being uninsured is no longer about being poor or associated with particular group identity, it is more and more about situations any person could experience. Much of the testimony, and many of the anecdotes of health care stakeholders, point to a need for oversight of how our health care dollars are spent in order to provide a complete picture of where changes can and should be made.

Lee Blitch, President of the San Francisco Chamber of Commerce and a former executive in the telephone industry when telecom was regulated as a utility, sees a solution to the affordability crisis and for universal access to care in the form of regulation and cost accountability.

*"I can remember the old days when there was one Bell system. And our goal at that point, we had two words, 'universal service.' And we dealt with this through the—through the private industry to do this. And we—we entered into a bunch of subsidies for long-distance subsidized local, business-subsidized consumer, and in a short period we got 98% of the people had telephone service. So maybe there's a model there somewhere that can be—that can be looked at again today...*

*"The goal of everybody that worked there was universal service. I mean, we got up every morning saying 'Whatever we do, our goal is that everybody has a phone in their home.' And before the breakup in 1984, I think we achieved ninety-six, ninety seven percent of America. I think it's down to around ninety now. I think it's dropped since the breakup.*

**"...98% of people had telephone service... The goal of everybody that worked there was universal service..."**

*"But we knew as a regulated monopoly that we had better give the best service possible because if the complaints would flow into the state Public Utilities Commission or the FCC, we'd be fined. So we really measured customer service at a very high level.*

*"It used to be as a monopoly, if you had anybody carried over out of service, you had to write a report to the president of the company the next day, saying why you didn't get it fixed. If it went past midnight, you were in trouble. So, that kind of intense pressure was put on to maintain the monopoly.*

*"If you could put that kind of pressure on the deliverers of a universal health plan, where they were held to very high levels of service and accountable for costs, you could make it happen."*
Lee Blitch, President & C.E.O., San Francisco Chamber of Commerce, former executive at AT&T[87]

There are different views of what an 'affordable' and efficient system would mean. Some worry whether the individual can afford coverage.

*"Talking about affordability, you know, actually it's so hard to be able to afford medical care.*

*"It's very hard, because, you know, either way we are lost, you know. We were talking before about the people who is able to spend the money and have the responsibility to spend and so there is people like us don't have that access to the money and that access to have—to share the responsibility of being able to have the proper care."*
Maria Andrade, uninsured consumer[88]

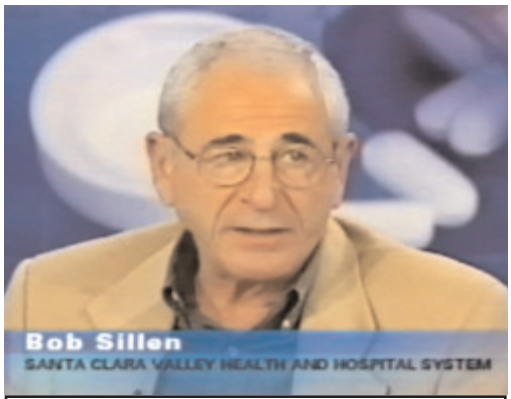
**"...people like us don't have that access to the money..."**

Others worry about both the costs to society as well as the consumer.

*"I was really thinking in both ways. I mean, I think it does have to be personally affordable or for a family and it also needs to be affordable for our society."*
Assemblyman Keith Richman (R-Northridge)[89]

**"...personally affordable ... and it also needs to be affordable for our society."**

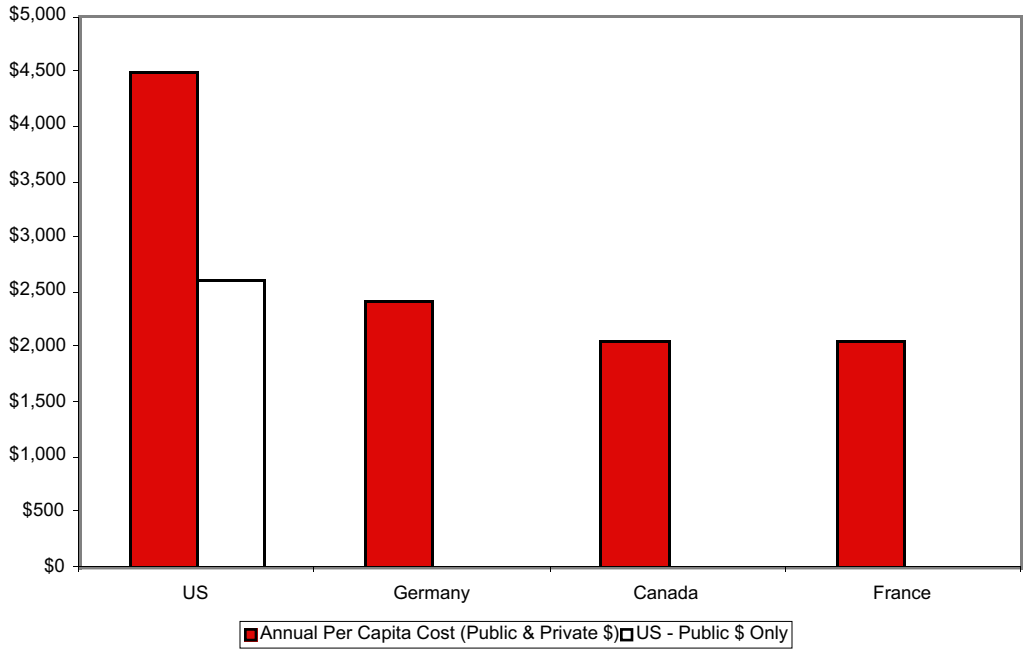
Overall, participants believe the system is losing money now, and that money would be saved if the system were improved. They believe a better system is possible.



**"That's criminal. That's shameful."**

*"...California now is the fifth richest economy in the world, within the richest economy in the world, and we can't do something like make sure that everybody has health insurance. That's criminal. That's shameful. It's nothing else."*
Bob Sillen, Executive Director, Santa Clara Valley Health and Hospital System[90]

Graph 11: Health Care Expenditures by Country, 2000[91]

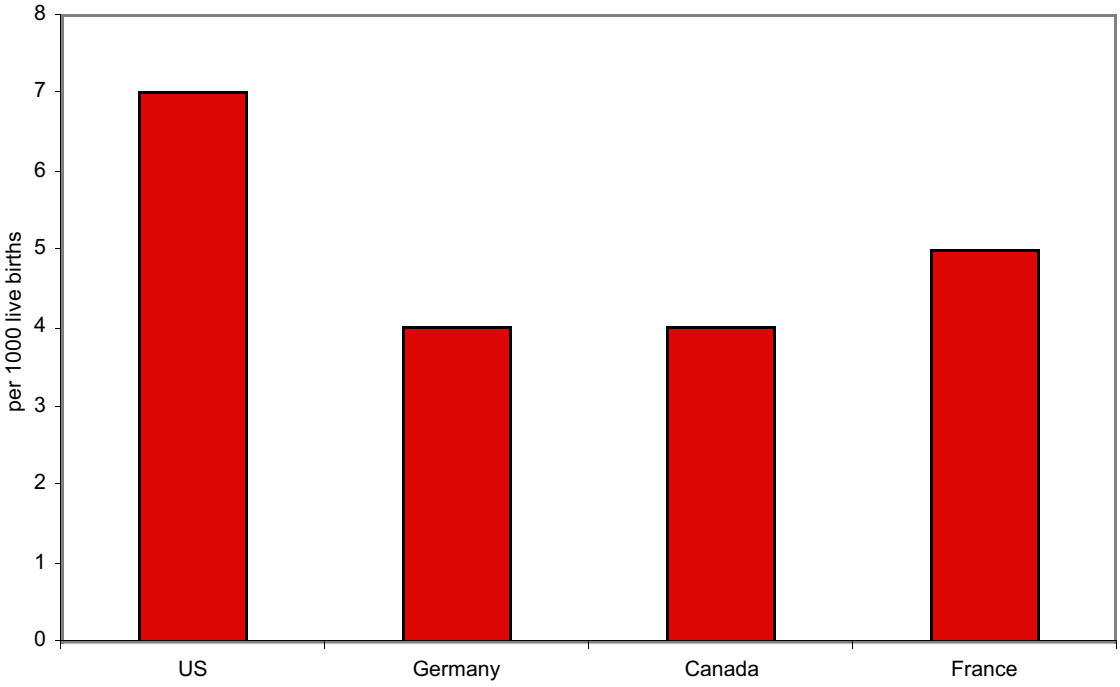



Source: World Bank Group, World Development Indicators Database

Compared to other nations that provide health care for all citizens, the U.S spends much more per capita but leaves 43 million people—1/6 of the U.S. population—without coverage.

A number of indicators, including infant mortality rates among other countries with high levels of economic wealth, show that spending more money does not always mean better health outcomes.

Graph 12: Infant Mortality Rate by Country, 2001[92]




Source: World Bank Group, World Development Indicators Database

The dynamic of higher expenditures and equal or lower health outcomes, led many participants to question the efficiency of the U.S. system.

*"We spend $30 to $40 billion in California, a trillion dollars in this country, on health care: where is the money going? The [health care] industry is enshrouded with lots of statutory immunity relative to disclosure. If we're going to have honest discourse, honest dialogue, we need to know where the money is going now so we can reallocate it together."*
Archie Lamb, Chief Counsel, California Medical Association[93]

**"[W]e need to know where the money is going..."**

HMO executives commonly cited high hospital, physician, and drug costs and over-regulation of the health care market as key drivers of cost increases.

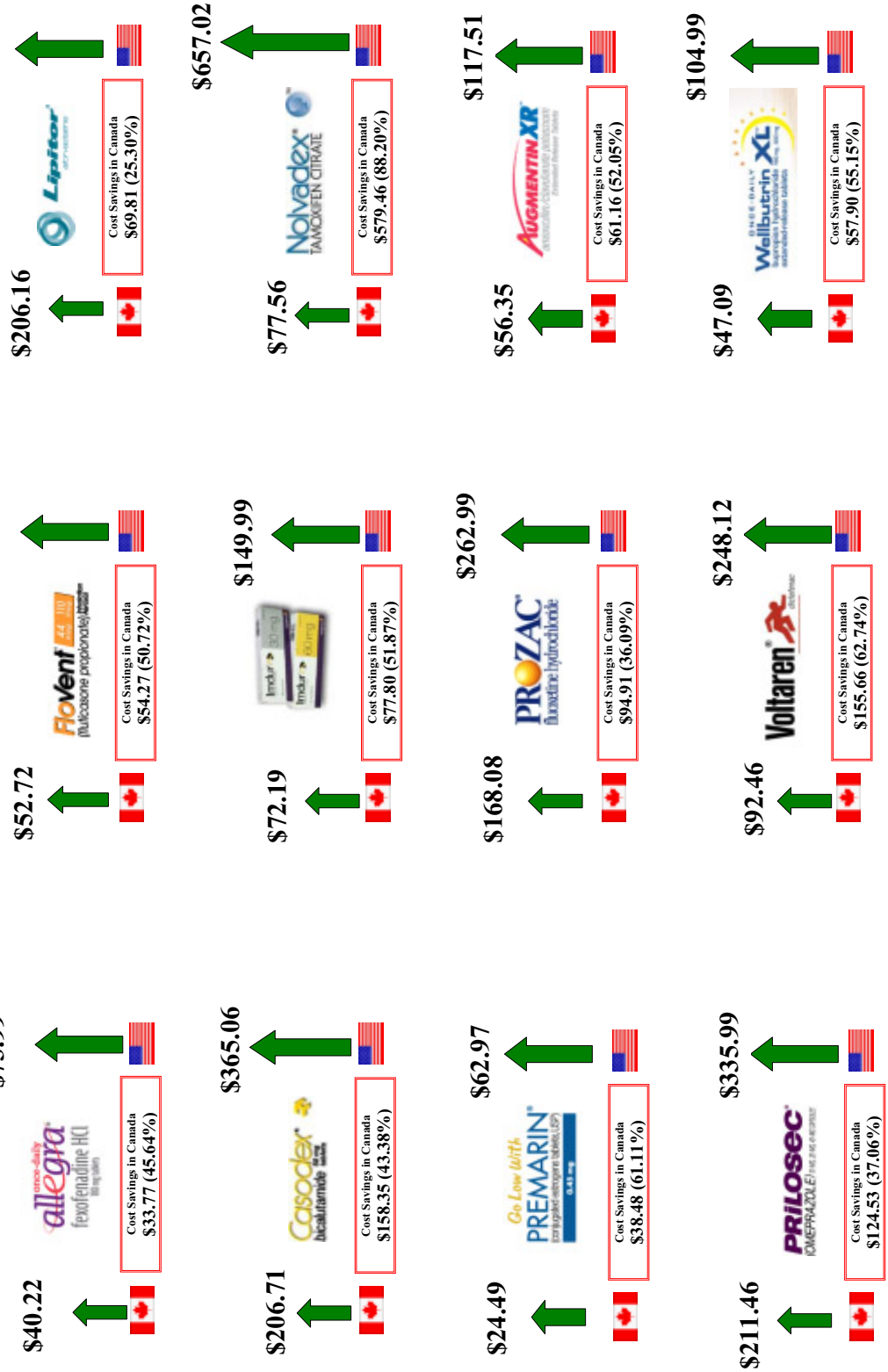
*"It's very difficult for a health plan to do something useful for purchasers of health insurance with the amount of overregulation that has been created over the last 15 to 20 years."*
D. Mark Weinberg, Exec. V.P., WellPoint[94]

## Stakeholders Blame Costs on Waste and Profiteering

Drug company profits and overhead costs were often the target of criticism. Prescription drug expenditures account for one the fastest growing components of health care spending in the U.S. Many challenged the notion put forth by the drug companies that high costs reflect the need to develop newer and more effective medicines.

- In the U.S., prescription drug costs are increasing at 5 times the rate of inflation in 2000, 10 times the rate of inflation in 2001, and 6 times the rate of inflation in 2002.[95]
- In the U.S., patients pay far more for the same drugs compared to other countries. Canadians, for example, pay an average of 40% less than Americans for U.S. approved drugs.[96]

Graph 13. Comparison of United States and Canadian Pricing for Popular Prescription Drugs[97]




Source: Drugstore.com (United States Pricing) and CanadaRX.com (Canadian Pricing) as of February 2, 2004

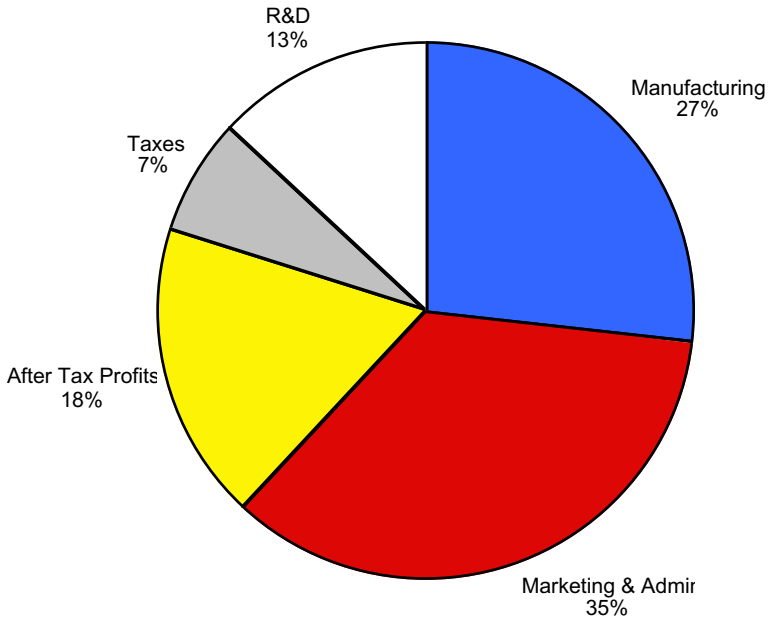
Though drug companies often blame high research and development (R&D) costs as the driving force behind double-digit annual increases in drug expenditures, the fact is that pharmaceutical companies spend nearly three times more on advertising and marketing the newest drugs than they do on research and development.

**"... a tremendous amount of waste..."**

*"Leaving health care to the market place has clearly not worked in California. There's a tremendous amount of waste, and I think that most people believe that the greatest part of the premium dollar actually goes to physicians and providers and hospitals when in fact it goes to many other things not in that primary loop; so the distribution of dollars is a very big issue..."*
Dr. Marie Kuffner, former President of the California Medical Association[98]

In 2001 pharmaceutical companies spent 53% of their revenue on profits, marketing and administration, which includes salaries and overhead.

Graph 14: Drug Companies' Cost Structure[99]




Source: Health Affairs 2001

In 2002, retail spending on prescription drugs increased to $155 billion over 2001 (a 17% increase), according to the National Institute of Health Care Management Foundation.[100] Promotional costs (e.g., providing samples to doctors, sending representatives to

doctors, advertising to consumers, advertising in medical journals) alone have nearly doubled since 1997, rising to $19.1 billion in 2001, according to a General Accounting Office analysis of industry data.[101]

Heavy spending on direct-to-consumer (DTC) advertising is associated with large increases in drug spending. According to research by the National Institute for Health Care Management, nearly half of the increase in retail spending on prescription drugs from 1999 to 2000 resulted from increases in sales of the 50 most heavily advertised drugs. The number of prescriptions written for these drugs rose nearly 25% compared to an increase of only 4.3% for less heavily advertised drugs.[102]

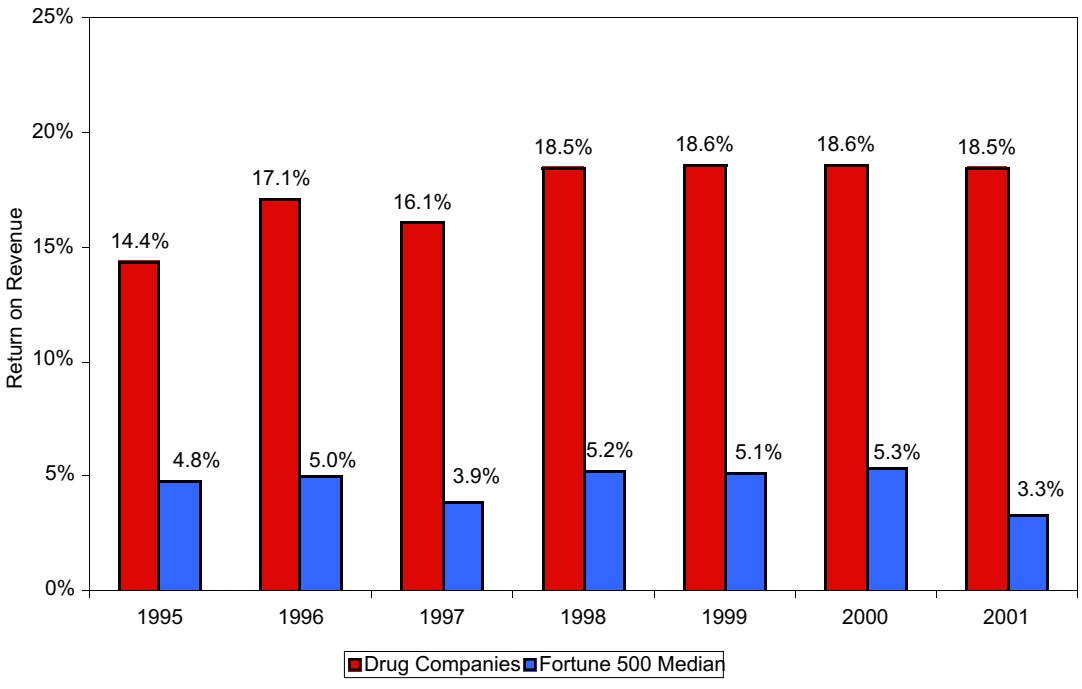
Citing marketing excesses, Art Kuebel, a former representative of the pharmaceutical giant Merck, called current drug company practices a "marketing orgy." Currently, the pharmaceutical industry spends more than $5 billion in promotional costs and gifts each year to market drugs to physicians in hopes that the newest and most expensive drugs are included in the physician's prescribing practices. Several legislative attempts have been made in several states, including California, to require pharmaceutical companies to disclose the gifts they give to physicians.[103]

**"...one of the biggest lies of the century..."**

*"The pharmaceutical industry saying it's going to voluntarily comply with ethical guidelines [regulating gifts to physicians] is one of the biggest lies of the century, right up there with 'The check is in the mail.'"* Art Kuebel, former representative of Merck[104]

In Fortune Magazine's 2002 survey of the top performing companies, the pharmaceutical industry ranked first on all three measures of profitability: return on revenues (18.5%); return on assets (16.3%), and return on shareholders' equity (33.2%).[105]

Graph 15: Drug Company Profits, 1995-2001[106]




Source: Fortune 500

The drug industry is consistently the most profitable in the United States. Executives for well-performing pharmaceutical companies receive higher salaries than executives of any other industry. In 2001, average compensation for the highest paid executives in the nine largest companies in the industry, exclusive of unexercised stock options, was $21 million annually.

Second only to pharmaceutical companies, health insurers spend more of our health care dollar each year on overhead, administrative costs, executive salaries, and unnecessary surpluses than any other stakeholder in the state. This is a painful irony for an industry whose raison d'étre when it first appeared in the late 70's was to aggregate administrative overhead and control costs.

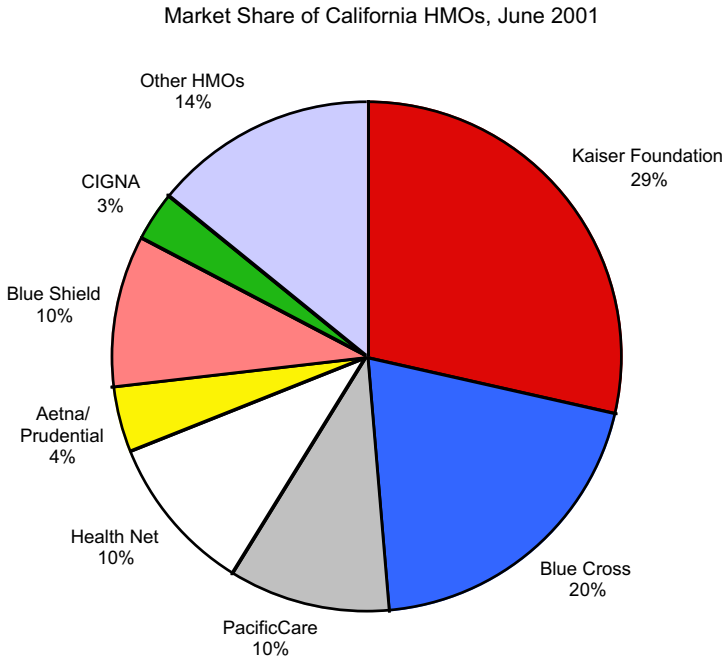
In the U.S., health insurance overhead increased by 16.8% in 2002 and by 12.5% in 2001, and accounted for the fastest growing component of health expenditure over the past three years.[107]

**"[HMO] profits and finances are affecting patient care...."**

*"One thing we know is that profits and finances are affecting their [patients'] HMO care or their managed health care, so I think a first step in clearing this up is disclosure. Let's have a look at those finances, how they're affecting patient care and then start cleaning it up."*
Daniel Zingale, former director, Department of Managed Health Care, former Gray Davis' Chief of Staff[108]

A lack of competition among health insurance companies in California has been singled out as a key market failure that has contributed to greater inefficiency and higher premiums.

Graph 16: Market Share of California HMOs, 2001[111]




Source: California Managed Care Review, 2002

In the state, seven insurers provide health insurance for 86% of the privately insured market. Four plans, Kaiser Foundation, Blue Cross, PacifiCare, and Health Net account more than half the market.[109]

**"...you have very little competition ..."**

*"...you have very little competition [in the health insurance market]. You do have effective regional monopolies. You also have a system that's based largely on the employer selecting the insurance, which again tends to narrow it down to a very few large insurers who can sell to large groups."*
Michael Tanner, CATO Institute[110]

Health insurers spend up to 25% of every premium dollar they collect on overhead, salaries, advertising and profit. The seven largest insurers diverted an average of 12.5% of their revenue away from medical care.[112]

Table 4: Medical Loss Ratios of 7 Largest California HMOs[113]

| Insurer | % Revenue Medical Care | % Revenue Administration | % revenue Profit/Income | Total % non Medical |
|---|---|---|---|---|
| Blue Cross | 78.9% | 13.8% | 7.3% | 21.1% |
| Cigna | 82.7% | 17.6% | -0.3% | 17.3% |
| Blue Shield | 85.4% | 13.2% | 1.4% | 14.6% |
| Health Net | 87% | 9.4% | 3.6% | 13% |
| PacifiCare | 90.4% | 8.6% | 1% | 9.6% |
| Aetna | 93.3% | 11.4% | -4.7% | 6.7% |
| Kaiser* | 94.9% | 3.7% | 1.4% | 5.1% |

* Kaiser includes the administrative costs of running its hospitals and medical group as medical expenses.

Source: California Medical Association

According to a report by the Standard & Poor's managed care analyst, Phillip Seligman, HMOs and health plans should continue to reap record profits fueled by premium price hikes in the 15% to 18% range. Premiums are expected to continue to outpace medical-cost inflation.[114]

*"I realize as I see health care costs rising, we are all reliant on the health insurance system to afford any kind of health care need. I have opted for catastrophic health insurance, the least expensive. Catastrophic coverage, however, is generally useful only in dire situations.*

*"Insurers have abused the system. They have too much power, outrageous rights, they can deny you coverage for almost any reason, they can raise rates for any reason, and they can even find reasons to drop you.*

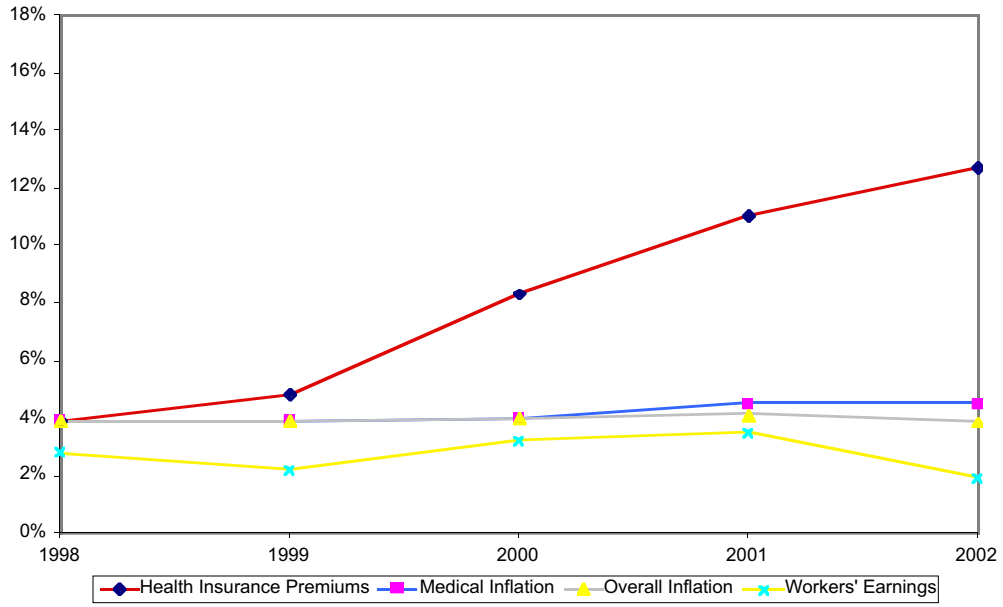
*"I want to see health care prices, and the industry, regulated. Let's face it, if you don't have your*

**"Insurers have abused the system."**

*health you don't have much else. Why should we allow a system to govern our health care that places profit far above our health care? This insurance system has to change."*
Jon Marcus, self-employed, San Francisco[115]

Health insurers claim skyrocketing premiums are triggered by increasing medical costs, particularly prescription drugs. However, in 2002, as the chart below shows, the cost of health insurance increased 250% more than the rate of medical inflation.[116]

Graph 17: Increases in Health Insurance Premiums Compared to Other Indicators[117]




Source: Kaiser Family Foundation, 2003

According to the California Medical Association,[118] health insurers spend up to 25 cents out of every premium dollar they collect on administration, salaries, and advertising, and are recording record profits.[119] The independent market analyst, Weiss Ratings, Inc., reported health insurers recorded a $2.3 billion profit in the first quarter of 2003—a 60% increase over the same time period in 2002. This comes on the heels of an 81% increase in 2002 over 2001 levels.[120]

*"....the insurance companies seem to have an image problem as far as greed goes, I think it's something they've helped to create. I don't know of any other industry where they raise rates three and four times a year and change the product after you've purchased it."*
Jon Pastoria, self-employed, Studio City, California[121]

**"...the insurance companies seem to have an image problem as far as greed goes..."**

As of September 2003, the 7 largest health insurers had more than $2.6 billion more than the state required cash reserves, a measurement called Tangible Net Equity (TNE). Although the Department of Managed Health Care (DMHC) has the authority to enforce mandatory minimum TNE levels to protect against insolvency, the Department has no authority to regulate insurers who divert too much money away from patient care by padding TNE accounts. These totals are not included in the above analysis of HMO revenues, thus an even larger percentage of health plan revenue is diverted from patient care.

While some level of extra reserves is commendable, the question becomes: when does careful financial management become a dangerous undermining of patient care?

At the end of 2003, PacifiCare had more than 500% of the required amount and Blue Cross and Blue Shield had over 400% of the required amount.

Table 5: Tangible Net Equity (TNE) Excesses of 7 Largest California HMOs, 2003[122]

| Plan Name | TNE | Required TNE | Excess TNE | % TNE To Req'd |
|---|---|---|---|---|
| PacifiCare | $367,284,329 | $71,936,937 | $295,347,392 | 510% |
| Blue Cross | $1,120,324,000 | $277,245,000 | $843,079,000 | 433% |
| Blue Shield | $905,575,000 | $214,584,000 | $690,991,000 | 422% |
| Health Net | $355,820,457 | $120,883,675 | $234,936,782 | 294% |
| Aetna | $76,233,125 | $27,942,301 | $48,290,824 | 272% |
| Kaiser | $1,095,322,000 | $533,159,000 | $562,163,000 | 205% |
| Cigna | $62,331,172 | $35,286,544 | $27,044,628 | 170% |

Source: DMHC

*"I believe that there's plenty of money in the system already. And I think it's being misallocated. It's not being used for patient care. It's being used for executive salaries, for excessive amounts of money to pay for drugs. Health care should not be profit driven."*
Kay McVay, President, California Nurses Association[123]

**"....there's plenty of money in the system already..."**

A recent report found that the highest-paid executives of 11 for-profit, publicly traded health insurance companies were paid an average of $15.1 million in 2002. The highest-paid of the health plan executives was Norman Payson, former Chairman and CEO of Oxford Health Plans. In 2002, his compensation, not including unexercised stock options, was $76,010,825, which included over $70 million for the value of shares acquired on exercise. The 11 companies paid their most highly compensated executives a total of over $166 million in 2002, exclusive of unexercised stock options.[124]

The executive with the largest value of unexercised stock options in each of the 11 companies had stock options worth, on average, $67.7 million in 2002, with a median value of over $14 million. For the executive with the largest unexercised stock options, the Chairman and CEO of UnitedHealth Group, the total reported value of those options was nearly $530 million.[126]

Table 6: Health Plan Executive Compensation Including Exercised Stock Options, 2002[125]

| Company | Name | Title | Compensation |
|---|---|---|---|
| Aetna | John Rowe | Chairman & CEO | $8,927,005 |
| Anthem | Larry Glasscock | President & CEO | $6,857,839 |
| CIGNA | H. Edward Hanway | Chairman & CEO | $5,976,890 |
| Coventry | Allen Wise | President & CEO | $21,664,330 |
| Health Net | B. Curtis Westen | Senior V.P. | $6,150,970 |
| Humana | Michael McCallister | President & CEO | $1,648,072 |
| Oxford | Norman Payson | Former Chairman | $76,010,825 |
| PacifiCare | Howard Phanstiel | President & CEO | $3,005,781 |
| Sierra Health | Anthony Marlan | President & CEO | $4,745,988 |
| Uniprise | R. Channing Wheeler | CEO | $9,588,699 |
| Wellpoint | Leonard D. Schaeffer | Chairman & CEO | $21,765,532 |

Average Compensation for these executives: **$15,122,076**

In the world of publicly traded health corporations, the way a company increases the value of the stock, and therefore the individual wealth of the top executive, is often at odds with the needs of patients. Simply put, a clear method to receive a glowing report from an industry analyst, and therefore to drive up stock sales and value, is to divert money away from patient care into profit and cash reserves.

*"We need a statewide approach. We need to eliminate the profit incentive that allows for-profit corporate health care entities to pay their CEOs, as the second largest one in the country just did, $111 million for one year, with stock options, and put that money back into taking care of people. Twenty five percent administrative costs for CEO compensation and advertising is not where the health dollar needs to be spent.*

**"We need to eliminate the profit incentive...and put money back into taking care of people."**

*"The fact is, government-regulated programs are administered at a much lower cost than privately administered ones. They are administered for about 5%. These other programs spend, like I say, 25% of their costs on executive compensation and advertising. We need to eliminate that allocation of money into those things and put it back into caring for people."*
Gerry Jenkins, R.N., UCSD Medical Center, Board of California Nurses Association, Region 2[127]

## Universal Health Care is Cost Effective

The State of California's own study, the Health Care Options Project (HCOP), conducted by the Lewin Group for the California Health and Human Services Agency (CHHS), demonstrated that a publicly funded health care system could provide insurance for all Californians and actually save billions of dollars off current total spending levels by eliminating layers of administrative costs and focusing on preventive care.[128]

**"Let's recognize that ... we do intend to provide care to people when they truly need it. And let's do it in a more cost-**

*"I think we should all try to at least agree on the goal being universal coverage. And the reason for that is, the economic evidence is really indisputable that we could actually better control costs if everyone were covered.*

*"The other reason I think that makes sense is, we're of two minds in this society. We don't want to say that it's a right for everybody all the time, but, in fact, when it comes to it and someone shows up in an emergency room and they're in dire need of health care, we also are not really willing to say, 'No, we're going to turn them away.'*

*So let's be honest about it. Let's recognize that — that we do intend to provide care to people when they truly need it. And let's do it in a more cost-efficient way."*
Daniel Zingale, former director, Department of Managed Health Care, former Gray Davis' Chief of Staff[129]

The savings of such a statewide universal health care system requires putting all health care dollars into a single fund in order to effectively use system-wide bulk purchasing power to access discounts on the price of pharmaceuticals and medical equipment. A single insurance pool provides the benefit of spreading risk across the entire population and therefore providing lower per individual costs.

**"...there are very large administrative savings that are realized through using a simple, single program to pay for health care."**

*"...[U]nder the single payer program, we show that there is a net reduction in spending. We actually spend less, in the aggregate, on health care. The reason for this is that there are very large administrative savings that are realized through using a simple, single program to pay for health care. There are also some bulk purchasing savings which we believe could be quite substantial."*
John Sheils, The Lewin Group.[130]

Consensus Town Hall Theme:
**"Access to care is threatened due to a lack of coordination between the public and private health care delivery systems."**

A growing number of Californians are finding that they simply cannot afford basic care for their families. They either do without, or turn to emergency rooms and paramedics for their health maintenance. Often a lack of coordination or access causes people who should be seen privately to clog the public system.

There are no uniform regulations or systems that coordinate the public and private sectors of the health care system. This leads to a highly fragmented health insurance and delivery system that is administratively complex and annually wastes billions of dollars that could be used for additional health care services. The human cost is great, as is the toll on the system and the cost to taxpayers.

Many nurses and doctors on the front lines of the health care system see uninsured patients who have to wait until their medical conditions are critical before accessing needed care. Many never receive needed treatment:

- Twenty-five thousand uninsured women are diagnosed with breast cancer each year. They are twice as likely as insured women not to receive medical treatment until their cancer has already spread in their bodies. As a result, they are 50% more likely to die of the disease.[131]
- Compared with those with insurance, the uninsured are 29% more likely to die from heart disease; 70% more likely to die of colon cancer; and 115% more likely to die from trauma.[132]

Community health clinics often provide a critical bridge to care for the uninsured. In fact, in 2003, 55% of all community clinic visits were made by the uninsured; however, roughly 12% of all visits were not compensated.[133]

*"Ninety percent of our patients are—are below the 100% poverty level. What we're finding is that the patients are now making major decisions about very minor resources that they have, and they're making decisions to stay away from health care.*

**"...patients are ... making decisions to stay away from health care..."**

*Because they make those decisions, the conditions that they have will be exacerbated and they will end up going to the emergency room, or they will not have the money to pay for their treatment."*

Irma Cota, CEO, North County Health Services[134]

Cuts in state funding have forced clinic operators to reduce their community outreach staff, which in turn means more people are unaware that they qualify for public health care programs.

**"We had to lay off outreach workers at our clinics"**

*"So part of the solution, I think, is we need to get together as a community and look at these partnerships with the business community and others to create an advocacy plan so that we can be heard by the state, you know, about the importance of this funding.*

*"The other thing I wanted to mention is with the Healthy Families and the Medi-Cal, significant funding was cut last year for the Medi-Cal outreach and the Healthy Families outreach. We had to lay off outreach workers at our clinics who are enrolling the people who are eligible for services that are not currently enrolled, and that's significant."*

Alaina Dall, Director of Policy, Council of Community Clinics[135]

As a result, patients that once visited clinics live sicker, tend to face higher unemployment rates, and access more expensive care in emergency rooms or by calling 911.

*"...[M]ost of the times it's not about being lazy and not taking care of ourselves. It's actually not hav[ing] the access to have ... a treatment in any clinic...you know?*

**"I have to call 911, because I haven't been able to get ...care that I need..."**

*"It's—if we don't get the medication, we don't have the treatment that we require—of course, like in my case, you know, I have to call 911, because I haven't been able to get the—the quality care that I need for my chronic diseases."*

Maria Andrade, uninsured consumer[136]

Many expressed frustration with a system that is placing an increasing burden on the state's already limited critical care resources.

*"I'd say over 85% of our calls are [non-emergency] medical calls. Nobody really knows until you get on scene if it's a real emergency or not... the advent of 911. It's an easy access for a lot of people. It's 3 simple numbers on the phone. When they call, we're gonna go. That's what we get paid to do. It's frustrating at times, because you wonder why those folks can't take care of themselves... they use the hospital E.R. room as their doctor's office. They use the 911 system and paramedics and E.M.T. as their doctor's office. So the impact is great."*

**"They use the 911 system and paramedics and E.M.T. as their doctor's office."**

Craig Weisman, EMT, Long Beach Fire Department[137]

Hospital administrators participating in the town halls cited data showing that the majority of California's emergency rooms are overcrowded as a result of hospital closures brought on by inadequate state, federal and private funding. Paramedics must often drive around for an extra 20 minutes in search of a hospital that will accept a patient in need of emergency care.

Though there are few hard numbers, doctors and public officials insist the problem of emergency room overcrowding should be a front burner issue for California's public and private interests.[138] The lack of coordination in the health care system can lead to tragedy, even when help is nearby.

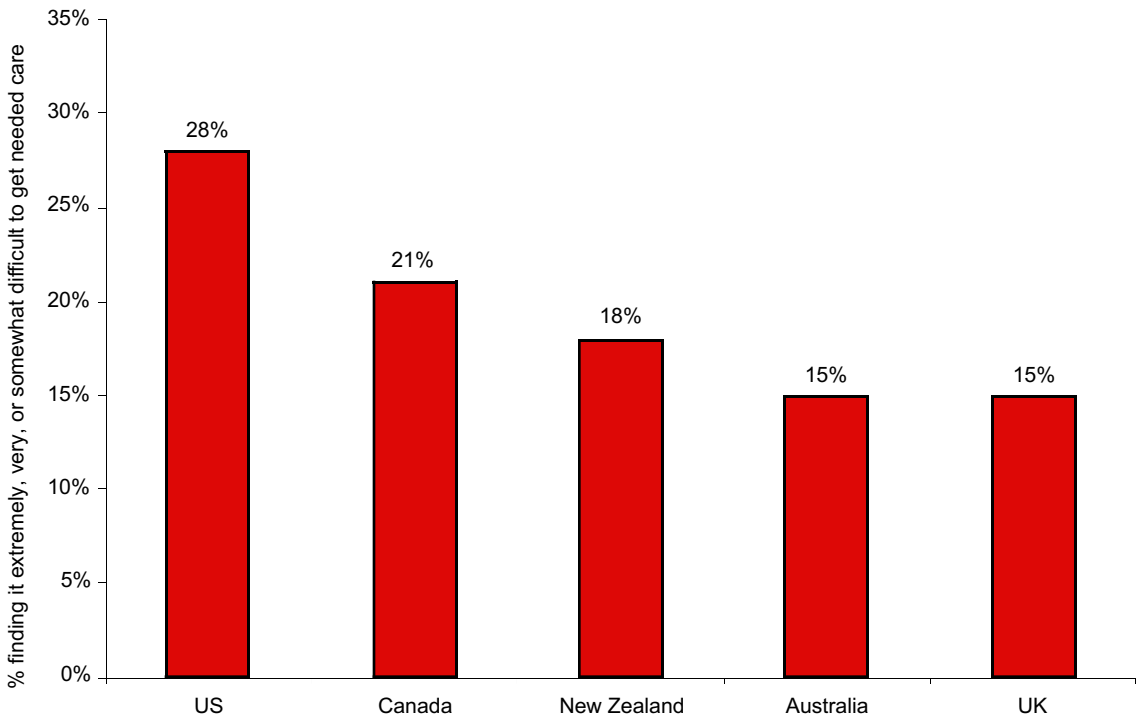
*"If you do get hit by a drunk on the freeway on your way home tonight and you're near County USC Medical Center or near Harbor UCLA, you're going to one of our hospitals. If that hospital isn't open, then the inundation effect, the ripple effect that it has on the remaining trauma centers may be that you won't get to a trauma center at all.*

**"...if the emergency room isn't open ... it's just the luck of the draw."**

*"If you have a heart attack on your way home from work tonight and if the emergency room isn't open, you know, it's been nice knowing you. It's just the luck of the draw."*
Los Angeles County Supervisor Zev Yaroslavsky[139]

Compared to other countries that provide universal access, government funded health care, U.S. patients reported greater difficulty getting care when they it.

Graph 18: Difficulties Getting Needed Care[140]




Source: Commonwealth Fund Survey, 19

## Business Sense

Millions of working people are eligible for public programs but are either unaware or unwilling to sign up because of the social stigma associated with public assistance. Business pays the price by either providing care to those eligible for state and federally funded programs, or, more likely, in lower paying jobs, or in the form of sick employees who miss work because they have no coverage whatsoever.

The business community stands to profit greatly, not only in dollars but also employee morale and a healthy work force, by becoming forward-looking and pro-active in the health care delivery system.

*"We have to make better use of our community clinics. You know, they provide excellent services at — at very low cost. And businesses must outreach to them in some fashion or form for preventive care...*

*"73% of our small businesses who do not insure their employees are not aware that 100% of that is tax deductible. That's a legitimate business expense. What we've found in just the short time we've been working this issue is that the small business community really doesn't understand the value of having health insurance for their employees. And in many cases those employees have never had health insurance.*

**"many employees working for our small businesses are eligible for public programs."**

*"They also don't understand that as you outreach, you also find that many employees working for our small businesses are eligible for public programs, both new ones we hope are coming on-line, and existing ones."* Richard Ledford, President, Board of Directors, San Diego Regional Chamber of Commerce[141]

Many business owners cite their fear of a government-run health care system as a key motive for their opposition to even moderate, business friendly, cost-saving, regulatory oversight. A deep seated ideological, and near mythological belief exists in the employer community, and with the public at large, that the private health care market is more efficient than government run systems.

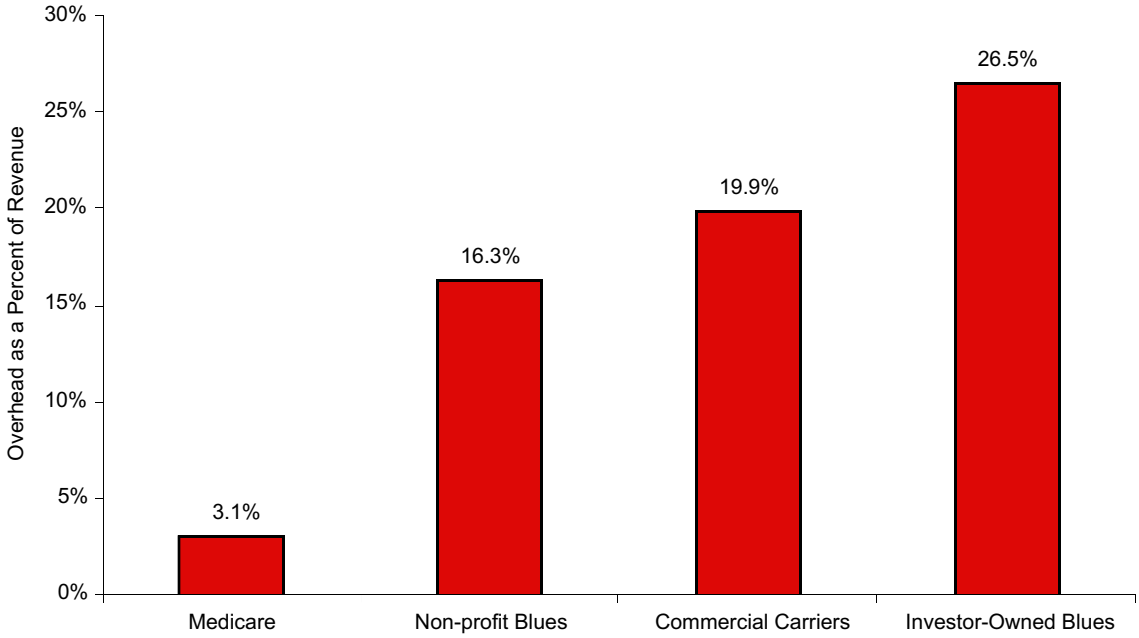
This belief could not be more wrong. Administrative costs in the private market are up nine or ten times that of public programs. When private market profit margins are considered—which don't have a corollary component in public programs—the comparison becomes even more polarized. In fact, some strategies implemented by public programs, like bulk purchasing and the sharing of clinical and other resources, could provide models for the private market.

*"The V.A. offers an interesting model that could be an effective blueprint for reducing inefficiencies in the private health care market. A combination of bulk purchasing, sharing resources and specialists between network hospitals should be adopted by for-profit hospitals."*

**"...bulk purchasing, sharing resources... should be adopted by for-profit hospitals."**

Gary Rossio, Director/CEO, V.A. San Diego Healthcare System

Graph 19: Private Health Insurers High Overhead[142]




Source: Schramm, Blue Cross Conversion, Abell Foundation, & CMS

Even those who often defend the role of health insurers in the market admit that public programs are more efficient than private care, but say government programs often obscure true overhead costs by shifting administrative duties to care providers.

*"...MediCare costs are actually larger than they're generally reported to be because the costs within the MediCare system are only a portion of their administrative costs ... If you actually look at costs across the entire government health care system as allocated, it's still less than the private sector..."*

**"If you actually look at costs across the entire government health care system ... it's still less than the private sector."**

Michael Tanner, CATO Institute[143]

## Public/Private Partnership

With the lack of a government-directed integration of the public and private health care systems, the players themselves have begun to bridge the gap and revive an old but relevant adage: there is strength in numbers, and those who join forces can achieve far more than they would working independently.

Perhaps nowhere is this feeling more alive than in San Diego County.

The San Diego Business Healthcare Connection operates as a collaborative between business leaders and the community. Its goal is to successfully develop and implement workplace-focused strategies to increase the number of San Diegans enrolling in, and maintaining, health care coverage.

Some stakeholders feel that they had found effective strategies for addressing specific aspects of the crisis, but admit that these solutions do not comprehensively address the health care continuum.

*"To take a look at chronic illness, chronic diseases, and try to find the best practices that work for that population, I think, has been a very effective way of incrementally addressing some of those health care needs...*

*"[E]ach of the hospital systems in particular try to integrate, through information systems, the records and so forth of patients, looking at measuring outcomes around certain treatment protocols. They see the practical reality of what their work is doing, and they try to apply that on a system-wide basis.*

**"They see the practical reality of what their work is doing, and they try to apply that on a systemwide basis."**

*"That doesn't answer the larger question of how do you comprehensively address the whole continuum of health care, from prevention, intervention, to treatment. We're spending the bulk of our resources on the treatment side, and we need to — again, to look at the larger continuum and put more money into prevention and early intervention."*
Steve Escoboza, C.E.O., Healthcare Association of San Diego and Imperial Counties[144]

Town Hall Consensus Theme:
**"More public control is necessary to create a rational decision-making process and to provide greater cost efficiency."**

Many participants believe that there are too many players making too many decisions about health care delivery and costs, often working for their individual interests rather than for the general good, the common pocketbook or community health.

Most agreed that a coordinated approach that gives control of the purse strings to the public or to a third party that does not have an economic stake in the outcome of policy decisions could help to ensure good health care at a rational price.

*"I think the key ... is public control over how the money is spent. The research—a great report by the Lewen Group found that if you took the $150 billion that we spend in California every year on health care to insure everyone, you could do that and save $17 billion off what our current spending is simply by treating the uninsured with preventive medicine.*

**"...the key ... is public control over how the money is spent."**

*"Remember, we have universal health care right now in California. The uninsured get service when they get really ill in the emergency room, which is the most expensive place to treat people, and it clogs emergency rooms so that really bad—other cases can't get in. And emergency rooms are closing because of that. It's a really irrational system. We need to control costs."*
Michael Cousineau, Associate Professor at USC Keck School of Medicine[145]

## Consumer Control

Most patients talk about an insensitive delivery system, with endless voice mail messages and computerized impersonality. The consensus: the health care system is rudderless. As a result, patients are prisoners of a dysfunctional bureaucracy. The solution, it seems, is a system where incentives are re-aligned by an independent oversight entity to ensure that quality and ease of navigation are motives, not just profit.

In statewide discussions about reformulating the health care system so that it better meets patients' needs, we regularly heard patients and physicians say that patients' rights are still lacking. Though California took a leadership role in 1999 with passage of the Patients Bill of Rights, a lack of system-wide oversight means that the needs of patients often take second place to the profit needs of the care providers.

*"It's very difficult to navigate through the system as a consumer.... I would like to see this whole thing simplified and streamlined. A*

*person ought to be able to walk in and consume health care without having a Ph.D."*
Kirk Wayman, father of a child born with a heart defect[146]

**"A person ought to be able to walk in and consume health care without having a Ph.D."**

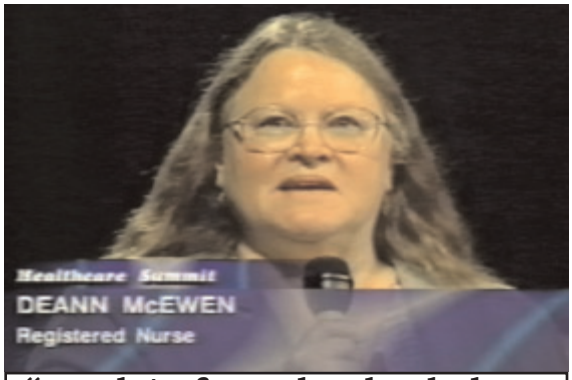
Complexity and a lack of transparency remove accountability from the system. As a result, consumers and patients cannot judge the quality and value of their care.

*"We are relying on the free market to solve the health care problem in America. We say we don't want single payer systems or government intervention. The problem is that you can't really shop for value in health care. When we go to buy a car, we kind of know how much we spend and how much of a value we are getting back in return. Not so in health care."*

**"When we go to buy a car, we kind of know how much of a value we are getting..."**

Dr. Thomas Garthwaite, Director, Health Services, County of Los Angeles[147]

Providers fight the same complexity. "Even physicians can't navigate the system," says Dr. Marie Kuffner. The complexity means that even insured patients don't get the care they need.




**"... a lot of people who do have health insurance still don't get decent care..."**

*"I've seen a lot of people without health insurance and a lot of people who do have health insurance still don't get decent care. ... As a registered nurse, I have been lost in the telephone triage system, waited as much as 20% of my day to get a call back or to even get put through to someone that can help me, that can get the message to the doctor about a critical patient that I need doctor's orders for."*
Deann McEwen, nurse, Long Beach Memorial Hospital[148]

## Bring Back the Human Element

Many of those participating in town halls and interviews expressed concern that those who manage the health care system can grow so absorbed with the bottom line that they forget the pain being endured by the patients who are coming to them for help.

**"You're dealing with human beings."**

*"Health care should not be profit-driven. You're dealing with human beings. You're dealing with lives. And you need to look at it in a more humanistic way. I'm a nurse. Believe me, I have had experiences that have been tragic. And yes, you can have all the laws you want, and you can say that patients can get in, but they aren't getting in to be treated. And I can tell you story after story of people going to emergency rooms and being turned away, dying on the lawn or having the child after the third emergency room denied them care, dying in the arms of the father."*
Kay McVay, President, California Nurses Association[149]

One reason for increasing uninsured rates is the lack of system-wide planning, which some say is due to short-term profit motive.

**" ...public health is not a quarterly commitment..."**

*"For-profits have little incentive to look past the next fiscal quarter, and public health is not a quarterly commitment. ... Public health experts say that to really have an impact you need to forget this generation and begin with kids twelve and younger."*
Wade Rose, V.P., Policy & Planning, Catholic Healthcare West

Some non-profit insurers agree that they have fewer demands on their resources which allows for better long range planning in comparison to for-profit health plans that have profit demands and shareholder responsibilities. However, the non-profit plans lament the for-profits' ability to raise capital from investors for facilities expansions and other improvements.

**"...[we] can afford to kind of take a longer view..."**

*"...We aren't driven by a quarterly return to our investors, so we're able to do some things that maybe some other health plans aren't able to. Kaiser is also a not-for-profit, and so the two of us are the two plans that can afford to kind of take a longer view."*
Tom Epstein, V.P. of Public Affairs, Blue Shield[150]

**"I think that we have the wrong incentives."**

Dr. Thomas Garthwaite see a solution to realigning the needs of society and the health care system with those of the individual by creating new incentives. Recently retired as director of the U.S. Department of Veterans Affairs, which oversees health care for 39 million veterans, Garthwaite is now the director and chief medical officer for the Los Angeles County Department of Health Services.

*"I think that we have the wrong incentives. There's incentives to do too much care under pay-for-service, and*

*there's an incentive, I think, to do too little care under managed care … So we really don't have the incentives aligned with what the patients really want.... Incentives should be for quality outcomes. And we should provide additional funding for quality outcomes."*
Dr. Thomas Garthwaite, Director, Department of Health Services, County of Los Angeles[151]

The consensus: the entire health care delivery system in California has grown so complicated that it needs to be reassembled almost from scratch with an eye on the end user; the consumer.

**"...basic, fundamental overhaul of the system."**

*"The market-driven system ... has driven [reimbursements] down to the point where it's impossible to provide a service. So I think there does need to be some basic, fundamental overhaul of the system."*
Gerry Jenkins, R.N., UCSD Medical Center, Board of California Nurses Association, Region 2[152]

## What Kind of Health Care Do We Want?

Many stakeholders agreed that though a major overhaul is needed, it is very difficult to dismantle the current system and replace it with something completely different. Those of the San Diego health care community said that the first step was to provide a statewide forum designed to allow the public to decide what kind of health care system we should have.

**"...let's start by having a community-wide meeting..."**

*"If I could wave a magic wand, do you know what I would do? I would start by deciding what we wanted... I would say let's start by having a community-wide meeting figuring out what level of service do we want, what kind of services do we want, how far down will we reach to get them."*
Richard Ledford, President, Board of Directors, San Diego Regional Chamber of Commerce[153]

The goal is universal access to care. But the question arises: What kind of care?

*"We need to have forums ... of this nature—where we have to talk about what kind of health care system do we want... Let's define the services we value.*

*"Then we have to ask an equally difficult question, that is: How much will the system cost, and can we afford that kind of system? And if we can't afford it, do we*

**"We need to have forums ...of this nature...we have to talk about what kind of healthcare system do we want..."**

*want to talk about raising taxes, or do we talk about lowering our expectations?*

*"Now, how do we then talk about making our system more efficient and effective where every dollar that we spend is well spent?"*
Dr. Roger Lum, M.D., Ph.D, Director, County of San Diego Health & Human Services Agency[154]

Some have tried, on a local or regional basis, to attack the problem, but see a glaring need for a broader approach. One such group is the Healthcare Association of San Diego and Imperial Counties (HASDIC), which was established in 1956 (then called the Hospital Council) and is a non-profit organization representing more than 35 hospitals and integrated health systems in the two-county area.

*"I think at the local level, all of us have tried our best to address the issues that many patients present to us. But it's just not something that can happen without a fundamental rethinking of health care from the standpoint of is it a business. Is it a commodity? Is it something that should be a right or a privilege? There are basic questions that have to be asked.*

**"There are basic questions that have to be asked."**

*"...look at the system that we now have, which is comprised of purchasers, payers, providers, and patients, and realize that of the models that are being discussed and have been discussed here in San Diego and will be discussed at the state level, whether it's pay or play or whether it's single payer, or universal care, that what we have to emphasize is changing behaviors of each of those stakeholders in that system: purchasers, providers, patients."*
Steve Escoboza, CEO of Healthcare Association of San Diego and Imperial Counties (HASDIC)[155]

Almost universally, patients, providers and employers say they want to have a hand in decision-making.

**"I'm not sure I want the government making that decision."**

*"The capacity of the medical system to render service is far beyond the ability of our society to pay for that service. The world hasn't really faced up to the enormous problem of who should live and who should die. That's a tough, tough problem. I'm not sure I want the government making that decision. I'm not sure I want companies making that decision. I'm not sure whether that decision should be made, but it's a very, very serious problem."*
Sol Price, Founder of Price Club

## Public Participation, for Some, Means Personal Responsibility

For some, public participation in the appropriation of health care resources means that increased individual responsibility is important, along with an emphasis on preventive medicine.

**"We want people to stay healthier, and ... we want them to be taken care of."**

*"You have to look at the public health trends... For example, the obesity epidemic, while on the other hand the decline in smoking. Those kinds of things are major factors in terms of cost and policy for health in California.... There's two things that we all value: We want people to stay healthier, and then when people do get sick we want them to be taken care of. If we don't take care of the first, we're never going to have the resources to do the second. If you want to quit smoking, you can't get smoking cessation [programs] out of the health care system, but once you get lung cancer, you go in, you get expensive treatment, and that's a horrible way to do it."*

Daniel Zingale, former director, Department of Managed Health Care, former Gray Davis' Chief of Staff[156]

Medical data supports the role of personal health maintenance and healthier lifestyles, but shows that many Americans do not have healthy diets or get enough exercise:

- ◆Only 45% of adults in the United States meet recommended physical activity goals.[157]
- ◆Twenty-six percent of Americans report no leisure-time regular physical activity.[158]
- ◆Only one school-aged child in four gets the recommended amount of physical activity.[159]

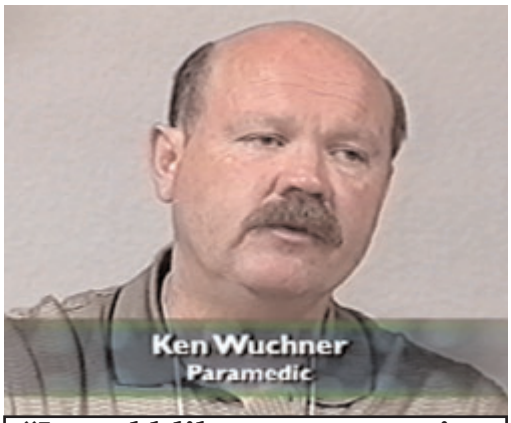
Currently in the U.S. population, fewer than 20% eat the recommended five or more servings of fruits and vegetables each day while more than 60% eat too much fat.[160] [161] [162]

- ◆Poor dietary intake contributes to the development of one-third of all cancers.[163]
- ◆Limiting fat intake to less than 30% of caloric intake and increasing fruit and vegetable consumption from 5 to 9 servings per day will reduce the risk of death from chronic diseases by up to 20%.[164] [165] [166]
- ◆Costs associated with poor diet are substantial, including:
- ◆Over $33 billion in medical costs; and
- ◆Over $9 billion in lost productivity due to heart disease, cancer, stroke, and diabetes.[167]

**"...look in the mirror and ask, 'What am I willing to do to?'..."**

*"...we do need to look at solutions that do include what the individual is willing to do. And again, it comes back to: If people really focus on what they really need, which is healthcare security and the policies that they buy are covering the major problems of life and not the day-to-day things, enormous savings accrue. It makes it much easier for business to provide that insurance, much easier for individuals to access it. Certainly we need to deal with preexisting conditions and all the Mickey Mouse games that insurance companies will do if you let them get away with it....*

*"[T]he—the thing I would take away is everyone who's interested in this also has to look in the mirror and ask, 'What am I willing to do to put in—to put in my two cents'—actually, it will be more than two cents, frankly—'in the process?'"*
Dr. Robert Hertzka, President, California Medical Association[168]




**"I would like to start seeing cause-and-effect type taxes."**

Many have ideas about how to provide new incentives in the health care system to make it respond to the needs of the individual and of society.

*"I would like to start seeing cause-and-effect type taxes. You buy a drink, you pay for the effect afterwards. You go to a bar, you pay for the effect afterwards. Uh, you buy a high-performance car, you buy a high-performance motorcycle, you pay for the cause and effect afterwards. That was part of the thing I was talking about, too, as far as personal responsibility."*
Ken Wuchner, EMT, Long Beach Fire Department[169]

Some uninsured patients that participated in the California Health Consensus Project agree that eating well and exercising are all a part of staying healthy, but were afraid that those personal responsibilities do not do much good if you get sick or are in an accident.

*"I believe in preventive strategies, eating healthy. Because I never know, one year I will be eligible for unemployment through Screen Actors Guild or Actors Equity, or ... I might not have a job. So I just pray and eat well and hopefully everything will be okay... But if I'm on the highway and get hit, what happens? ... who is going to protect me then? What do I do?"* Felicia Wilson, uninsured actress[170]

**"I believe in preventive strategies... But if I'm on the highway and get hit, what happens?"**

## Independent Oversight

Some asked that if indeed public participation is the flip side of individual responsibility, in what forum can the public participate?

Many consumers say they do not have time to be personally involved in re-shaping the health care system, but that they want independent oversight and planning to provide the framework for reform.

Laurel Kaufer, a 41-year-old single mom, lives in the San Fernando Valley with her two teen-aged boys. Rising health care costs have forced her to ration care, and there are times she simply can't afford to take her sons to the doctor. The spiraling costs are "having a chilling effect on people seeking early health care," when they could prevent an illness or stop it early in its attack.

It angers Laurel that the system is virtually unregulated. Taking the decisions out of the hands of the insurers, who are in the business for profit only, is key, Laurel says. "In order for the consumer's needs to be protected, the insurance industry must be watched and held accountable."

*"The insurance companies have a huge lobby, with a great deal of financial backing, and so remain in control. I'd like to see the Legislature mandate caps on increases. And every increase should be approved by a panel of non-industry personnel."*
Laurel Kaufer, Self-employed, San Fernando Valley, California[171]

**"...every increase should be approved by a panel of non-industry personnel."**

Laurel's sentiments were echoed by many, including Art Letter, now retired, who was a civil servant and consultant for decades. Art is conversant with the way government works, and has developed an expertise on the state's health care delivery system gleaned from serving on an independent health commission in the early 1980s. So when Art's monthly premium went up 40%, from $231 to $323 last year, he thought he would have little trouble getting to the bottom of why it happened.

Despite his expertise, however, Art ran head-on into a stone wall. He was flabbergasted by the runaround he encountered. Insurers pointed the finger of blame at doctors, who pointed at politicians, who pointed back at insurers. It was a vicious circle of evasion. The hands that weren't pointing were covering a rear end.

When all was said and done, Art discovered this: Nobody is effectively regulating health care in California. "They can do whatever they want. It's outrageous what's going on." Art wants a change and he wants it to be far-reaching. "I feel passionate about this," he says, and not just for himself. "What's happening to me," he says, "is happening to a lot of people."

He wants to see an independent commission that would monitor and have regulatory control over cost increases. He also would like to see it gather specific information that it would provide to governmental leaders.

*"For the most part these people [health care insurers] are ripping off the system in an incredibly ugly and arrogant way. Politicians can't stand up to these big lobbying organizations. Big money is controlling our democracy. It's poisoned the system.*

*"I would like to see an independent commission that would monitor and have regulatory control over cost increases. I would like to see it gather specific information that it would provide to governmental leaders."*
Art Letter of San Diego, long-time civil servant and consultant[172]

**"an independent commission that would monitor and have... control over cost increases."**

The time is now, Art Letter says. "For the most part, these people are ripping off the system in an incredibly ugly and arrogant way. The people we elect let it happen because the insurance lobby has plenty of money to spend on politicians—money they gouge from consumers."

## A Lack of Political Will

The forums drew forth a consensus that the best opportunity for reform is a system where everyone is covered, because by including everyone in the insurance pool the cost of everyone's coverage will come down.

Participants also came to the conclusion that the complexity of the task and the political muscle of the status quo has kept lawmakers from enacting sweeping reforms.

*"An essential question that I think ought to be addressed is the incredible conflict between how the public feels and the political will to make it happen. Nearly 90% of Americans, and almost every poll, believe that every American ought to have basic universal health insurance or basic universal coverage. And yet, 25% of Californians do not receive any health care benefits. What is preventing the health care system from delivering something that is so fundamental to every American?"*

**"What is preventing the health care system from delivering something that is so fundamental to every American?"**

Steve Thompson, V.P. of Government Relations, California Medical Society[173]

Legislators who are aware of the problem say their colleagues will act if public pressure grows intense. Senator Liz Figueroa (D- Fremont) was asked what she was willing to give to achieve a more rational and fair health care system.

*"We're talking about a crisis in health care. We thought we had an energy crisis in California, but it's nothing compared to our health care crisis.*

*"Our emergency rooms are closing. Physicians are leaving the state and the profession. There are too few nurses for all the patients that need care.*

*"Every single day I deal with this, but the health care issue is not the sexy, political issue that's going to get you elected....*

**I wish the voters would be angry enough to say, 'We're going to kick out every legislator that doesn't feel that health care is the number one issue facing our society.'**

*"There isn't the leadership in Sacramento. We're not going to see a lot of activity regarding health care because the public has told us that it's really not important.*

*"I, for one, am willing to give up my position. I wish the voters would be angry enough to say, 'We're going to kick out every legislator that doesn't feel that health care is the number one issue facing our society.'"* Senator Liz Figueroa (D-Fremont)[174]

## People Power

One of the key concerns stakeholders have raised over the past two years is that systemic reform will not occur until access to health care becomes a middle-class issue. Recent polls demonstrate that this is now happening.

**"...that's where the power is."**

*"When this becomes a much wider spread, middle-class problem—if there's any middle class left in this country, let alone upper middle-class—you'll see the system change, because that's where the power is."*
Bob Sillen, Executive Director, Santa Clara Valley Health and Hospital System[175]

A 2003 poll by National Public Radio, the Kaiser Family Foundation, and Harvard's Kennedy School of Government points to a significant medical divide in the United States along socio-economic lines. That divide reaches far beyond low-income Americans and well into the middle and upper middle classes. Although Americans with higher incomes say they experience fewer problems accessing necessary medical care, many of them are worried that their good fortune will not continue.[176]

◆54% of those polled think that access to health care and insurance is the most important issue for the government to address.

◆67% think the amount of "greed and waste" in the health care system is a key component of rising health care costs, while 51% worry that health insurance will become so expensive that they will not be able to afford it.

◆50% worry that their current health care plan will be cut back substantially, while 78% think that getting a fair price for health insurance would be harder if they had to purchase health insurance without the help of their employer.

## Consumers Want Action

Many health care customers are ready for the government to act now.

At the time of the interview, Jon Pastoria, 38, was a corporate recruiter and financially savvy small business owner. However, being sophisticated about finances is no match these days for the deficiencies of the California health insurance system, whose abuses, many participants observed, are now undermining access to care for the middle class in the same way they historically impacted lower income populations.

*"Individual policyholders have no leverage; we need all the help we can get. My family and I have been victims of bait and switch tactics and frequent, exorbitant cost increases. We need limits imposed, including on the number and percentage of rate increases."*
Jon Pastoria of Studio City California[177]

**"We need limits imposed, including on the number and percentage of rate increases."**

After years of struggling to provide basic health care for his wife and two sons, Jon has finally resorted to taking out catastrophic health insurance, which provides coverage only in emergencies. It was a last option, but health insurers forced Jon into it after years of "mistreating my family."

"You feel like you're being screwed to the point where you have no hope," Jon says. "You have two choices: Go along [with whatever insurers offer] or go without health insurance."

Jon's huge medical bills kept getting worse as Blue Cross regularly raised rates. Annoyed, Jon nevertheless was handling the costs. Then, one day, Blue Cross, which had raised his rates three times in one year, raised them again. Thinking "this is ridiculous," Jon in October 2001 signed on with Nationwide Health Plans, which had been Cal Farm Insurance.

The insurer made him take out two policies—one for Susan and the kids and a separate one for Jon, who had always had an erratic heartbeat although he has never had any heart problems.

The practical effect was to make him pay two separate deductibles. In addition, Nationwide jumped his premium by 50%. Jon didn't like it, but he felt it was a better deal than Blue Cross offered. The two premiums combined cost $473 a month.

Two months later, Nationwide socked it to the Pastoria family. It increased premiums by $2,088 annually ($174 per month) and added new deductibles, when they originally purchased zero deductible policies, that tacked on another $2,000 to the Pastorias' annual tab.

Jon finds it hard to believe that Nationwide did not know when they signed him up in October what they were going to do to him in December. "We had switched to them because Blue Cross had increased our premiums over three times in one year," and Nationwide was advertising a better deal. It was a classic bait and switch. But they felt stuck. To go on another Nationwide plan, or to another insurer, they would have to start the underwriting process all over again.

The 'pre-existing condition"—his erratic heartbeat—would have cost him all over again, or perhaps led to him being turned down altogether. And, as Jon notes, even if you do switch, "what's to keep them from raising rates again, and again, and again."

The strain on the family is palpable. "It definitely makes you think twice about going to the doctor," Jon says. The extra money the family pays for health care comes from other family needs—the number of days Anthony attends pre-school, for example.

The quixotic quest to take care of one simple thing—his family's health—seems never-ending to Jon. And the quandary is spreading. "Access to affordable health insurance affects everyone, from the poor to the middle class. The situation is only going to get worse."

The government needs to provide oversight, Jon says. It should limit the number and percentage of increases. It should crack down on bait and switch tactics. "Individual policyholders have no leverage; we need all the help we can get."

# Section III.
# Consensus Summary

What consumers want is simple: health coverage that is available when needed. For other stakeholders, there is a divide between what they need and what they think they can get.

## All stakeholders except consumers, say they want:

◆Universal health care, as long as they don't have to give anything up to get it or, better yet, if it puts money in their pocket;

◆Affordability; but no one wants to be, and all claim they cannot afford to be, the target of the budget knife;

◆Everyone agreed that bloated administrative costs, overhead and profit are inappropriately diverting money from care; but all dodged responsibility.

## What they say they need:

◆Stable budgets to allow for adequate planning for facilities expansions, reserves to protect against insolubility, and long-term planning necessary to assure stability;

◆Adequate compensation to attract and retain care providers, satisfy profit needs, and pay for necessary overhead costs;

◆Rationalized health care financing that eliminates cost shifting so that no consumer pays for more than the care provided.

## What we concluded:

◆Middle-class Californians now face a greater threat of being uninsured or under-insured than they have in the last decade;

◆The uninsured often must turn to emergency rooms or call an ambulance to access non-emergency treatment, resulting in poor health outcomes, increasing the cost of care and utilizing scarce critical care resources;

◆All players are affected by dramatic cost increases, but only health insurers and pharmaceutical companies have consistently achieved high profit margins;

◆Achieving universal access to health care will require all players to settle for what they need, not what they want;

◆The only way universal health care will not require additional funding is if administrative savings are maximized at all levels by removing excessive overhead and profiteering;

◆Only a break from the current regime—where an unregulated and uncompetitive market controls health care planning—will allow for system-wide distribution of resources, rationalized costs and equitable financing. Those with an economic stake in the outcome of policy decisions should be servants, not masters.

## Section IV.
## The Politics of Universal Health Care Reform

After nearly two years of town halls and media exposure of the Project's efforts to achieve a consensus universal access health care plan, 2003 saw significant legislative action. Taken together, several proposals contained each of the California Health Consensus Project's policy elements (See Section V), though the final law failed to adequately address affordability.

Ironically, it was concern over rising costs that fueled the renewed attention to health care reform in Sacramento. Nearly daily news reports of the growing number of working Californians unable to afford health insurance, and the rising number of all Californians paying more for fewer benefits, brought a level of action not seen in nearly a decade.

Among the greatest pressures for reform was that which came from the employer community. Those who provide health insurance, in addition to legally required workers' compensation insurance, in effect pay two premiums for medical coverage for their workers.[178] California workers' compensation insurance premiums are among the nation's highest, while benefits for injured workers rank among the lowest third nationally.

*"One thing that has always been difficult to understand, both politically and in the public policy arena, is why can't businesses and consumers and medical providers be shoulder to shoulder in this push for universal care, because it should be of paramount concern to business how their money is spent. And if 25 to 30 cents out of every dollar that they give to an insurer is really going to overhead or administrative problems instead of actually providing healthcare for their employees, that's a tremendous waste of money."*
Sara Nichols, former Legislative Advocate, California Nurses Association[179]

**"why can't businesses and consumers and medical providers be shoulder to shoulder..?"**

Several approaches to the problem were undertaken. The most far-reaching proposed to save money by removing health insurers from the system entirely; others sought rate oversight and an expansion of employer-sponsored coverage.

Senator Sheila Kuehl (D- Santa Monica) introduced legislation, SB 921, to bring about a Canadian-style, government-run universal health care system, known as "single

payer." Though the bill was held in its Assembly policy hearing after passing the Senate, key concepts in the bill—most importantly a state-run insurance pool and universal access—continue to play an important role in shaping the reform debate. Senator Kuehl's bill has garnered significant support from a broad range of organizations.

Senator Liz Figueroa (D-Fremont) proposed legislation, SB 26, designed to implement a "prior approval" process for health insurance rates similar to that which exists for auto and other types of insurance in California under Proposition 103. This bill would require health plans to get approval for their non-medical costs—profit, administration, salaries, reserves—before raising premiums, co-pays or deductibles. The proposal would allow a regulator to deny rates deemed to be unfair or excessive.

Senate President Pro Tem John Burton (D- San Francisco) and Senator Jackie Speier (D-San Francisco), Assemblyman Dario Frommer (D- Los Angeles) and Assemblywoman Rebecca Cohn (D- Saratoga) introduced three similarly constructed proposals to require employers to provide health care benefits—either directly or by contributing to a state-run purchasing pool—a reform model known as "pay or play."[180]

The lead "pay or play" proposal, SB 2, authored by Senators Burton and Speier, was sponsored by one of the Project's core participants, the California Medical Association, and the California Labor Federation (AFL-CIO). Genentech, a large California employer, supported SB 2, acknowledging that spreading risk by expanding access and focusing on preventive treatments is the best method to keep health care costs down in California.

Even the state's health insurers came to the table with a plan for reform based on expansion of employer-sponsored health care, though health plan executives admit that requiring employers to purchase insurance coverage without cost controls would be an economic boon for the industry.

*"We've been criticized because the idea here of mandating health care coverage and insurance is self-serving. It's true. If we expand coverage to 6 million Californians, we'll get our fair share. I sure hope we do. And we'll compete with others in getting it. That's not why we're doing it.*

**"...it's our problem. And we only solve it together."**

*"The entire system, the health care delivery system, the insurance system, is going to get worse unless we do something. And we can't solve that problem by ourselves. No managed care company can solve this problem by itself, Blue Shield or anyone else. This has gotta be a problem that all Californians stand up for and say we gotta get this right, we gotta fix it. We gotta fix it together. It's not that hospital administrator's problem, it's not my problem, it's our problem. And we only solve it together."*
Bruce Bodaken, CEO, Blue Shield of California[181]

AB 1528, by Cohn, proposed possible new taxes and universal employer participation to help fund access to health care benefits, but like SB 2, did nothing to ensure that the rates that doctors, hospitals, and insurers can charge are reasonable. Health insurers, notably the non-profit Blue Shield of California, and the California Healthcare Association, representing hospitals, supported the Cohn proposal.

## The "Pay or Play" Conference Committee Validates and Amplifies Project's Findings

In September of 2003, Senate Pro Tem John Burton convened a conference committee to work out differences in the Senate and Assembly "pay or play" proposals. Simultaneous to the conference committee on health care reform, Senator Richard Alarcon (D- Sun Valley) convened a conference committee to unite 20 proposals designed to cut costs in the workers' compensation system.

By the end of the 2003 session, several workers' compensation reform bills had been approved with the expectation that they would provide several billion dollars in savings though the workers' compensation insurers downplayed their potential. These bills focused on controlling the amount of money health care providers could receive under the workers' compensation system. Specifically, new laws now limit the number of chiropractic visits an injured worker can receive and requires outpatient surgery centers to abide a controlled rate structure.

Knowing that employers would not support an expansion to health care unless cost savings were promised, and that insurers and hospitals that supported the "pay or play" proposal would not allow rate controls that would hurt their profits, legislators sought to trade cost savings in the workers' compensation system for an expansion of employer-sponsored care. Senator Burton's SB 227 proposed to freeze workers' compensation premiums at existing levels for all businesses that provided health care benefits to their employees.

Among those who testified at the "pay or play" conference committee hearings were health care consumers, doctors, nurses, health clinic directors, minority groups, labor unions, employers, consumer groups, manufacturers' groups and those who spoke for small business. Health insurers weighed in, as did the California Chamber of Commerce. See Appendix 3 for a summary of the conference committee.

Some objections to health care reform were ideological as well as economic. The California Chamber of Commerce, for example, opposed any interference with what they argued was a functional market. Some saw the Chamber's views as obstructionist and negative.

"Are we going to create an environment where we create jobs, or not?" asked Richard Costigan of the Chamber. Costigan called SB 2 a "job-killer" and a "multi-billion dollar health care tax."… "We are not going to swell the ranks of the insured; we're going to swell the ranks of the unemployed," Costigan said. Businesses that otherwise might come to California "are going to stop at the Nevada border."

When the Chamber sought to kill SB 2 despite the efforts of others to find a consensus solution, Burton rebuked Costigan: "Instead of always saying no, no, no, no, no to everything, try to be part of a solution." (Since the hearings, Costigan has left the Chamber to serve as Governor Schwarzenegger's Legislative Secretary).

In the final hours of the conference committee, AB 1528 was gut-and-amended to become the California Health Care Quality Improvement and Cost Containment Commission. The commission was directed to study cost controls and deliver a report to the Legislature in January of 2005. To date no commission members have been appointed.

## The Next Phase of Reform

Eventually signed into law by Governor Davis, the final version of SB 2 requires employers with 20 or more employees to either provide health care benefits directly to workers or pay a fee for the worker to receive care from a state-run health insurance purchasing pool.

The implementation date of the new program has been delayed until 2006 for large employers and 2007 for medium sized employers. Employers with 20-49 employees will not be required to participate unless a 20% tax credit is provided.

The law does not contain cost control provisions, nor does it provide protections for consumers on the amount of out-of-pocket charges they will be required to pay in order to access medical services. Despite this, SB 2 does contain key elements of the consensus provisions uncovered by the California Health Consensus Project (see Section V). Senator Burton and Assemblyman Dario Frommer have introduced prescription drug bulk purchasing and re-importation legislation this year to help reduce drug expenditures and contain overall health care costs, but more must be done to cap hospital and physician rates and regulate insurance premiums.

Citing insurmountable costs, the California Chamber of Commerce and the California Restaurant Association qualified a referendum for the ballot to repeal SB 2. On December 12 a Sacramento Superior Court judge found that the petition circulated with the referendum was misleading and that it violated California election law—ruling that the referendum would not be allowed to appear on the March 2004 ballot. By the end of January, the San Francisco First District Court of Appeals reversed the earlier decision and allowed the referendum's appearance on the November 2004 ballot. Early polling indicates strong voter support for SB 2, thus against the referendum.

Simultaneous to efforts to roll-back employer-sponsored care, public health programs face up to $3 billion dollars or more in spending reductions in the 2004-2005 state budget.

Furthermore, savings in the workers' compensation system have not met expectations. Workers' compensation insurers have refused to meet the 15% reduction called for by Insurance Commissioner John Garamendi. The announcement highlighted a key flaw in

the workers' compensation reform scheme: no section of law requires the insurance companies to pass along to employers savings brought about by the 2003 legislative reforms. As a result, many workers' compensation insurers' profit margins experienced a 200-300% increase.

The health insurance market has been experiencing this same phenomenon over the last six years. Now, four insurers control more than half the state's health care market. According to the California Medical Association's annual report, state health insurers divert as much as 25% of every health care dollar to cover profit, salaries, overhead and advertising. As a result, in 2002 health insurance premiums increased 250% more than the rate of medical inflation.

The best opportunity to preserve SB 2, as well as to stave off future budget cuts to government sponsored health care, may well be to redefine the debate in terms of making health care more affordable by eliminating waste and cracking down on profiteering. Re-investment of this savings into new or existing programs will help stabilize and increase access to care.

Most important for the future of the California health care system is for patients, business owners, doctors, nurses, hospital administrators and clinic directors to continue to demand a cost-effective universal health care system for California. The next two years will be a critical period to determine if the current health care crisis will provide the opportunity for system wide reform.

## Section V.
## Elements of a Universal Solution

In the following section we will present an analysis of each of the consensus reform elements identified by the California Health Consensus Project. In Section VI we provide a model reform proposal that contains each of the following policy elements. Section VII provides three model cost control laws that could be used to address the immediate affordability crisis.

Although there are disagreements among stakeholders over what the reform vehicle should be and the specific characteristics of the overall proposal, there is a high degree of consensus over the policy elements of a universal health care solution:

- ◆Universal access;
- ◆Affordability;
- ◆Systematized to improve quality, accountability and streamlined oversight;
- ◆Employer-based and portable;
- ◆Integrated with the workers' compensation system;
- ◆Public decision-making process.

It is important to note here that the Project's findings in terms of the public perception of the viability of health care reform mirrors closely that of the FrameWorks Institute's ongoing research.[182] Specifically, Californians believe that:

- ◆The health care crisis requires extensive overhaul of the system; but,
- ◆People are extremely nervous about wholesale change; because,
- ◆They do not trust the state government and policy makers to do the right thing; thus,
- ◆There is support for a stepped, "moving in the right direction" approach that incorporates a vision for a systemic overhaul and a broad range of reform elements but implements them gradually.[183]

The following universal reform elements were extracted by the California Health Consensus Project coordinator, the Foundation for Taxpayer and Consumer Rights, and would likely be accepted by the majority of stakeholder participants.

> *Universal Access:* A new state health plan and purchasing pool should provide comprehensive health care coverage for all who do not have access to benefit plans provided by employers, including the unemployed, retirees, and self-employed. To maximize administrative efficiency, the

new state health care plan should be administered by the 2 million member California Public Employees Retirement System (CALPERS). Hospital and physician networks should be organized directly, bypassing insurers, and drug purchases should be aggregated in order to achieve maximum bulk discounts. Drug re-importation should be considered as a component to bulk purchasing. Competition between the state plan and private plans would help to control costs. To the extent possible, available federal funds should be tapped to help fund the state pool used to purchase workers' health coverage.

Most Californians do not realize that the state already provides care to all who need it, albeit in an incredibly inefficient way. Those who do not qualify for public health care programs and cannot afford care through the private market are provided care in emergency rooms when their conditions become critical. Preventive care, which provides for better health outcome, is far less costly than care in emergency rooms, and is less draining on limited critical care resources, is often not available to the uninsured. The result is poor health outcomes and fiscal irresponsibility.

Currently, SB 2 would create a new health insurance purchasing pool to be overseen by the Managed Risk Medical Insurance Board (MRMIB). MRMIB is far less efficient than the proposed CalPERS network because it relies on managed care companies to administer care that spend up to 25% of every premium dollar on overhead, salaries, advertising, and profit.

Further, SB 2 only covers those who are employed by a business with more than 50 employees (along with eligible dependents), not the millions of self-employed, unemployed, and pre-Medicare retirees without health care coverage. The benefit of covering all Californians is that the more participants there are in the purchasing pool, the more affordable it is for each because the risk is spread more widely. Leaving no patient behind is critical to achieve maximum cost efficiency.

Small companies that choose not to purchase health care from private HMOs and thus choose to join the CalPERS pool would benefit greatly from lower rates resulting from the aggregate purchasing power of the state-purchasing plan.

*Affordable:* There is no equitable way to guarantee sustainable coverage for the insured and provide coverage for the uninsured without ensuring fair and reasonable insurance premiums, doctors' fees, hospital services and prescription drug expenditures. An independent body should be charged with monitoring and controlling overall costs of California's health care system by weeding out waste, inefficiency, and profiteering at all levels.

Existing law provides no mechanism for stabilizing the growth in health care spending, which is quickly outpacing growth in GDP. Absent budgeting capabilities, growth in health care spending is rapidly surpassing the ability to afford current levels of benefits or to add new benefits related to technological improvements.

The overall aim of rate setting should be to:

- ◆Stabilize and control health costs by predicting demand and eliminating waste in all cost centers: hospitals, medical groups, health plans, and prescription drugs
- ◆Assure that providers, hospitals and health plans are sufficiently reimbursed to maintain financial stability, and that net revenues do not exceed reasonable requirements for profit and reinvestment.
- ◆Control price spikes through market-wide planning and bulk purchasing.
- ◆Ensure that the health care system has the financial and regulatory flexibility to provide efficient, high quality and comprehensive services to all Californians.
- ◆Increase the equity and fairness of health care financing.
- ◆Protect hospitals, ERs, community clinics and medical groups against insolvency.

This is not a new or untested idea. Hospitals are regulated in Maryland as a result of legislation passed in 1971. That law created the Health Services Cost Review Commission (HSCRC) as an independent agency, with seven members appointed by the governor. The HSCRC was given broad authority to set hospital rates for all payers.

Since 1977, Maryland hospitals' average cost per admission has declined from 25% above the national average to 8% below the national average. Such a model could serve as a basis for all-payer rate setting for California's health care system.

California has regulated auto and home insurance for over a decade. The landmark auto insurance reform initiative, Proposition 103, established a "prior approval" system for many lines of insurance. During the decade after Proposition 103 was adopted, auto insurance rates in California went down by 4.0% while insurance products remain broadly available and competitive, and the uninsured motorist population declined by 38%. Nationally, rates rose over 25% during this period. California consumers have saved over $23 billion since 1988 under the prior approval system.[184]

*Systematized to Improve Quality, Accountability and Streamlined Oversight:* Government and providers should be accountable for assuring that health care is fully available, financed, improved and provided. Quality reporting is undertaken by numerous private and governmental agencies. While there is widespread disagreement on what constitutes

quality, how to measure it and how to achieve it, progress is being made. A single state agency should be responsible for setting quality standards, collecting data and reporting outcomes. Outcome reports should be fed back into the rate setting process so that providers and plans with the highest outcomes are rewarded.

Government regulation of health care is pervasive, but few laws require that regulatory agencies be accountable for the impacts of their decisions or consider the systemic implications of their acts.

Quality of care is improved through:

- ◆Equitable distribution of resources;
- ◆Focus on preventive care and incentives for best practices;
- ◆Public participation in policy making;
- ◆Provision of preventive care to everyone;
- ◆Risk-adjusted budgets that pay the true costs of care;
- ◆Integrated statewide health care data bases used to perform comprehensive planning;
- ◆Public access to non-confidential information;
- ◆Linkage of research and innovation to health care needs;
- ◆Use of evidence-based medical practices and pharmaceuticals;
- ◆Return of decision-making to providers and patients; and
- ◆A system of consumer advocates with authority to resolve complaints.

Computerized medical records and decision support software can reduce serious medical errors by as much as 88%[185] and can cut costs by improving the quality of health care.[186]

For example, as a result of implementing computerized prescription drug order entry, Boston's Brigham and Women's Hospital in Boston recorded an 88% reduction in prescription errors (from 20 per thousand to less than 1 per thousand).[187]

According to a study in the Journal of the American Medical Association, use of a computerized prescription order entry system reduced hospital length of stay by 0.89 days per patient and reduced costs by 12.7%.[188]

*Employer-based and Portable:* Health care should be employer-based and stay with a consumer as he or she changes jobs. Such an employer mandate, known as "pay or play," could require employers to either "play" by providing health care or "pay" into a state-run health care purchasing pool. The goal of such a model is to reduce the number of uninsured people while distributing the costs of health coverage more equitably.

With appropriate cost controls, an employer-based health care system with the option to join a CalPERS run purchasing pool could provide many significant benefits, including:

- ◆The potential to significantly increase access to health care because more than 80% of California's uninsured are working families.
- ◆Save California taxpayers millions of dollars because health care will be provided preventively rather than later in an emergency room when the patient's condition is critical and care is much more expensive.
- ◆By insuring more people, the cost of care will come down for all consumers because risk is spread more widely.
- ◆Level the playing field for employers by taking away the competitive advantage of those employers that currently do not offer health benefits to their workers.

Hawaii has had a positive experience with a similar "pay or play" system. When costs became too great in the late 1990's, that state took effective action by providing a government body to review and deny rate increases it deemed unfair and excessive.

> *Integrated with the Workers' Compensation System:* Employers who currently provide health care benefits are in effect paying two premiums for medical care: one for occupational injury and another for non-occupational health. Integration of medical care, rehabilitation, and workplace injury has a proven track record of saving direct costs by consolidating premiums and administration, as well as saving employer losses associated with lost work days and low productivity. Though employers can implement integrated benefits programs on an individual basis, much can be done at the state level to integrate the existing workers' compensation system with SB 2.

Benefits integration focuses delivery of employee disability, absence and health benefits on the worker's health and ability to quickly return to the activities of daily living—including work. Though approaches vary by employer, typical integration strategies include: consolidation of claim management in an integrated claim practice, integration of wage replacement on the non-occupational injury side, and transition to a single vendor for the integrated program.

Benefits of integrated workers' compensation and health care coverage include:[189]

- ◆Analysis of absence, lost productivity and health show that the average benefits and lost productivity value of a lost day are five times the cost of benefits paid.
- ◆Integrated case management and return-to-work programs can lead to savings through reductions in lost work days.

◆Disability durations can be reduced and chronic conditions can be better managed by building a single network of quality, cost-efficient medical providers.

◆Integration initiatives driven by strategic planning rather than an immediate crisis can result in quality-oriented cost reduction strategies.

◆Quality-oriented strategies often involve partnerships with employees who increase their level of self-care, especially for ongoing chronic conditions.

> *Public Decision-Making Process:* In order to achieve equitable distribution of resources and incentives to practice in under-served areas, health care priorities should be determined by the population as a whole. Currently, there is no integration of disparate state decision-making bodies; as a result, changes in the health care market are often brought about by market forces alone that rarely reflect the needs of individuals or the needs of the system as a whole.

The overall goal of comprehensive reform should be to provide universal access, effectively manage costs, and improve quality. The overall objective of successful reform of the current system of health care delivery should be to establish comprehensive standards for the provision of care and stabilize health care financing.

In order to achieve these goals, greater public accountability and input as well as system wide coordination of the health care system are necessary. The key to balanced governance of the system is to ensure that those who have an economic interest in the outcome of policy decisions do not have controlling influence in the decision-making process. Therefore, an elected Health Care Commission, made up of members representing 9 state health care districts, should be provided the legal authority to coordinate all government agencies that regulate the health care market, including: the Office of Statewide Health Planning & Development, the Department of Managed Health Care, the Department of Health Services, the Managed Risk Medical Insurance Board, the Department of Mental Health, and the Department of Childhood Services.

# Section VI.
# Model Universal Health Care Law: Health Care Stabilization and Cost Control Act

The following model law provides a framework for each of the consensus universal health care policy elements discussed in Section V as well as principles to guide in their implementation. The next stage of the California Health Consensus Project will be devoted to further refining and developing this model law through town hall meetings and stakeholder workgroups.

## Health Care Stabilization and Cost Control Act

The overall goal of comprehensive reform should be to increase access, effectively manage costs and improve quality. The overall objective of successful reform of the current system of health care delivery should be to establish comprehensive standards for the provision of care and stabilize health care financing.

In order to achieve the benefits of this goal, existing state agencies should be reorganized into new structures that will improve access to care, stabilize financing and improve quality.

### *Section 1. Findings and Declaration.*

The people of California declare that there exists in this state a long standing, and growing crisis in health care that affects every patient, consumer, employer and health professional. Each individual hardship is unacceptable, and their aggregate societal costs threaten to further undermine California's economy and quality of life.

Enormous cost increases fueled by profiteering and waste have made health care unaffordable and unavailable to millions of Californians. The California legislature has been unwilling to address the health care crisis in a systemic way that protects patient access to care and affordability.

Therefore, the People of California declare that reform is necessary:

- ◆First, health care costs shall be maintained at fair levels by requiring insurers, hospitals and medical groups to abide by rate caps. Savings to government programs will be used to fund additional coverage.
- ◆Second, access to comprehensive health care benefits provided by an employer or through a state purchasing pool will be open to all Californians. This will ensure better health and save taxpayer dollars by focusing on preventive health care.
- ◆Third, financial incentives for quality will be provided in order to ensure an appropriate focus to the market.
- ◆Last, the health care system will be reorganized and made accountable to the public by establishing a Health Care Commission, members of which will be elected every 4 years through a statewide ballot. The Health Care Commission will have the legal

authority to coordinate all government agencies that regulate the health care market, including: Office of Statewide Health Planning & Development, Department of Managed Health Care, Department of Health Services, Department of Mental Health, and Department of Childhood Services.

### *Section 2: Principles of Reform*

Reform of the health care system shall be guided by the following principles:

1. Regulation is appropriate for the health care market. This market, left to its own devices, has not and cannot produce results consistent with the goals of cost containment, access, solvency and equity.

2. Hospitals, facilities, medical groups, community clinics and health plans have the obligation to fulfill their mission in an efficient and effective manner. Society has an obligation to maintain the solvency of efficient and effective providers.

3. Universal access to care will save California taxpayers millions of dollars because health care will be provided preventively rather than later in an Emergency Room when the patient's condition is critical and care is much more expensive. By insuring everyone, the cost of care will come down for all consumers because risk is spread more widely. Public service, including the provision of medical care to the uninsured and underinsured is an essential public duty of the health care system. The financing of uncompensated care is a responsibility to be borne by all payers.

4. A single state agency should be responsible for setting quality standards, collecting data and reporting outcomes. Outcome reports should be fed back into the rate setting process so that providers and plans with the highest outcomes are rewarded.

5. The health care system will be accountable to the public with the creation of an elected Health Care Commission, through rate reviews and public access to data, open meeting laws, legislative oversight, and comparisons of California results with those of other states. Information regarding an individual patient should be kept confidential.

6. The medical dictum, "first, do no harm," should be applied to regulators as well as doctors. Regulators should endeavored to develop the least intrusive system to accomplish social goals.

### *Section 3. California Health Care Cost Review Commission*

A. In order to stabilize health care financing, provider and insurance rates need to be regulated. A rate-establishing agency that reviews and approves rates charged by insurance plans, including the State Plan, will be established. The same agency will establish rates for hospitals and physicians.

B. To help ensure the independence of the Commission, 9 commissioners shall be elected every four years. 1 commissioner shall be elected to represent 1 of the 9 newly designated state health care districts. To qualify as a candidate, prospective commissioners must pledge not to receive campaign contributions from any health care industry source and must have been a resident of the health care district for no less than 5 years. Commissioners may serve no more than two 4-year terms or the remainder of a term in the event of a commission vacancy.

C. The overall aim of rate setting is to assure that providers and plans are sufficiently reimbursed to maintain financial stability and reinvest in improved health care programs, and to assure that net revenues do not exceed reasonable requirements for stability and reinvestment.

D. The Commission will review operating expenses and net revenues of health insurers, hospitals, physicians and medical groups. The Commission will assure that net revenues are adequate to maintain viable plans and providers, that expenses are reasonable and that sufficient revenues are kept within the health care system to pay for care and investment in improved infrastructure.

E. Hospitals, health facilities, medical groups and health plans will be accountable to the public through rate reviews and public access to data. Regulators will be held accountable through open meeting laws, legislative oversight, and comparisons of California results with those of other states.

F. The Commission oversight authority will include both state and private health plans. The Commission will provide separation between the financial motives of the State Plan and the need to keep costs in line in order to assure stability and access. Parameters for medical loss ratios, administrative expenses and net revenue would be established for plans, both private and public.

G. Hospitals, long term care facilities and community clinics will report to the Commission on their costs and projected revenue requirements. The Commission will make judgments about geographic market conditions. The objective is to assure that health facilities are paid sufficiently for their services. A range of adequate net revenues will be established.

H. In order to assure access, physician expenses also need to be within ranges that are affordable. Physicians cannot opt out of providing care to any patient, but payments must be adequate to cover expenses and provide for their livelihood. The Commission will set rate ranges for services.

### *Section 4. California Comprehensive Health Care Plan*

A. Health benefit payment plans will be both private and public. A state plan will be created to provide access to care for all who do not receive, or choose not to utilize, benefit plans provided by employers. Private plans will remain an option for employers and individuals. Competition between the state and private plans will help to stabilize premium costs.

B. The state plan shall be operated by the California Public Employees Retirement System (CalPERS) and bypass insurers, organize hospital and physician networks directly, and buy prescription drugs at bulk discounts. The new state purchasing pool will provide care for all who do not have access to benefit plans provided by employers. Competition between state and private plans will help stabilize premium costs.

C. The state health plan shall include medically necessary health services provided by any licensed, certified or registered health service provider without regard to preexisting conditions. Funding for the state plan will be provided for by employer funding and existing monies in public programs. A federal Medicare waiver shall be sought in order to allow the State Plan to increase its bulk purchasing leverage as well as aggregate and streamline plan administration.

D. State agencies exist that administer significant health insurance plans. Medi-Cal, Healthy Families and Access for Infants and Mothers are the largest programs and support beneficiaries based on income eligibility. All agencies should be reorganized and merged into a single state health insurance plan that offers a standard comprehensive set of benefits for categorical income eligible beneficiaries and for residents wanting or needing to participate in the plan.

### *Section 5. California Health Care Quality Board*

A. The Board will coordinate existing quality control measurements including Office of Statewide Health Planning & Development data, health plan report cards, and physician data compiled by the California Medical Board.

B. The California Health Care Quality Board ("Board") will gather information on quality, monitor quality reporting, and report on standardized quality outcome measurements. Outcome and quality reports should be fed back into the rate setting process so that providers and plans with the best outcomes are rewarded. Quality reports will be disseminated to the public and purchasers.

C. 9 unpaid board members will be appointed to staggered two-year terms, 3 each by the Governor, the President pro Tem of the Senate and Speaker of the Assembly. Each appointing body will choose 1 candidate representing academia, 1 representing care providers (doctors and nurses), and 1 representing consumers. Assembly and Senate appointees shall be approved by a majority vote of the judiciary committees of each respective house and by the full voting body. Governor appointees shall be approved by a majority vote of the Assembly and Senate.

D. The efficacy of clinical services should be understood and the services should be sufficient for the development and maintenance of a healthful life. Scientifically based outcomes research should be promoted to evaluate and advance appropriate care and the result disseminated widely.

E. Public and private health plans are required to offer a minimum benefit package that would assure comprehensive care. Additional benefits could be offered by plans and acquired individually or offered by employers.

F. Hospitals, long term care facilities and community clinics will measure quality outcomes as required by the Board, and report on a regular basis. Outcomes within specified ranges will be required. Safety procedures shall be established, monitored and reported.

G. Physicians will monitor specified quality measures and report outcomes. Outcomes will be reported to the public.

### *Section 6. Implementation*

A. Commissioners shall design and implement plans for the reorganization of all state health agencies, including the Office of Statewide Health Planning & Development, Department of Health Services, Managed Risk Medical Insurance Board, Department of Mental Health, and Department of Childhood Services and enactment of new responsibilities. Commission activities should be predicated on a transparent process based on public hearings and input. A period of 4 years will be allocated for the reorganization of agencies.

B. This Act shall be implemented in a tiered process: first, the Cost Review Commission shall initiate rate reviews for insurers, hospitals, and medical groups. Simultaneously, the CalPERS health system will be opened to all Californians. Next, the Health Care Quality Board will compile quality and outcome data, which will then be fed back into the rate setting process.

C. Based upon the commission's evaluation of performance, modifications can be made to the structure of the agencies. Based upon the Commission's evaluation of performance, modifications can be made to the structure and duties of agencies in order to meet the Principles of Reform as defined in this Act.

## Chart 2: Model Universal Health Care Law: Health Care Stabilization and Cost Control Act

| | Increased Efficiency and Stabilized Costs | Equity in Health Care Financing | Streamlining of Regulatory Oversight & System Coordination | Public Decision Making Process |
|---|---|---|---|---|
| Consumers | •Increases access to care by eliminating waste and excessive profiteering.<br><br>•Protects consumers from skyrocketing premium costs. | •Ensures that all consumers pay for only the care provided to them.<br><br>•Increases access for the uninsured. | •Provides better information with a centralized database of uniform quality indicators.<br><br>•Improves quality of care through performance incentives. | •Gives consumers a voice in the state's health care system. |
| Providers | •Provides adequate compensation for care.<br><br>•Encourages doctors and nurses to remain in California. | •Ensures that providers are paid a fair price for services.<br><br>•Protects medical groups from insolvency. | •Awards health care providers for quality care.<br><br>•Removes bureaucratic red tape by coordinating state oversight. | •Gives doctors and nurses a voice in the state's health care system. |
| Employers | •Controls premium costs.<br><br>•Allows all employers to provide health benefits.<br><br>•Reduces HR burden. | •Protects small employers from insurer cost shifting.<br><br>•Provides incentives to employers who offer health benefits. | •Provides efficient oversight of employer-based health care.<br><br>•Keeps employees healthy by encouraging quality care. | •Gives employers a voice in the state's health care system. |
| Hospitals, Emergency Rooms & Community Clinics | •Keeps health facilities open by reimbursing uncompensated care.<br><br>•Provides budget stability through prospective rates. | •Ensures that all facilities share costs of the uninsured.<br><br>•Protects health facilities from insolvency. | •Removes bureaucratic red tape by coordinating state oversight.<br><br>•Compensates health facilities for quality care. | •Gives hospitals, ERs, and community clinics a voice in the state's health care system. |

# Section VII.
# Model Cost Control Laws

Three immediate cost control strategies are necessary to address the immediate affordability crisis: 1) prescription drug bulk purchasing; 2) hospital market stabilization; 3) health insurance premium oversight.

## 1. Prescription Drug Bulk Purchasing Expansion

California Assembly Member Dario Frommer (D-Los Angeles) and Senate Pro Tem John Burton (D- San Francisco) have authored legislation addressing prescription drug reimportation and bulk purchasing. The Burton proposal, SB 1144, directs the State of California to bulk purchase prescription drugs from Canada for use in state-run programs and institutions. Frommer has introduced draft legislation, AB 1958, to expand the existing CalPERS prescription drug purchasing program and a separate proposal, AB 1957, to provide a state website with information about Canadian-based pharmacies currently reimporting affordable prescription drugs to the United States. Concurrently, U.S. Senator Ted Kennedy (D- Mass.) announced plans to introduce legislation modeled after California's new law, SB 2. Kennedy's approach incorporates some of the California Health Consensus Project's key cost-saving recommendations; namely, prescription drug bulk purchasing, drug reimportation, and limitations on direct-to-consumer marketing.

Under the bulk purchasing model, the state of California could dramatically increase its bargaining power with manufacturers by combining current drug purchases for Medicaid recipients, state employees, patients of state hospitals and health departments, state university students, and prisoners. Bulk purchasing programs can also include private entities. In fact, the proposal by Burton builds upon a 2001 law (SB 1315) that directed the state purchasing agency (Department of General Services) to investigate the feasibility of including individuals, employer groups, and other private purchasers.

In California, the state Department of General Services purchases $176 million worth of drugs for 4 state agencies, including the Department of Corrections and the California Youth Authority. The California Health and Human Services Agency is projecting that it will spend $4 billion in 2004 for prescription drugs for the Medi-Cal program.

CalPERS purchases drugs for state employees enrolled in the PPO plan (Preferred Provider Organization) directly from a pharmaceutical benefits manager (PBM), CareMark. The PPO drug purchasing pool includes 300,000 state employees. An additional 900,000 state employees are currently enrolled in HMO plans which include prescription drug coverage. CalPERS is considering ending prescription purchases in the HMO plans and instead including state HMO enrollees in the PPO drug purchasing pool. Such a plan could significantly increase CalPERS' purchasing power, thus providing even deeper discounts on prescription drugs.

To maximize bulk purchasing savings, CalPERS should allow patients and businesses to join the PPO drug purchasing pool. By doing so, CalPERS would achieve deeper savings on drugs it purchases for state workers and individual patients and businesses would benefit from the negotiated bulk discounts.

### *Enrollment*

◆Currently CalPERS pays CareMark a per member/per month fee based on the number of enrollees in the PPO plan.

◆New non-state worker enrollees will pay CalPERS a yearly fee reflecting CareMark's administrative costs of providing drugs for those new enrollees.

◆CalPERS will provide open enrollment periods for new non-state enrollees to join the purchasing pool every 6 months.

◆Enrollment forms will be made available on the web and at participating pharmacies.

### *Pharmacy Card & Network*

◆New enrollees will be issued a pharmacy card that may be used at participating pharmacies, in addition to those already included in the CareMark pharmacy network.

### *Drug Cost*

◆New non-state employee enrollees shall pay the discounted drug rate at the point of sale; either in a participating pharmacy or when purchasing drugs through the mail order option.

◆Drugs purchased at participating pharmacies shall be priced at the negotiated rate plus a pharmacy dispensing fee.

### *Mail Order Option*

◆New non-state employee enrollees shall have access to the mail order option currently provided by CareMark, which provides for even deeper savings on drug purchases.

Prescription drug bulk purchasing has been used to effectively control prescription drug expenditures by large U.S. purchasers and Canada to bring down the price of drugs[190]:

◆The U.S. Department of Veterans Affairs (DVA) and other federal agencies purchase drugs through a bulk discount established by the Federal Supply Schedule. The DVA saves 52% off of the list price of a drug (average wholesale price–"AWP"). Therefore a drug with an AWP of $50 would be available for $24.

◆The Canadian government negotiates bulk purchasing agreements with U.S-based pharmaceutical companies and pays about 60% of AWP—40% less than the average Californian.

◆Health insurers also use their membership clout to negotiate bulk discounts on drugs to save 33% off AWP. Therefore a drug with an AWP of $50 would cost an HMO $34.

◆In comparison, a cash customer in the U.S. will pay 4% above AWP: a drug with an AWP of $50 would cost $52.

## 2. Hospital Market Stabilization

Tenet Healthcare Corporation's recent announcement that it intends to sell 19 California hospitals, the majority of which are located within Los Angeles County, brings to the fore several key failures of the California hospital market:

- ◆The state has no authority to require that hospitals have an exit strategy to replace hospital and emergency room capacity when they decide to sell or close.
- ◆The current market incentivizes hospitals to close their emergency rooms in order to avoid treating uninsured or underinsured populations. As a result, emergency room patient diversions and long waits are on the increase.
- ◆Disparities in hospital rates – reflective of a hospital's market clout and regional monopolies – mean that some hospitals reap tremendous financial rewards while others struggle to keep their doors open.
- ◆No entity has the authority or tools to do the comprehensive long-term planning necessary to meet the emergency and acute care needs of our growing communities.

New legislation should address the immediate crisis created by the Tenet Healthcare Corporation's sell-off of Los Angeles hospitals by:

- ◆Authorizing the Los Angeles County Emergency Medical Systems Agency ("EMS") to require all general and acute care hospitals that do not provide emergency and trauma care to pay into the Trauma Fund ("Fund"). EMS may disperse these monies to emergency rooms under threat of closure and those with excessive levels of uncompensated care.

New legislation should provide for the long-term stability of the Los Angeles hospital system and protect against future hospital pullouts by:

- ◆Creating the Los Angeles Hospital District and oversight committee within EMS with the authority to provide the long-term planning necessary to meet the emergency, trauma and acute care needs of our communities.
- ◆Requiring as a condition of licensure that hospitals keep their emergency and trauma rooms open for a specified period from the time of purchase.
- ◆Providing for long-term stability by authorizing EMS to complete an actuarial study of the actual cost of providing hospital services, which shall include adequate revenue for profit, technological upgrades, and seismic and facility expansions. This analysis shall be used as a benchmark to determine disbursement of Trauma Fund monies. This study shall be made available to EMS and the chairs of the state Assembly and Senate Health Committees.
- ◆Requiring those developing new housing units to provide notice to EMS and provide a fee based on hospital capacity expansion needs.
- ◆Developing a Hospital Enterprise Zone to provide appropriate incentives for facility expansions where necessary.

### *General*

There is hereby created the Los Angeles Hospital District ("District") which includes all hospitals within the borders of the County of Los Angeles under the authority of the Los Angeles County Emergency Medical Systems Agency ("EMS"). EMS shall have authority to oversee the District as authorized herein.

### *Trauma Fund*

- ◆Hospitals that do not provide emergency and trauma care must pay a fee (based on the number of patients served annually) into the Trauma Fund ("Fund") to be dispersed by EMS to offset uncompensated care in ERs and trauma centers within the Los Angeles Hospital District.

### *Stability*

- ◆The Attorney General shall require as a condition of licensure that hospitals keep their emergency rooms and trauma centers open for a specified period from the date of purchase. The Attorney General shall establish an appropriate time period in conjunction with the authorizing party, the Los Angeles County Emergency Medical Systems Agency ("EMS").
- ◆Empower EMS to complete an actuarial analysis of the true cost of hospital services within the newly designated Los Angeles Hospital District, which shall include reasonable rate of return (profit) and facility upgrade needs. This analysis shall be used as a benchmark to determine disbursement of Trauma Fund monies. This analysis will be made available to the Chairs of the Senate and Assembly health committees.
- ◆The actuarial study shall be paid for with funds collected by the Trauma Fund. EMS is authorized to solicit and accept private funds to cover the costs of the study. No funds may be accepted from those entities over which EMS has oversight authority.

### *Local Control & Long-term Planning*

The Los Angeles County Emergency Medical Systems Agency ("EMS") serves as the lead agency for the emergency medical services system in the County and is responsible for coordinating all system participants in its jurisdiction, encompassing both public and private sectors.

EMS is responsible for planning, implementing, monitoring and evaluating the local EMS system. This includes establishing policies, addressing the financial aspects of system operation, and making provisions for collection, analysis, and dissemination of EMS related data. In addition, the EMS Agency is responsible for establishing operational policies and procedures; designating EMS base hospitals and specialty care centers, such as trauma centers; developing guidelines, standards and protocols for prehospital patient treatment and transfer to county operated hospitals and specialty hospitals.

This Act creates a special committee within Los Angeles EMS with the authority over all hospitals with in the Los Angeles Hospital District to:

- ◆Create systemwide and institution specific plans that take into account: population growth, new capacity needs, technological upgrades, geographic discrepancies in care, and seismic and facility upgrades.
- ◆The EMS committee shall include, in addition to EMS staff, 5 unpaid members serving 2-year terms representing consumers, business owners, and hospitals. 2 members shall be appointed by a majority vote of the Los Angeles County Board of Supervisors and 2 members by the Governor of the State of California. One member shall be chosen from the Los Angeles EMS Commission.

### *Expansion*

- ◆In addition to providing funding for general infrastructure upgrades (water, sewage, etc), new residential developers shall provide notice to EMS of new residential projects of more than 20 units at the same time they apply for permits with the county planning commission.
- ◆EMS shall notify contractors of hospital infrastructures needs and determine an appropriate fee on a per unit basis.

### *Hospital Enterprise Zones*

EMS, in coordination with appropriate local, state and federal agencies, shall provide incentives for hospitals to build or maintain infrastructure.

Currently, the California Health Facilities Financing Authority (CHFFA) within the state Treasurer's office provides financial assistance to public and non-profit health care providers through loans funded by the issuance of tax-exempt revenue bonds. CHFFA financing may be used for the construction and renovation of new or existing health care facilities, the purchase of equipment or the refinancing or refunding of prior debt.

Among other initiatives, EMS shall work with the state Treasurer's office to make changes to the CHFFA to provide for streamlined approval of bonds. In order to qualify, a recipient hospital must commit to provide all requested information and abide by each of the provisions of this Act. Bonds granted under this Act must be used to meet facility expansion needs approved by EMS to meet emergency, trauma, and acute care needs.

## 3. Regulation of Health Insurance Rates

At present, consumers and small employers are being forced to choose between paying higher premiums, co-pays and deductibles, or reducing coverage. Some health insurance premiums in California are increasing 20-30% and more annually.

Skyrocketing health care premiums have resulted in a record number of uninsured Californians, 80% of whom are working, and an unprecedented increase in middle class uninsured rates. The numbers and percentages of uninsured Californians have been steadily

growing for the past 25 years and are projected to continue to grow for the next decade absent action to control costs.

Health insurers claim that skyrocketing premiums are the result of increasing medical costs. However, in 2002, the cost of health insurance for a family of four increased 250% more than the rate of medical inflation. Meanwhile, inefficient health insurers spend up to 25 cents out of every premium dollar they collect on administrative costs, salaries, and advertising and are recording record profits. In 2003, health insurance administrative costs were the fastest growing component of health care spending (see page 48 ff.).

What is required is a neutral party with the power to investigate and verify insurers' claims and the power to correct any abuses, if and when they are found. Similar standards exist in California for home and auto insurance and 26 other states require some type of approval process for health insurance rates.

The following model legislation requires that before a health insurer increases premiums, co-pays or deductibles, approval must first be obtained from the Department of Managed Health Care or the Department of Insurance. Proposed rate increases may be denied if they are deemed excessive or unfair.

The landmark auto insurance reform initiative, Proposition 103, established such a 'prior approval' system. During the decade after Proposition 103 was adopted, auto insurance rates in California went down by 4.0% while insurance products remained broadly available and competitive, and the uninsured motorist population declined by 38%. Nationally, rates rose over 25% during this period. California consumers saved over $23 billion since 1988 under the prior approval system.

In addition, the model legislation:

- ◆Requires health plans to provide detailed financial information to the regulator with each premium increase request.
- ◆Establishes a clear legislative directive that no premium, co-payment or deductible shall be approved or remain in effect which is deemed to be "unfair or excessive."
- ◆Allows consumers and consumer groups to intervene in rate review proceedings to ensure that the legislative intent is implemented.

## Health Insurance Premium Regulation Model Law:

SECTION 1. The heading of Article 1.5 (commencing with Section 510) of Chapter 1 of Division 2 of the Business and Professions Code is amended to read:

The Legislature finds and declares the following:

(a) Managed care strategies in the private marketplace have failed to control the amount of the premiums charged for private health care coverage. As a result, premiums for private health care coverage are soaring.

(b) Small employers and individual consumers who have little bargaining power bear the burden of those premium increases. California employers with 50 or fewer employees experienced a premium increase of approximately 20% in 2002, 19.99% in 2001, and 17.12% in 2000. Experts predict that this trend will continue indefinitely. According to the State Trade and Commerce Agency, small businesses comprise nearly 98%, or 2.5 million, of all businesses in this state, employ more than 50%, or 7.5 million, of California's workforce, and generate more than one-half of the state's gross domestic product.

(c) During this same period of soaring private health care coverage premiums, California private health care service plans have enjoyed record profits. This demonstrates that these soaring premiums are disproportionate to, and not required to pay, the increasing hospital, pharmaceutical, or health care provider costs.

(d) During this same period of soaring private health care coverage premiums, private health care service plans have also amassed unprecedented surpluses, far beyond surpluses traditionally required to support the benefits they provide. This, as well, demonstrates that these soaring premiums are disproportionate to, and not required to pay, the increasing hospital, pharmaceutical, or health care provider costs.

(e) Employers that have chosen to value their employees and their families by providing them health care benefits are increasingly burdened by the skyrocketing cost of private health care coverage premiums. These employers may already be at a competitive disadvantage to companies that do not provide health care benefits to their employees.

(f) Skyrocketing health care coverage premiums, copayments, coinsurance, and deductibles forced many employers to drop coverage altogether, reduce benefits, or purchase plans with high deductibles, copayments, or coinsurance obligations.

(g) When employers drop or reduce coverage or pass on large costs to employees, the number of uninsured and underinsured Californians who must seek care at the state's expense increases.

(h) The great majority of the 6.5 million Californians without health care coverage are members of working families who are without this coverage largely due to the fact that private health care coverage premiums are too expensive. This trend will only increase as private health care coverage premiums continue to skyrocket indefinitely during a period of slow economic growth.

(i) For California businesses to remain competitive and to safeguard California's fiscal solvency, the cost of private health care coverage premiums must be brought under control.

(j) Prior to 1988, the marketplace for automobile insurance was in a similar state. For the last 15 years, since the adoption of Proposition 103, automobile insurance companies in California have been required to justify proposed premium increases and seek approval from a state agency before imposing those rates.

(k) During the decade following institution of the approval process for premium increases, the average automobile insurance premium per policyholder decreased four percent while those insurance products remain broadly available and competitive, and the uninsured motorist population declined 38%. Nationally, rates increased 25% during the same time period. California has experienced the lowest rate change of any state in the nation since the adoption of Proposition 103.

SEC. 4.

SEC. 2. Article 6.5 (commencing with Section 1385.1) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 6.5. Approval of Rates

1385.1. (a) The following definitions apply for the purposes of this article:

(1) "Applicant" means a health care service plan seeking to increase the rate it charges its subscribers.

(2) "Rate" includes, but is not limited to, premiums, copayments, coinsurance obligations, deductibles, charges, and the cost of coverage per exposure base unit.

(b) Definitions for the terms used in subdivision (a) of Section 1385.4 may include, but shall not be limited to, whether approving the application will result in a rate that is in accordance with generally accepted actuarial principles.

1385.2. (a) No applicant shall increase the rate it charges a subscriber unless it submits an application to the department, and the application is approved by the department.

(b) Every application submitted to the department pursuant to this section shall be signed by the officers of the applicant who exercise the functions of a chief executive and chief financial officer. Each officer shall certify under penalty of perjury that the representations, data, and information provided to the department to support the application are true.

(c) Every application submitted to the department pursuant to this section shall include, in summary form, the following information:

(1) The rate of return that will result if the application is approved.

(2) The average premium increase per affected subscriber that will result from approval of the application.

(3) The medical loss ratio reserves and surpluses that will result if the application is approved.

(4) A summary of all of the applicant's nonmedical expenses for the most recent fiscal year.

(d) All materials submitted to support an application shall be a public record. The summaries required by the applicant shall be posted on the department's Internet Web site within 10 days of the date of their receipt by the department.

1385.3. A rate increase imposed by a health care service plan between April 1, 2000, and January 1, 2004, shall be a rate application for purposes of this article. If it fails to comply with the requirements of subdivision (a) of Section 1385.4, the department shall order a refund in an amount required to ensure compliance with those requirements, together with interest at the prevailing rate from the date the rate increase was imposed.

1385.4. (a) No application, pursuant to Section 1385.2 or 1385.3, shall be approved if its rate is excessive, inadequate, or unfairly discriminatory or if the plan's benefits are unreasonable in comparison to the rate, or the application otherwise violates this article.

(b) The applicant has the burden to provide the department with evidence and documents establishing the application's compliance with the requirements of subdivision (a).

1385.5. The department shall conduct its review of an application pursuant to subdivision (a) of Section 1385.4 in accordance with regulations determining reasonable rates of return, reserves, surplus, and nonmedical expense amounts.

1385.6. (a) If the department disapproves the application submitted under Section 1385.2 or orders a refund pursuant to Section 1385.3, the applicant may petition for a hearing pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(b) The applicant has the burden at the hearing of proving by a preponderance of the evidence that the application or the rate charged by the health care service plan between April 1, 2000, and
January 1, 2004, meets the requirements of subdivision (a) of Section 1385.4 or the failure to approve the application or requiring the payment of a refund pursuant to Section 1385.3

will result in an unconstitutional confiscation. If the applicant prevails in this proof, the department shall order the minimum nonconfiscatory rate or refund.

(c) At least 30 days before the date of a hearing held under this section, the department shall notify the public of the hearing and the procedures for intervening in the hearing pursuant to Section 1385.8 by posting this information on its Internet Web site.

(d) Nothing in this section limits the discretion or authority of the department to provide interim or temporary relief from a potentially confiscatory rate or from a confiscatory rate.

1385.7. A consumer or an intervenor participating pursuant to Section 1385.8 may request that the director hold a hearing to determine whether an existing rate charged by a health care service plan satisfies the requirements of subdivision (a) of Section 1385.4.

If the request is denied, the director shall provide a written explanation of his or her reasons for the denial.

1385.8. A consumer or a group representing the interests of consumers may petition to intervene in a proceeding under this article and to obtain compensation pursuant to the provisions of Section 1348.9 and the regulations adopted to implement that section.

1385.9. A violation of this article is subject to the penalties set forth in Section 1859.1 of the Insurance Code. The director may also suspend or revoke the license of a health care service plan for a violation of this article.

1385.10. (a) The department may charge health care service plans a fee for the actual, reasonable costs of implementing this article.

(b) The fees shall be deposited into the Health Care Service Plan Rate Approval Fund which is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, all moneys in this fund are continuously appropriated to the department for the sole purpose of implementing this article.

1385.11. The department has all necessary and proper powers to implement this article including, but not limited to, the authority to adopt regulations. The department shall adopt regulations to implement this article not later than July 1, 2004.

SEC. 5.

SEC. 3. Article 4.5 (commencing with Section 10181) is added to Chapter 1 of Part 2 of Division 2 of the Insurance Code, to read:

Article 4.5. Approval of Rates

10181. (a) The following definitions apply for the purposes of this article:

(1) "Applicant" means a health insurer seeking to increase the rate it charges its policyholders.

(2) "Rate" includes, but is not limited to, premiums, copayments, coinsurance obligations, deductibles, charges, and the cost of insurance per exposure base unit.

(b) Definitions for the terms used in subdivision (a) of Section 10181.3 may include, but shall not be limited to, whether approving the application will result in a rate that is in accordance with generally accepted actuarial principles.

10181.1. (a) No applicant shall increase the rate it charges a policyholder unless it submits an application to the department, and the application is approved by the department.

(b) Every application submitted to the department pursuant to this section shall be signed by the officers of the applicant who exercise the functions of a chief executive and chief financial officer. Each officer shall certify under penalty of perjury that the representations, data, and information provided to the department to support the application are true.

(c) Every application submitted to the department pursuant to this section shall include,

in summary form, the following information:

(1) The rate of return that will result if the application is approved.

(2) The average premium increase per affected insured that will result from approval of the application.

(3) The medical loss ratio reserves and surpluses that will result if the application is approved.

(4) A summary of all of the applicant's nonmedical expenses for the most recent fiscal year.

(d) All materials submitted to support an application shall be a public record. The summaries required by the applicant shall be posted on the department's Internet Web site within 10 days of the date of their receipt by the department.

10181.2. A rate increase imposed by a health insurer between April 1, 2000, and January 1, 2004, shall be a rate application for purposes of this article. If it fails to comply with the requirements of subdivision (a) of Section 10181.3, the department shall order a refund in an amount required to ensure compliance with those requirements, together with interest at the prevailing rate from the date the rate increase was imposed.

10181.3. (a) No application, pursuant to Section 10181.1 or 10181.2, shall be approved if its rate is excessive, inadequate, or unfairly discriminatory or if the insurer's benefits are unreasonable in comparison to the rate, or the application otherwise violates this article.

(b) The applicant has the burden to provide the department with evidence and documents establishing the application's compliance with the requirements of subdivision (a).

10181.4. The department shall conduct its review of an application pursuant to subdivision (a) of Section 10181.3 in accordance with regulations determining reasonable rates of return, reserves, surpluses, and nonmedical expense amounts.

10181.5. (a) If the department disapproves the application submitted under Section 10181.1 or orders a refund pursuant to Section 10181.2, the applicant may petition for a hearing pursuant t Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(b) The applicant has the burden at the hearing of proving by a preponderance of the evidence that the application or the rate charged by the health insurer between April 1, 2000, and January 1, 2004, meets the requirements of subdivision (a) of Section 10181.3 or the failure to approve the application or requiring the payment of a refund pursuant to Section 10181.2 will result in an unconstitutional confiscation. If the applicant prevails in this proof, the department shall order the minimum nonconfiscatory rate or refund.

(c) At least 30 days before the date of a hearing held under this section, the department shall notify the public of the hearing and the procedures for intervening in the hearing pursuant to Section 10181.7 by posting this information on its Internet Web site.

(d) Nothing in this section limits the discretion or authority of the department to provide interim or temporary relief from a potentially confiscatory rate or from a confiscatory rate.

10181.6. A consumer or an intervenor participating pursuant to Section 10181.7 may request that the commissioner hold a hearing to determine whether an existing rate charged by a health insurer satisfies the requirements of subdivision (a) of Section 10181.3. If the request is denied, the commissioner shall provide a written explanation of his or her reasons for the denial.

10181.7. A consumer or a group representing the interests of consumers may petition to intervene in a proceeding under this article and to obtain compensation.

10181.8. A violation of this article is subject to the penalties set forth in Section 1859.1. The commissioner may also suspend or revoke in whole or in part the certificate of

authority of a health insurer for a violation of this article.

10181.9. (a) The department may charge health insurers a fee for the actual, reasonable costs of implementing this article.

(b) The fees shall be deposited into the Health Insurer Rate Approval Fund which is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, all moneys in this fund are continuously appropriated to the department for the sole purpose of implementing this article.

10181.10. The department has all necessary and proper powers to implement this article including, but not limited to, the authority to adopt regulations. The department shall adopt regulations to implement this article no later than July 1, 2004.

SEC. 4. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

# Appendix I: Consumer Profiles

## Murray Axelrod, retired, Los Angeles, California

There are many ways for health insurers to sock it to health care consumers these days. They knocked Murray Axelrod around because of his address. Because of where he hangs his hat—or hung it—Murray's health care costs have shot into the stratosphere.

Murray, 64, is a retired grocery clerk. His union, Local 770 of the Retail Clerks, took care of his coverage originally, and he had no complaints. His provider since he was 20 years old has been Kaiser. He has been a conversion plan member for 34 years.

Over the past few years he noticed his premiums increasing, generally $20 to $30 in each go-round. By December of 2002 he was paying $237.

On Christmas Eve, Kaiser dumped a large lump of coal in Murray's stocking: They told him that he would be paying $421 a month, beginning in January.

Murray was flabbergasted. He contacted Kaiser and asked them why they were treating a man who had been with them for nearly half a century so badly. They told him it was because he had a zip code in western Ventura County, which Kaiser had declared an "expansion zone." People in expansion zones were going to pay more, Kaiser had decreed.

Murray explained that he lived in Moorpark, which is in eastern Ventura County. So Kaiser made an adjustment: no, not in Murray's premium; in everyone else's. The health care provider declared all of Ventura County an expansion area and everyone's rates shot up.

Well, Murray thought, I could go to another insurer. But Murray had a heart attack 10 years ago, which means he has a pre-existing condition. Most plans would either reject him or make him pay exorbitant prices.

Murray did the math. His premiums, which were $2,844 annually in 2002, were about to go to $5,052—an increase of $2,208.

There was another way out, and he took it: He moved to Los Angeles County. He had been using the Woodland Hills Kaiser facility anyway, so it made sense, at least in terms of affording health coverage. His rates still jumped by $984 a year, which was not good but was better than the $2,208 he was facing in Ventura County.

But this begs the question: should a man have to move in order to receive the health care he needs?

*Murray, 64, is a retired grocery clerk. On Christmas Eve, Kaiser dumped a large lump of coal in Murray's stocking: They told him that he would be paying $421 a month, beginning in January.*

Murray believes the answer is no.

"It's bull....!" Murray fumes. "It's corporate greed. They've become more of a business and less patient-oriented."

The increased costs and the uncertainty create especially heavy anxiety for people in his age bracket, Murray notes. "It's created a nightmare. I'm on a fixed income, and along with large losses in my retirement IRA I am deeply worried about my future." He says people in his situation seemingly are being forced to choose between moving from Ventura County and giving up their health coverage.

"How can Kaiser get away with such practices?" Murray asks. He would like to see health care providers come under regulation, to prevent this kind of callous and greedy behavior. Beyond that he would "like to see them start having a humanitarian aspect" in their treatment of their patients, and in particular take a look at the longevity of patients with the company before throwing them to the wolves.

## Brad Brown, self-employed, Healdsburg, California

Brad Brown still is scraping together enough money to buy health insurance for his wife and two children. But it is getting more difficult with every increase, and the relentless rise in costs—the most recent was 45%—is depleting not only his bank account but also his faith in the system.

"You have to stay positive, but we are both cynical as hell,' Brad says of himself and his wife. "Blue Cross's attitude is, pay it or don't; they'd love to have you fall off."

Brad has reason to be cynical. A 49-year-old licensing agent, he is self-insured. He signed on with Blue Cross, a PPO account for himself, his wife and his two grade-school-aged children.

He has watched his rates climb steadily. Two months ago, the deductible shot from $2,000 per person, per year to $2,500 per person. As the deductible increased, the coverage lessened, with Blue Cross paying a smaller percentage of the costs.

In addition, the premium went from $356 bi-monthly for all four to $498—a 45% jump that tacks on $852 to the yearly bill.

*Health insurance needs be regulated, Brad says. "You can't trust private industry to regulate itself. You can't give Enron the keys to the building and say, 'don't steal anything.'"*

It would be an understatement to say that Brad was angry at his family's shoddy and arbitrary treatment. But with an active family, he felt he had to maintain coverage in case of catastrophe. "I have two young boys who like to throw themselves off things," he jokes. "I can afford to pay $2,500; I can't afford to pay $25,000" for a major injury or illness.

Brad may have to hold on to coverage, but he doesn't have to like it, and he wants to see changes made. He sees the health care industry ripping off consumers in numerous ways.

For one thing, the cost increases have nothing to do with his family's actual use of health care. "We have not had any major surgeries or large claims." To Brad—and many others—it looks as though they are paying for services not rendered. If for some reason you leave or change to another outfit, that represents pure profit. "If you're out of there and never had a major claim, they've taken your money—a significant amount of money."

The amount of the increases as well as their frequency also need to be checked, he says. "You just get clobbered," he says. And nobody stops these insurers. "Why do they do this? Because they can," he says.

"It needs to be regulated," Brad says. "You can't trust private industry to regulate itself. You can't give Enron the keys to the building and say, 'don't steal anything.'"

Brad would like to see the government conduct a cost analysis that would regulate

coverage as well as the cost of premiums and other medical expenses, such as deductible. "They're trying to get everything they can," he says, and "until the government steps in" they will continue to do so.

"We paid our dues for the American dream," Brad says, "and we're getting hosed. What the hell happened?"

## Jo Christie, self-employed, Cupertino, California

Jo Christie has been with Kaiser for 35 years, but longevity, she has discovered, does not breed loyalty from the Kaiser executives who have been taking her money for decades. They have inched her rates up over the past several years until this year she has finally decided she may not be able to afford it anymore. Her premiums shot up to $490 a month, and after all these years she is looking for some other way to take care of her health care needs.

That, she believes, is exactly the outcome Kaiser and other insurers are looking for among their aging patients.

Jo, 58, is a San Francisco native who lives in Cupertino and is self-employed. Her husband, whom she divorced six years ago, had their family covered through Kaiser as a Lockheed employee. They raised three children in Woodside. The Lockheed coverage ended six years ago, and Jo went on COBRA for three years. Then began the upward spiral.

Now, she says, "I don't know what I'm going to do. I cannot obtain affordable coverage from Kaiser, and I have not found other coverage. I am ready to drop health insurance and take my chances on staying healthy, but I know that is quite risky."

Her travails are aggravated by the fact that she has a pre-existing condition, which, along with age, makes insurers leery of taking on a patient. She has the condition under control. She has not seen a health care provider for 20 months, nor has she taken any medication for a condition Kaiser labels "incurable. I have totally changed my lifestyle. That means nothing to them."

Jo is bothered by more than the disloyalty and cost. She feels she is not getting her money's worth in this buyer-seller relationship. While costs have gone up, service has declined. One example: Kaiser tries to dissuade patients from using the services they've paid for.

"I have to convince them I need to come in," Jo says. "Their attitude is, 'it's too bad you're dying, it's too bad you're sick."

"For this I pay $5,000? I'm paying more money for less service."

*"I have to convince them I need to come in," Jo says. "Their attitude is, 'it's too bad you're dying, it's too bad you're sick."*

*"For this I pay $5,000? I'm paying more money for less service."*

Jo has thoughts about health care reform. First, she says, there should be some way for the self-employed to get a group rate. The safety net is yanked away when you leave the safety of a large employer.

Kaiser and others also have to control costs. "That's a big thing that has to happen." The health care industry is spending far too much on advertising, to cite just one excess, she says, especially on prescription drug advertising.

Drugs are playing too much of a part in health care, she adds. "There's way too much emphasis on medication. It's an easy out now," with doctors prescribing them excessively to both children and adults.

Jo adds that the health care system should place more emphasis on preventive medicine.

Should the government get involved? Jo is wary about that. She doesn't trust the government to be more efficient. She would, however, like to see a government panel regulate premium and other costs. Insurers should not be able to arbitrarily raise rates outrageously, dismissing the act with a glib "our costs have gone up," she says. They need to prove it.

As the population ages, Jo points out, the situation is going to grow more acute. And it is not only patients who will suffer. "The country can't really afford it."

## Sharon Fowler, small business owner, San Diego, California

Compared to some other Kaiser subscribers, the premium increase facing Sharon Fowler Jan. 1 is modest—"only" 10%, from $515 to $565 for Sharon and her husband, Barry, who both are self-employed in San Diego. Many Kaiser patients have seen fees jump by 40, 50, even, in some cases, 70%. But the fact that her boost barely made it to double digits does not make Sharon feel a whole lot better.

For one thing, the price increases in corollary costs—hospital stays, pharmaceuticals, cat scans and other medical expenses—are also odious. Furthermore, Sharon continues to see proof of Kaiser's fiscal sloppiness and mismanagement, especially in collecting payments from medical providers; mistakes that cost Kaiser hundreds of dollars in her case alone.

Sharon feels the entire system needs fixing and says Kaiser and other insurers are not going to improve matters all by their lonesome. That state must help by regulating costs and other aspects of health care delivery, she says.

Sharon and Barry joined Kaiser in 1997, just before she turned 50. Her husband is five years older. They were in a PPO and "dearly loved our old doctor." But he advised them to change, because "as you get older, it (the cost increase) is going to eat you up."

*Fear of the future, she says, "is always there. I'll think, if I'm OK till I'm 65" and can get Medicare, she might muddle through. "It's going to be tough. We're freaking a little.*

*"We have a cost problem, " she says "and I don't think (the insurers) will fix it themselves. There ought to be a board to monitor all of this..."*

Sharon saw that first hand almost as soon as she signed on to Kaiser. When her birthday rolled around, "it went up a lot; 50 is the magic age."

Still, she and Barry have stuck with Kaiser. Now that they are 56 and 61, they feel they might be locked in because both have pre-existing conditions. "I'm not sure I can change. I have degenerative disc disease," as well as migraines and problems related to menopause. She notes that most people as they grow older develop pre-existing conditions. "Everybody is going to get arthritis. Everybody goes through menopause" with its attendant ailments.

When she got the Kaiser notice this month, Sharon was taken aback less by the premium than by the rest of the charges. "We were expecting the increase, but not the cut in benefits." There is a new $200 a day hospital fee, up from zero last year. There is a $250 deductible on brand name drugs, also a new charge. Cat scans and MRIs, which had been free, are $50. The out-of-pocket maximum is $500 per family, up from $300. Mental health, ambulance, co-pay all have gone up.

The timing could hardly have been worse for Sharon. Her small business is about to shut down temporarily because of the southern California grocers' strike. She provides

glass vases to floral departments at Ralphs supermarket, and she is about to close for a couple of weeks, putting herself and her two employees out of work at the holiday season.

All these health care cost increases have made her apprehensive. Fear of the future, she says, "is always there. I'll think, if I'm OK till I'm 65" and can get Medicare, she might muddle through. "It's going to be tough. We're freaking a little."

Sharon's concerns do not revolve only around her own costs, however. She has seen Kaiser spending money foolishly. She cites shots she received three times, the year before last, of Imitrex, which helps alleviate pain from migraines. In June 2002 she had a shot in Ventura; it cost $95. Six months later, at Thanksgiving, she was at Lake Havasu City in Arizona and needed the shot again; the medical center gave it, and billed Kaiser $1,600. On New Year's Eve, the same Havasu clinic charged $600 for the same shot.

Kaiser balked at the $95 charge, although it ultimately paid. But it forked over the $1,600 and $600 to the Arizona clinic with hardly a blink. When Sharon complained, Kaiser led her on the bureaucratic shuffle, from one department to the next. She never has received a satisfactory answer about why Kaiser is wasting money this way.

"Kaiser is inefficient, and is paying out of town bills without even checking" with patients, Sharon complains. She wants reform in the system, and she has several ideas about where it should take place.

"We have a cost problem, " she says "and I don't think (the insurers) will fix it themselves. There ought to be a board to monitor all of this," beginning with the increases in costs and the accelerated take-always. Those all need to be justified, she says.

In addition, there's fraud. "People should look at their bills," Sharon warns. Barry does that, and has found Kaiser being charged for treatment he did not receive. "Bills should not be paid until they are reviewed by the patients."

Sharon also says the state should stop providing medical treatment to undocumented immigrants, which is costing billions, in her view.

The whole system is broken, she says. Like many people who are hurting financially and emotionally by health care cost increases and other abuses, Sharon is dismayed that the government and the country at large seem absorbed with other things. "The focus in America is skewed," she says. "It should be on education and on health care. We should all be horrified about the health care situation, the prescription situation."

## Michael Fry, retired, Poway, California

Like many health care subscribers who have been with one provider for many years, electronics engineer Michael Fry thought he had some minimal security from his health plan. He doesn't think that anymore, after receiving a notice from Kaiser that pushes his monthly premium up by 73%, to $961, beginning Jan. 1.

The increase is $406 and means he and his wife will have to pay $11,532 next year. There is also a new $200 daily hospital co-pay, and a regular office co-pay increase to $25.

Fry, who has spent hours on the Internet researching health care since his notice arrived, says he and his wife can weather the storm—in the short term. "We could ride through a year of this," he said. But after that they would be in trouble.

And not just financial trouble: this price gouging takes away something that you can't put a dollar value on: security and a sense of well being and optimism about the future. "Now you think, what if I had to go to the hospital for a month?"

"It's a real violation of security," Fry says. "You think that you're under a nice umbrella. It's a fatal event in what's become a dysfunctional relationship."

This is the second straight increase. "Last year was quite a shock," Fry says. His premium went from $450 to $550. But when he opened the envelope this year, "the world became a dark place."

It is all the more alarming, he says, because Kaiser heretofore has been "a moderating force" in a world of health care excesses, "a real giant. Now they are accelerating the increases."

*Fry worries about those who are even less able to pay for health care coverage. "The whole bottom third is going to fall off the charts," he says. "They're low-income people and they're going to do without. They're going to die quietly, at home or in emergency rooms."*

Fry, a San Diego native who lives in Poway and attended San Diego State University, has been with Kaiser since 1967. He has not had serious complaints with the coverage although he warns that "you have to be proactive with Kaiser. You'll fall through the cracks if you're not vigilant."

Still, he was satisfied, until the rates started shooting into the stratosphere. Now he's angry, and worried, and he wants to the state to step in and regulate the health care giant. "There needs to be governmental control of the rates," Fry says.

He adds that employers also are suffering. "Kaiser has existing contracts with huge employers," and they, too, are struggling to keep up with increases.

As bad as it is for him, Fry worries about those who are even less able to pay for health care coverage. "The whole bottom third is going to fall off the charts," he says. "They're low-income people and they're going to do without. They're going to die quietly, at home or in emergency rooms."

## Tom Garbin, self-employed, Garden Grove, California

Tom Garbin, a 60-year-old comedian from Australia who came to the United States a quarter of a century ago, is anything but amused at the way his health care provider has treated him over the past five years. First it stalled him relentlessly as he tried to get authorization for treatment, a series of delays that in one case almost cost him his life. On top of that it has raised his premiums with a dismaying steadiness, culminating in a staggering boost between January and March 2004 of 63%—from $427 to $692.

"They're criminals in what they're doing." Tom says. "They're denying me left, right and center." As to the increasingly unaffordable price increases, Tom is convinced that "this conglomerate has made up its mind to dump me."

Tom's travails began in 1994 when he signed on with Foundation Health, which was later bought out by Health Net in 1998. "Back then I wasn't sick. But it (health insurance) is one of those things you buy for peace of mind." That's especially true after you turn 50, Tom says. So he signed on, self-insured.

Things moved along smoothly enough until 1999, when Tom was entertaining at a trade show. There was a health fair there and Tom had a PSA test, which measures for prostate cancer. That was on October 7. The doctor at the health fair told Tom that his test was abnormal and "suspicious for cancer." He recommended that Tom get a biopsy.

Then came a maddening series of visits to his health care plan doctors. They ordered up an Ultrasound, which came back negative, then assured him that everything was just swell, not to worry about it and come back in a year.

Tom, they soon discovered, was not so easy to brush off. "I came here to get a biopsy," he told a health plan doctor as he slipped into his native Australian, "and I'm not leaving until I get a bloody biopsy."

The doctor ordered the biopsy on the condition that Tom leave him alone. The test, performed Dec. 21, came back positive. On Dec. 30, 10 weeks after the health fair diagnosis, the doctor told Tom he had prostate cancer and needed a radical prostatectomy within the next two months. Had Tom slunk away as they first suggested, he would not be telling his story, unless he found a way to communicate from beyond the grave.

But Tom's struggles were not over. He researched, exhaustively, available therapies for treatment of prostate cancer. But the medical director of Affiliated Doctors of Orange County, which administered his health plan, would approve neither his choice of doctor nor the treatment, brachytherapy. Finally he relented and let Tom see his second choice, a doctor at UC Irvine, under two conditions: first, that Tom not tell anyone that he was being allowed to go out-of plan; and that the UC Irvine doctor accept Health Net's rates.

The radical retropubic prostatectomy was performed on March 31, 2000, at UCI Medical Center. It is a $35,000 operation and Tom paid his $1,000 co-pay. He later discovered that Health Net paid only $880 to UCI Medical. "Now UCI won't touch any insurance company," Tom says.

Tom went to see his surgeon for follow up visits for two years, with no problems. Then one day his health plan refused a visit to the doctor who performed his surgery. Since then the plan has denied other payments, including $20 office visits. Tom is paying for his own PSA tests.

"I believe that money is not the issue here," Tom says. "My premiums are a whopping $4,536 a year and they can't approve a $20 office visit?" Tom is not buying that argument, or the providers' standard line that health care costs have gone up and are simply being passed on to customers. He thinks that, like many people over 55 in health care plans, he is being squeezed out.

"Between 60 and 65 (when Medicare kicks in) is no man's land," Tom says. Tom has fought all this hard, writing letters to everyone from his assemblyman to U.S. Attorney General John Ashcroft. That has not endeared him to Health Net.

Meanwhile, his rates continue to rise. He was paying $166 in January of 2000. On March 1 he will be paying $692. He believes he is being singled out and has the comparative figures to make his case. But he says many folks in his age group are facing the same dismissive treatment.

*"They're criminals in what they're doing." Tom says. "They're denying me left, right and center." As to the increasingly unaffordable price increases, Tom is convinced that "this conglomerate has made up its mind to dump me."*

The plan providers' efforts to deny treatment, combined with their profiteering, is a rancid combination, Tom believes. "You have to fight them tooth and nail for everything you have done, and they keep raising their rates and taking away benefits."

Tom wants to see health care providers forced to prove that the rate boosts are financially necessary, and that they are administered equitably. He noted that one plan representative had rattled on about how "you can count on it, take it from me, it's the same for everyone."

Tom wants proof, and he wants someone to make health care providers justify their rate increases.

## Laurel Kaufer, self-employed, San Fernando Valley, California

When Laurel Kaufer's divorce came through and she became a single mom to two kids, she took over responsibility for their health care. Self-employed, she knew it was going to be a struggle, but she had little idea just how tough the health care industry was going to make it for her.

Because of relentless rate increases, Laurel has to measure each proposed trip to the doctor very carefully against her other household expenses, and no longer takes her children to the doctor with every illness.

Neither she nor anyone else should be forced into that kind of juggling act with their children's health, she believes

Laurel, a mediator, moved to California from Florida in the early 1980s. Now 41, she lives in the San Fernando Valley with her sons, 14 and 12. While she was married, she and her husband and the boys were covered by family plans, through Blue Cross.

In the late 1990s, rates began to mount steadily. The pace accelerated in February 2001: She has faced six increases since then. In April 1998 Laurel paid $129 a month in premiums to Blue Cross, for a policy that had a $1,500 deductible per family member, for herself and her two children.

A year ago, that same policy, with fewer benefits, cost Laurel $448 a month. She was steamed at the time, but this year's notice, which she received in January, really raised her temperature

"As of March 1, my policy will go up from $448 to $470 a month. For that increase I get the benefits of a new $6,000 per year maximum co-pay (per individual, two member max), (up) from $4,000 in the past. I get to pay a $100 co-pay for ER visits, instead of $30. I also get to pay 50% of the costs of non-formulary drugs rather than the standard $10/$30 for generic/brand name."

"How cool is this?" she adds sardonically. "I feel like such a valued customer. Here my insurer goes, sticking it to me yet again"

Being self-employed and unwilling to subject herself and her children to an HMO system, Laurel has few options for private health coverage. Blue Cross and the few other companies that offer similar individual policies know this, and have continued to capitalize on the monopolies they have built at the expense of consumers like Laurel.

A financially savvy consumer, she has shopped around and tried to secure the best coverage for the best rates. But the dizzying pace of rate increases, as well as changes in what exactly is offered, to whom, for how much and under what circumstances, have her reeling.

Like other parents in this age when medical insurers put profits first, she finds herself making decisions that she would rather not make. Last year, for example, her son was not feeling well. But she didn't take him to the doctor, as she would have, because of the higher deductible she had to accept in 1998, after another premium increase, in order to keep her premiums affordable.

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*Skyrocketing rates are "having a chilling effect on people seeking early health care," when they could prevent an illness or stop it early in its attack.*

Skyrocketing rates are "having a chilling effect on people seeking early health care," when they could prevent an illness or stop it early in its attack.

Laurel, like so many other health care consumers, is educating herself about health care in California. One thing she is discovering is that it is virtually unregulated. "The insurance companies have a huge lobby, with a great deal of financial backing, and so remain in control," Laurel says. That, she adds, must change.

"I'd like to see the Legislature mandate caps on increases," she says. "And every increase should be approved by a panel of non-industry personnel." Taking the decisions out of the hands of the insurers, who are in the business for profit only, is key, she says. "In order for the consumer's needs to be protected, the insurance industry must be watched and held accountable.

## Don Lapin, San Francisco, California

It isn't that Don Lapin doesn't appreciate the refrigerator magnets. They have their uses: holding a recipe to the frig door, or a maybe a cartoon or family photo. But all things considered, Don would rather that Blue Shield just kept its magnets and other promotional diversions and instead spent its money on keeping his health care costs down.

He figures Blue Shield also could help him and others by cutting back on its false advertising and fraudulent business practices.

Like so many other health care consumers in California, Don has watched his costs go through the roof with increases that seem to come every full moon. It has driven him to the point where he is now choosing not to seek preventive health care. Don wants the government to step in.

Don Lapin is a 46-year-old engineering consultant. Born in St. Louis, he attended MIT, received an M.A. from the University of Houston, and moved to California in 1987.

For the first several years, he was covered through his employer. He went on his own in 1995, with Blue Shield. Since then, it has been all downhill for health coverage and uphill for costs.

*Don says the health care system, unregulated, is running wild. "Blue Shield is supposed to be non-profit, but its managers act like they're with Exxon."*

*All information from Blue Shield is accompanied, Don notes, "by a stack of endorsements, full of detailed, confusing clauses changing the terms and conditions of coverage."*

Don's deductible has jumped from $1,000 to $1,500; his co-payments are up between 20 and 40%; he has a $250 deductible for brand name medicine.

A careful consumer, Don has investigated each proposed increase and found that the information Blue Shield gives out does not jibe with reality. For example, when he looked into going for a $2,000 deductible earlier this year, he checked the Blue Shield web site. It said a man his age would pay $140 a month. When he applied, however, Blue Shield told him that figure was only for 'squeaky clean' applicants, and he would have to pay $175.

By squeaky clean he thinks Blue Shield means he has a pre-existing condition—he had back problems when he had a bicycle accident in Houston in 1983. After learning that Blue Shield considered him unclean medically, Don tried Kaiser. They turned him down altogether because of his pre-existing condition

All information from Blue Shield is accompanied, Don notes, "by a stack of endorsements, full of detailed, confusing clauses changing the terms and conditions of coverage." Blue Shield also tries to distract members from its financial shenanigans by offering "free benefits that I didn't ask for, like toll-free hotlines, health magazines, and web site features." And, of course, refrigerator magnets.

The whole operation is based on diversionary tactics. "They shoot you with a bunch of verbiage" so you won't notice they're picking your pocket.

Don, like other victims of the system, is now hesitant to seek care. For example, he developed a serious cold last Christmas and lost his sense of smell. It still isn't all the way back, but he is balking at taking his doctor's advice to see a radiologist. "It depends on how much it's going to cost," Don says.

Don says the health care system, unregulated, is running wild. "Blue Shield is supposed to be non-profit, but its managers act like they're with Exxon."

Consumers suffer, but it shouldn't be that way. "With the amount of money we have in this country, there should be good health care for everyone."

At a minimum, Don believes health care providers should be forced to present information in a format that is truthful, and that makes it easy for consumers to compare the offer to similar offers by other providers. Web sites should contain honest information, including the truth about coverage of pre-existing conditions and upcoming increases. And insurers should be required to tell how much of consumers' payments go to actual medical services.

"Millions of people don't have coverage," Don notes, and many of those who do are lied to and misled by insurers. They won't police themselves, so until the government provides oversight, the system is little more than "a scam."

## Art Letter, retired, San Diego, California

Art Letter has been around the block a few times. As a civil servant and consultant for decades, he is intimately conversant with the way government works, and he developed expertise on the state's health care delivery system when he served on an independent health commission in the early 1980s. So when Art's health care costs shot through the roof last year, dumbfounding him with their steep ascent, he thought he would have little trouble getting to the bottom of why it happened.

Despite his expertise, however, Art ran head-on into a stonewall. He was flabbergasted by the runaround he encountered. Insurers pointed the finger of blame at doctors, who pointed at politicians, who pointed back at insurers. It was a vicious circle of evasion. The hands that weren't pointing were covering a rear end.

When all was said and done, Art discovered this: Nobody is effectively regulating health care in California. "They can do whatever they want. It's outrageous what's going on."

This is the first time Art, now 60, has homed in on how bad things have gotten in the health care industry. A native New Yorker and current resident of San Diego, he is celebrating his 30th year in California. He was director of governmental relations for the San Diego Association of Governments and in the 1980s served on an independent health commission that had regulatory control over medical costs. The commission was eventually dissolved and its duties supposedly absorbed by the government.

*While some health care insurers and providers are on the level, "for the most part these people are ripping off the system in an incredibly ugly and arrogant way." The people we elect let it happen because the insurance lobby has plenty of money to spend on politicians—money they gouge from consumers."*

*Politicians "can't stand up to these big lobbying organizations," Art says. "Big money is controlling our democracy. It's poisoned the system."*

A self-insured consultant, Art has been covered for 10 years by Blue Cross. He was used to them raising his rates regularly as well as changing the coverage. But he bobbed and weaved with each new Blue Cross move, keeping expenses in line by adjusting the nature of his coverage.

This year, however, no amount of maneuvering could help. Art's costs went up 40%. His monthly premiums rose from $231 to $323.

When Art opened the notice from Blue Cross containing the bad news, he set out to discover why this boost had taken place. "I did a whole bunch of research," he says.

The Blue Cross consumer representative said she thought the state had approved the increases—the Department of Health Services. He checked with DHS: no, they said, it wasn't them: try the Insurance Commissioner. It wasn't them, either. They told him to try the Department of Managed Health care—which turned out to be another dead end.

This bureaucratic game of Where's Waldo produced nothing more than a circle of people busily avoiding responsibility for sticking it to the health care consumer. "They all point to and blame each other," he says.

Art wants a change and he wants it to be far-reaching. "I feel passionate about this," he says, and not just for himself. "What's happening to me," he says, "is happening to a lot of people."

He wants to see an independent commission that would monitor and have regulatory control over cost increases. He also would like to see it gather specific information that it would provide to governmental leaders. He supports Sen. Liz Figueroa's bill SB 26.

The time is now, Art says. While some health care insurers and providers are on the level, "for the most part these people are ripping off the system in an incredibly ugly and arrogant way." The people we elect let it happen because the insurance lobby has plenty of money to spend on politicians—money they gouge from consumers."

Politicians "can't stand up to these big lobbying organizations," Art says. "Big money is controlling our democracy. It's poisoned the system."

## Kathy Locke, small business owner, Novato, California

Kathy Locke, like so many other small business, is feeling the pinch. She has run a successful small advertising business in Novato for 20 years. It is a labor of love, with Kathy's hours definitely not 9 to 5. Her husband is also self-employed, a contractor.

Kathy and her husband have always taken care of their own health insurance, and have managed well enough. They have not had major health problems.

In the past seven or eight years, however, she has watched her premiums creep up, and then rocket up. "I'm 52 and my husband's 53," she says. "As we've gotten older, our premiums have started to double and triple."

Not that long ago, Kathy's premium under Blue Cross was $120 a month. Now it is $420 a month. She has to multiply that figure by two to include her husband, and they get no dental or vision coverage. The deductible is $2,500 a year per person.

It's a classic squeeze, similar to what other self-employed and small business people are enduring. There is something basically wrong with an insurance firm or anyone else making a customer pay more money for fewer services. But that seems to be the way the bizarre health care system works in California.

What can Kathy do? Not much. She is thinking of changing to Blue Shield, and taking out a higher deductible, which will bring the premiums down a bit. She could just drop all coverage, but when you are on the far side of 50, the notion of not being covered at all seems less and less realistic, even if you are, as Kathy describes herself, "at the end of the hippie generation"—a generation that once disdained such things as insurance coverage. Of course, they were young then, and now they have to consider that "something really serious" could go wrong, as Kathy puts it.

So she and her husband will continue to try to scrape up the money, while staying healthy and hoping nothing goes wrong. The extra money going to health insurers will of course come from other places. "When you go to the grocery store, you buy less food."

*Kathy understands that the health insurance crisis is damaging all kinds of people. She has no answers as to what to do about it under the current rules and regime. "I think there should be universal health care."*

Kathy understands that the health insurance crisis is damaging all kinds of people. She has no answers as to what to do about it under the current rules and regime. Perhaps, she thinks, something drastic—by U.S. standards—should come into being. "I think there should be universal health care."

Until that happens, she and tens of thousands of other small business owners and self-employed people will pay more money to medical insurers for poorer care.

## Jon Marcus, San Francisco, California

Jon Marcus, an executive recruiter, has been insuring himself for several years through Blue Shield. But endless rounds of rate hikes have his head spinning.

"I realize as I see health care costs rising, that we are all reliant on the health insurance system to afford any kind of health care need."

Jon has been driven to sign on for catastrophic health insurance, the least expensive. Catastrophic coverage, however, is generally useful only in dire situations.

How have insurers stuck it to Jon and others who, like him, are self-insured? The daggers are too many to enumerate. But here are some of them:

*Insurers, Marcus says, have "abused the system." They have "too much power, outrageous rights: They can deny you coverage for almost any reason, they can raise rates for any reason, and they can even find reasons to drop you.*

In the past three years, his rates went up: first, 14%, then 30% and finally 20%. Jon once had a zero deductible; now it is $750. He had 20 chiropractic visits covered at a discount; now his insurer covers only 12. Blue Shield used to cover the lab work for his annual physical; "not any more." His co-pay has gone from $35 a visit to 30% of whatever the visit costs. Taking everything into account, he says his health care costs have increased 300% over the last three years.

The result: "I am asking doctors ahead of time what it's going to cost." Like others swirling in the vortex of out-of-control medical costs, Jon is making health decisions not on the basis of health, but on the basis of expense.

His situation is further exacerbated by the fact that he has a pre-existing condition, which insurers will not cover. "Denying people insurance for pre-existing conditions is a common practice in the health insurance industry," Jon says. He has a friend, a contract worker, who cannot get coverage for himself, his wife or his kids because he has the pre-existing condition of high cholesterol, which is treatable with medication. Another is in the same boat, with his family, because he has sleep apnea.

It annoys Jon that health care providers do not ask those who work for a company the kinds of detailed health questions they ask the self-employed. "People who work at CISCO, for example, are just as healthy (or unhealthy) as anyone else," Jon says. But "if you apply for health insurance through a job there are no questions."

Asked if he has suffered emotionally because of all this, Jon grows impatient. "What do you think?" he asks. Is he dissatisfied? "It's not a matter of dissatisfaction; it's a matter of being screwed. They've got you. What are you going to do?"

Greed rules the marketplace, he says, and "the politicians have sold out to these companies. What happened to the capitalist system?"

There is no rational relationship between the rise in health care costs and the rest of the economy, he notes. While health care has risen 30%, the consumer price index has risen only three percent.

Things are getting worse, Jon says. "With more people losing their jobs, and more people doing contract work, more people can't get health insurance. Roughly 6.5 million people in California (about 17%) don't have health insurance."

Insurers, Jon says, have "abused the system." They have "too much power, outrageous rights, they can deny you coverage for almost any reason, they can raise rates for any reason, and they can even find reasons to drop you."

"I want to see health care prices, and the industry, regulated," Jon says. "The government should totally take control. Let's face it, if you don't have your health you don't have much else. Why should we allow a system to govern our health care that places profit far above our health care? This insurance system has to change."

## Peggy McPhee, self-insured, Santa Rosa, California

Seamstress Peggy McPhee has worked at a Santa Rosa bridal shop for 20 years. She has a good relationship with her boss, but the owner, like many small business people, simply can't afford to pay for Peggy's health insurance. So Peggy, 51, has fended for herself.

Until now, she has always gotten by. It was easier back in the early 1980s when her husband, now her ex-husband, worked at Sonoma State University, which covered their health needs. When they divorced she went on to a Kaiser conversion plan. She was able to make the payments, and Kaiser was easy to deal with. "They were pretty easygoing back then," Peggy says.

But rates began to creep up, and this year it was no longer a creep; it was a full gallop. Her premium jumped from $300 a month to $490, her co-pays escalated, hospital rates climbed. It was a devastating blow to someone who, like Peggy, has to watch every penny.

"I was very angry," she says. She went to Kaiser's health plan office, which said there was no mistake about the numbers. She does not qualify for Medi-Cal. Other plans are out of the question because she has pre-existing conditions.

She doesn't know where she can cut back this time. She dumped her cell phone last year, and endured the winter without turning on the heater. "I bit the bullet," Peggy says. "But now, it's just out of reach. I can't afford this now. I don't know where the $190 is going to come from."

*She doesn't know where she can cut back this time. She dumped her cell phone last year, and endured the winter without turning on the heater. "I bit the bullet," Peggy says. "But now, it's just out of reach. I can't afford this now. I don't know where the $190 is going to come from."*

Ironically, the added financial pressure has worsened her physical condition by giving her irregular heartbeats. That's not the worst of it, though: it is the discouragement. "It's gotten me depressed," Peggy says.

How will Peggy adjust to this unconscionable rate boost? She simply doesn't know.

## Dorothy Miller, uninsured, Pittsburgh, California

Dorothy Miller was not happy when she was downsized in 2000, but at least, she figured, her health care was taken care of in her retirement years. The company she had worked for, Industrial Indemnity Company, had arranged coverage for veteran employees before it was taken over by Fremont General.

Dorothy figured wrong, as she was to find out last year. Fremont General put the company into bankruptcy and in so doing evaporated health benefits for Dorothy and many others. Now she is not covered at all.

Dorothy, a corporate records manager, had worked for Industrial Indemnity Company for 34 years and she was 59. That combination added up to more than 75, which was the magic number that made employees eligible for the benefits. Dorothy's coverage was through Kaiser, and her premiums were low and rising annually. The plan didn't include dental or vision, but she had no complaints.

When Fremont General chose bankruptcy for Industrial Indemnity, Dorothy was flabbergasted. "There was anger," she says, "and surprise, because I wasn't expecting it."

*"...I'm taking the risk that nothing will happen to me before I reach 65 and am eligible for Medicare. I'm betting my life every day for three years."*

"I thought Fremont General bought Industrial Indemnity's obligations," including the obligation to continue her coverage. She made some inquiries and learned that apparently, laws that would protect her and others in her position do not apply to Fremont General, although she is not clear about why. "There's a legal loophole in there someplace."

Dorothy got the notice about her coverage from the insurance conservator in October. The conservator tried to persuade the company to continue the coverage that Industrial Indemnity Company had provided, even under its new name of Fremont Industrial Company, but to no avail.

"What really ticks me off," Dorothy says, "is that Fremont General stock has really been going up," from $2 to $16 or $18 in a couple of years.

She and a friend from Industrial Indemnity who also lost her coverage are exploring legal options. And she wonders why nobody seems to be doing anything about health care and health insurance. "I know I'm not the only one. I read the papers every days, and there's always a story. But nobody seems to talk about it" at a governmental level.

Dorothy, a divorcee with two grown children, is taking care of her granddaughter full time. She is on a fixed income and cannot expect help from her grown children. She now has become one of millions of Americans who cannot afford health insurance.

"I'm in better shape than a lot of people, so I'm taking the risk that nothing will happen to me before I reach 65 and am eligible for Medicare. I'm betting my life every day for three years."

## Laura Moe, small business owner—uninsured, Marin County, California

Five years ago, as she watched her health care costs surge to stratospheric heights, Laura Moe opted for what seemed to her the only feasible solution to the problem of intolerable health care costs: stay healthy and wait for Medicare to kick in.

Laura, 61, a native San Franciscan, simply can't afford to buy health care. Not having it makes the self-insured small business owner nervous, but she feels there is no other out.

*In the mid-1990s Laura and her husband divorced. She went on Cobra coverage for two years, but that ended and she sought health insurance for the self-employed. The least expensive option she could find would have cost her $320 a month.*

It wasn't always that way. When she was married, her husband's Kaiser coverage took care of both of them as well as their children. She wasn't all that enthused about Kaiser—the giant HMO made it difficult to get and hold on to a regular doctor. Nevertheless, "I was happy thinking that anything that came up would be covered. It was just sort of a net."

In the mid-1990s Laura and her husband divorced. She went on Cobra coverage for two years, but that ended and she sought health insurance for the self-employed. The least expensive option she could find would have cost her $320 a month. When she turns 65 that would climb to $727. She simply can't afford those kinds of numbers.

She had to ask herself if she was taking a dangerous gamble in dropping health insurance. Perhaps she was, she thought—her work, although she loves it, is stressful. Since 1984, Laura has owned a video production company in San Francisco, and shoots events—weddings, Bar Mitzvahs, other celebrations—from beginning to end, then edits what she has filmed. It is a job that takes time, energy and physical stamina, especially with the camera.

Nevertheless, Laura reasoned, "I'm a very healthy person. I'm holistic-oriented. I don't run to the doctor all the time." She decided to roll the dice and abandon health coverage. So far she has not faced a serious medical problem. She is hoping to get through to 65. "I'm just holding on for four more years, and then it's Medicare."

As medical advice, "drop your coverage and come back when you're 65" is even less reassuring than "take two aspirin and call me in the morning." For Laura it has created tremendous anxiety. "It's very scary."

## Dana Morrison, Magalia, California

The episode that changed Dana Morrison's life lasted only moments and began with her doing what this dedicated nurse always has done: looking out for her patient. But it ended with Dana enduring tremendous pain, being knocked out of the work force, and then facing the slings and arrows of a workers' comp system that never was all that kind to employees and now threatens to get even worse.

Dana, idled, wants only to receive her due from workers compensation and put her injury-riddled year behind her. Oh, yes, and she also wants to be involved in Governor Schwarzenegger's proposed reforms to workers comp.

"There are problems with workers comp," she says. "If you put a nurse in there to do it, they'd have it fixed in no time."

*"There are problems with workers comp," she says. "If you put a nurse in there to do it, they'd have it fixed in no time...*

*"I have yet to listen to a health care executive that is not adept at dancing around the real problem..."*

Dana's odyssey through the workers comp system began in January 2002. At the time she was a hemodialysis nurse at a new clinic in Yuba City, doing work that essentially detoxified the blood of patients whose kidneys had either failed or were not working.

It was by no means her first nursing assignment. A Santa Barbara native, she has been in nursing since 1971 in California and Nevada and "I've done just about everything in nursing that you can: Indian health services, patient care" and all manner of other work. She is an RN, CRRN, certified Director of Staff Development, certified to teach FAS/FAE, and certified to teach about AIDS/HIV.

Dana, 53, an articulate and dynamic woman, also describes herself as a "rabble rouser. My patients come first. I'm a professional busybody who's a nurse."

One late January afternoon, a frail man came to the clinic's door, propelling himself with a walker or a cane and carrying his oxygen. He was "a very sweet man," Dana recalls, in his 80s, with heart and lung conditions.

The man fell. "I heard a plunk and there he was, laying face down. He had hit his head." Dana's training kicked in automatically. "I said 'Oh, my god, my patient's laying on the floor.' He was three feet away." She went to his aid, going down on her knees to assess his condition. . "It wasn't like I had a choice," she says. "When there's an emergency it's the RN's responsibility." The man himself was embarrassed, but couldn't get back up unaided.

A male technician arrived and he and Dana each took a side. Squatting, they began to hoist him back to his feet. "Halfway up, my right knee went 'bing!' The pain was, oh my god." But if she had taken care of the knee, "he would have gone down again." That was unthinkable: the patient always comes first.

Dana tried to work through the injury, even though "there's a lot of walking. There are 15 stations. You walk back and forth all over the place." But, she figured, "I've got patients to take care of" and that is what she did. Later when she went home she took some ibuprofen. Her boss called and told her to go to the occupational health clinic. He made the appointment.

The clinic doctor prescribed anti-inflammatories but no work restrictions. "I was working 12 to 14 hours a day, I was the only RN, I was charting, the clinic had just opened. Each day I worked it got worse."

Finally, Dana got to see an orthopedic surgeon, who put her on restrictions: eight hours a day maximum, and sit as often as possible. The pain still found its way through, because "even when you sit there are a lot of ups and downs." She called him again, "basically in tears," but nothing changed and "the pain kept getting worse."

Soon, "the bigwigs showed up" from the corporate headquarters in Boston. By then, Dana had "raised hell, written the Labor Commission and all kinds of (stuff)."

A woman from headquarters spoke to her. "The first thing out of her mouth was not, 'how are you doing?' It was, 'this isn't workers' comp because you already had an injury.'"

Dana had had a knee injury from her horse-riding days as a teen-ager, and also had some arthritis in the knee. "But it never kept me from doing anything." Still, the company sought to use this 30-year-old injury as an excuse to keep from kicking in the workers comp. Eventually, "workers comp finally conceded that I was hurt at work." At the end of April, Dana underwent arthroscopic surgery. That left her on crutches.

Then she had knee replacement surgery, continued on crutches and eventually changed to a cane in February 2003. She stopped work April 13 and has not worked since.

A month after that, workers comp began to pay Dana based on two-thirds of her income. Her yearly take plummeted from $50,000 to $20,000. The checks were routinely late and, coupled with the fact that she was not making as much money, forced her to run through her vacation and sick time and miss some bill payments. That, in turn, hurt her credit.

Workers Comp, arguing that her injury was already present when she went to lift up her patient, declared Dana 50% disabled, a percentage that Dana disagrees with. She can barely bend her knee, cannot be on her feet longer than 20 minutes, and is unable to kneel, squat or lift anything heavier than 20 pounds.

Dana continues to fight, although right now what she would like most is to start up her life again. "I'd like to go back to what I was doing, but there are no positions open to me because of the restrictions. There are some sedentary jobs." She thinks perhaps she could work as a consultant.

Dana has taken a long hard look at the workers comp system and Gov. Schwarzenegger's proposals to 'reform' it. Her most recent perspective is that of an injured worker, but she has seen the issue from both sides. When she was in risk management, "I always tried to do what was best for the employee because that is what was best for the company."

She says she has "seen the fakes, but I've also seen legitimate injured workers who got the shaft. You can't leave it alone, because it needs fixing."

But Schwarzenegger is about to make it worse, she believes, because he is catering to business.

"I have yet to listen to a health care executive that is not adept at dancing around the real problem..."

"You need to make it equitable," Dana says. What Schwarzenegger is proposing will "make it harder on my profession."

She has specific proposals, such as basing the disability on 100% of salary rather than two-thirds, and not keeping people waiting so long for a resolution of their case.

But her larger point is that the reforms need to be fair to all, and that can happen only if all points of view are included. "The governor needs to get out of it totally. He needs to get a mix of people working on workers comp reform: lawyers, employers, blue collar workers." And of course, nurses. "Nurses who work the regular floors with a wide range of patients ..and who work hands on in skilled nursing facilities."

"Unless it's equitable, there's not going to be a benefit to workers, employers or anyone else in the end. If workers get hurt and can't get the care they need and deserve, then that's one less employee, a decrease in productivity, and a decrease in profits. It's a vicious circle."

## Jon Pastoria, self-employed, Studio City, California

Jon Pastoria, 38, is a corporate recruiter, a financially savvy entrepreneur who makes decent money. But being sophisticated about finances is no match these days for the depredations of California's health insurance system, whose abuses are now striking down the middle class in the same way they've always struck down the poor.

After years of struggling to provide basic health care for his wife and two sons, Jon has finally resorted to taking out catastrophic health insurance, which provides coverage only in emergencies. It was a last option, but health insurers forced Jon into it after years of mistreating his family.

"You feel like you're being screwed to the point where you have no hope, " Jon says. "You have two choices: Go along (with whatever insurers offer) or go without health insurance."

*The government needs to provide oversight, Jon Pastoria says. It should limit the number and percentage of increases. It should crack down on bait and switch tactics. "Individual policyholders have no leverage; we need all the help we can get."*

Jon and his wife Susan came to Southern California from Michigan in the mid-1990s, ultimately moving to Studio City. Susan gave birth to Nick, prematurely, in 1996. He spent two weeks in intensive care. Jon's huge medical bills kept getting worse as Blue Cross regularly raised rates. Annoyed, Jon nonetheless was handling the costs. Then, one day, Blue Cross, which had raised his rates three times in one year, raised them again. Thinking "this is ridiculous," Jon in October 2001 signed on with Nationwide Health Plans, which had been Cal Farm Insurance.

The insurer made him take out two policies—one for Susan and the kids (Anthony had joined the family), and a separate one for Jon, who had always had an "erratic heartbeat," although he has never had any heart problems.

The practical effect was to make him pay two separate deductibles. In addition, Nationwide jumped his premium by 50%. Jon didn't like it, but he felt it was a better deal than Blue Cross offered. The two premiums combined cost $473.

Two months later, Nationwide socked it to the Pastoria family. It increased premiums by $2,088 annually ($174 per month) and added new deductibles, when they had originally purchased zero deductible policies, that tacked on another $2,000 to the Pastorias' annual tab.

Jon finds it hard to believe that Nationwide did not know when they signed him up in October what they were going to do to him in December. "We had switched to them because Blue Cross had increased our premiums over three times in one year," and Nationwide was advertising a better deal. It was a classic bait and switch. But the Pastorias felt stuck. To go on another Nationwide plan, or to another insurer, they would have to start the underwriting process all over again.

The 'pre-existing condition"—his erratic heartbeat—would have cost him all over again, or perhaps led to him being turned down altogether. And, as Jon notes, even if you do switch, "what's to keep them from raising rates again, and again, and again."

Enraged, Jon filed a class action suit against Nationwide, but the judge spent only five minutes on his case before dismissing it. Jon has appealed. Meanwhile, the Pastorias received another letter from Nationwide—with another hefty increase.

Jon finally went to catastrophic coverage, which has relatively low premiums but huge deductibles and really is of use only in "worst-case scenarios." He is trying to get back on Blue Cross, as the lesser of evils.

To Jon, the bottom line is that, for the individually insured there is no control over health insurers. "They know they've got you by the balls," he says.

The strain on the family is palpable. "It definitely makes you think twice about going to the doctor," Jon says. The extra money the family pays for health care comes from other family needs—the number of days Anthony attends pre-school, for example.

The quixotic quest to take care of one simple thing—his family's health—seems never-ending to Jon. And the quandary is spreading. "Access to affordable health insurance affects everyone, from the poor to the middle class. The situation is only going to get worse."

The government needs to provide oversight, Jon says. It should limit the number and percentage of increases. It should crack down on bait and switch tactics. "Individual policyholders have no leverage; we need all the help we can get."

Jon has since found work with large employer which provides health coverage for he and his family.

## Pat & Dave Parker, retired, Orange, California

When Pat Parker sorted through the mail she threw the envelope from Blue Cross on the pile with the other bills to be paid, without opening it right away. That's what she always did: After all, the amount never varied, and Pat had an efficient system for making sure she and her husband Dave paid what they owed.

What Pat didn't realize when this particular bill plopped into her mailbox in early April was that it had raised her health care premium by 38%—from $673 to $941. The increase was due to take place May 1.

Pat was soon to find out that there is very little she can do about it: the health insurance industry in California can raise premiums at any time for any reason, with no accountability. The only restriction put on them: They must give 30 days notice.

There is never a good time to get hit with a piece of bad financial news, but this blow came at a particularly bad time for Pat. She and her husband, who have lived in Orange for 27 years, are semi-retired. Dave was let go from his job at a small electronics sales firm in October 2001. They have been on COBRA since then. Dave had open-heart surgery in November 2002, the first time either of them had incurred major medical expenses.

As with so many people who are nearing or have arrived at unexpected retirement, the Parkers struggle to get by month to month. Every nickel matters.

When she realized Blue Cross was jacking up the premium, "it made me angry," says Pat. "I was under the impression that we had a year's contract" on COBRA, in the Parkers' case from October to October.

*Pat didn't realize when this particular bill plopped into her mailbox in early April that it had raised her health care premium by 38%—from $673 to $941. The increase was due to take place May 1.*

Pat tried to get to the bottom of the matter. She thought Blue Cross had made a mistake, or the rise was tied to her husband's open-heart surgery. Neither proved to be the case.

A Blue Cross employee told her there is no year-to-year contract and that rates can and do go up arbitrarily. Pat asked to speak to a supervisor and, after a long delay, was told that the supervisor was too busy to speak with her. Blue Cross then sent her on the all-too-familiar bureaucratic shuffle, bouncing her from agency to agency.

Although the bottom line was the same—she is stuck with the increase—she did learn one new piece of information: health care premium increases do not need to be based on the insurer's actual costs. In fact, when she went on line to look up Wellpoint's (Blue Cross' parent company) report to its stockholders, she discovered that in the most recent reporting period revenues had gone up 39% while medical costs had risen by only mid- to high single digits, hospital costs by the mid-teens and drug costs rose in the low double digits.

Why the huge premium increase, then? Pat does not know. Blue Cross never has explained it, nor does it feel any need to do so. The inference is inescapable: this is pure profiteering.

That was not the only maneuver Blue Cross tried on the Parkers. They also told Pat that Dave's COBRA expired in May. Pat checked into it, however, and found that because Dave was over 60 when he was laid off, and had been with the company longer than five years, he could stay on COBRA until he turns 65, in December of 2004.

Pat did get some satisfaction from Blue Cross, because it failed to meet the 30-day notice requirement when it sent the rate increase: The envelope was postmarked April 3 for a May 1 increase. Blue Cross gave her a $138 rebate.

But that is not nearly enough. Pat figures if Blue Cross missed the 30-day requirement with her, it may have done the same with others, and she is looking into a class action lawsuit.

Beyond that, she wants the state to regulate this industry. "They're sticking it to everybody," Pat says, but prey especially on the weak—people under COBRA, retirees, older people. "They are out of work and already struggling to maintain their medical insurance on limited incomes, trying not to go into retirement accounts or Social Security."

Blue Cross and its industry peers are "entitled to make a profit," Pat says, but not in a way that discards the people they are supposed to help.

"The whole system is completely out of control. I just don't understand it."

## Dr. Doug Roberts, small group practice, Sacramento, California

Dr. Doug Roberts spent years working for the mega-health care corporations, the ones that force doctors to treat patients like a fork-lift driver treats cartons in a warehouse. As he cared for those who came to him for help, he gradually developed a better idea. Now he has put it into practice, and he expects that other physicians will follow.

Roberts and a couple of other doctors have, as he puts it, "hung up a shingle" in Sacramento. By careful management and cutting overhead dramatically, he and his colleagues are able to dispense good medical care out of small offices. Their guiding principle, Roberts says, is that the doctor takes responsibility for and develops a long-term relationship with his patient.

*"The technology has allowed me to go back" to the days when doctors focused on patients and not paperwork and bureaucracy. "I take an hour with each new patient, half an hour with everyone else." Roberts estimates that he has reduced overhead by as much as 70%.*

That is a shift in focus from the large HMOs and medical groups where, as Roberts says, a physician "serves two masters."

Roberts is a rheumatologist specializing in arthritis and diseases involving abnormally regulated immune systems, such as lupus. He worked for a large medical group in Arizona, was transferred here in the mid-1990s, and tried to hold on to some professional stability as the ownership of his medical group changed three times.

He noticed a fundamental problem in medical care delivery during these financial comings and goings: "a basic lack of commitment or feeling of responsibility for patients as being your own. In a big group, you're serving two masters."

"You want to know the patient," he said. That was difficult in the factory-like HMOs.

In Sacramento, a large group of cardiologists bought a building, and had extra space. Roberts and a couple of internists went in on a piece of it.

By sharing, they cut costs, which allowed them to provide better treatment and, incidentally, make their own lives more fulfilled, which in turn leads to better medical care.

Their office, Roberts says, is "like a barber shop, where you rent a chair," or the medical equivalent thereof. The doctors share staff, and that staff is minimal: one receptionist-scheduler.

There is one exam room. The doctors use a computer for medical records, which eliminates filing and "saves the need for another room to store charts."

"The technology has allowed me to go back" to the days when doctors focused on patients and not paperwork and bureaucracy. "I take an hour with each new patient,

half an hour with everyone else." Roberts estimates that he has reduced overhead by as much as 70%.

Most of his patients, Roberts says, are from Medicare, which he describes as "a sort of single-payer system for seniors." Others have PPOs, some are insured through their employers, some are self-insured.

The key, he says is "to remove the for-profit" aspect of medical care. This is do-able if you have the right model. I'd like to see the formation of a non-profit plan."

"This," Roberts says, is the way I want to practice. I didn't want to (struggle) with HMOs, getting approval of tests that have to be done."

He stresses that a happy doctor is good for the system. "I get a lot of enjoyment," he says. That includes working three long days and taking off the other two, so he can spend more time with his children, who are 3, 5, and 9. "I can't tell you how nice it is to stay at home two days." The doctors cover for one another when the situation calls for it.

"Job satisfaction," Roberts says, "is better for everybody."

Roberts believes the model is catching on. "It has in our building. If there are enough doctors, and a plan that is available to the general population," it should spread, Roberts says.

## Alex Rose, self-employed, Santa Barbara, California

Alex Rose is exasperated by the continuing rise in health care costs, increases that threaten to take away his health insurance. But Alex also is disgusted by the larger picture: a United States health care system that is inefficient, uncaring and so confusing to health care consumers that they figure out how to navigate it only with great difficulty, and sometimes not all at all.

"The whole thing is outrageous," says Alex, a self-employed, 51-year-old art and antiques dealer and appraiser from Santa Barbara. His Blue Shield premium jumped this year to $391, which Alex says is "unaffordable. What do I do? I can't pay, but if I don't pay don't get care."

It is a question that tens of thousands of anxious Californians are asking themselves.

Unlike most Californians, Alex, who came to the U.S. as a teen-ager, went back to Canada, then returned here for keeps in 1982, has something to compare the system to: the much-maligned (by U.S. physicians and media) Canadian health care delivery system.

He believes the single-payer system should be imported.

While he concedes that the Canadian system has its difficulties, "for the majority of people in Canada, it is extremely efficient, extremely good. It raises the (general) health level, because people aren't afraid to go in" to see the doctor. They know they're covered in case of a calamity, he adds, so there is some peace of mind as well. It costs $50 a month today, and Canadians know they will be taken care of.

Alex points to a study that showed a dramatically lower rate of breast cancer in Canada, brought about because women were getting checked up regularly because it didn't cost anything. "Here, they put it off until it's too late."

"Down here it's a for-profit business. They don't want the people who are high risk. If you're healthy, you go in the asset column. If you're unhealthy you go in the debit column. They don't bother to see the people who are cast aside. It's outrageous."

That attitude is especially brutal to California's aging and elderly population, now being squeezed out by insurers and their rising rates, he says. "They work their whole lives," Alex says, only to be treated scurrilously at the end. "We're supposed to be civilized, not living in the Stone Age. The whole thing stinks."

*If the military is government-run and supposedly the best in the world, why then can't the health care system be government-run and also be the best in the world?" Alex asks.*

*California might set the trend by tossing out the health insurance companies and establishing itself as the first state to offer universal single payer health care.*

"Health care should be like education," he adds. The industry and the nation "should think about the health of the citizenry."

One of the many nonsensical aspects of California's health delivery system, Alex says, is the fact that you have insurance when you work for someone else, but face exorbitant rates when you're on your own. "If you quit your job, or lose your job, you're basically out of insurance," he notes.

The entire system, Alex goes on "is incredibly confusing. Nobody can figure it out." It generates an endless amount of paperwork and files, he adds, which not only creates confusion and inefficiency, but also increases costs.

"There's nonsense and legalese up the wazoo. They should keep it simple."

Some Americans fear that single-payer is unwieldy.  President Bush played on that fear during his State of the Union address, when "he decried the prospect of a government-run health insurance system, invoking the ghost of bureaucracy. That is really unfair. He doesn't complain about the government-run military as being an inefficient bureaucracy. If the military is government-run and supposedly the best in the world, why then can't the health care system be government-run and also be the best in the world?" Alex asks.

"We always seem to feed the special interests," he went on. "What kind of disgusting society is this, anyway? I say put all the insurance companies out of business; they're all just one step up from gangsters."

"Years ago," Alex notes, "British Columbia decided that the automobile insurance business was an outrageous scam and threw them all out, establishing a quite efficient provincial insurance plan. California might set the trend by tossing out the health insurance companies and establishing itself as the first state to offer universal single payer health care.

"A single-payer system is the way to go."

## Gail Saivar, small business owner, San Diego, California

Gail Saivar is still feeling a little sheepish about the answer she gave to a local newspaper doing a feel-good Thanksgiving story last year. Asked what she is thankful for, Gail, not exactly gushing but nevertheless feeling a holiday glow, said "Kaiser Permanente."

Two days later, Gail received her Kaiser notice for coverage in the upcoming year. As soon as she saw the envelope, her warm fuzzy feeling melted like snow on the sun, replaced by an icy chill slithering down her spine. So sure was she that the news was bad, she waited a couple of days before opening it. "I didn't want to ruin my weekend," she says.

The damage was extensive: her monthly premium shot from $295 to $493. Her hospitalization costs went from nothing to $200 a day, and her co-pay increased. "I was stunned," she says. "Shocked. I thought, this has to be a mistake."

It was no mistake, however. Gail, like so any Kaiser members, is receiving double digit increases in health premiums. Some subscribers have seen their rates double in two years.

Many Kaiser victims are long-time Kaiser subscribers. Others, like Gail, have signed on in the past decade. A native of St. Paul, Gail came to California in 1970. For the next couple of decades, health care was not a major concern, and she handled her coverage routinely and without incident.

*"I'll somehow manage," Gail says, but she admits she is worried. Business has slid the past three or four years. The uncertainty brings great stress and anxiety. "I'll panic. If it's this bad now, what's it going to be in three to four years? What am I going to do (then)?"*

*"...Are there no restrictions placed on these HMOs at all? How is an ordinary person supposed to pay these outrageous fees?"*

In 1998 Gail signed on to a Kaiser personal plan. When she turned 50 later that year, "my rates went way up." She was appalled that her girlfriend, who joined at the same time, had much lower rates because she was under 50. Still, Gail was able to handle it, and didn't feel unhappy with her coverage.

Since then, however, her rosy words on Thanksgiving notwithstanding, each year has brought a jump in Gail's Kaiser rates, culminating in this year's mega-boost. It is getting to be too onerous a burden for Gail, a self-employed contractor who owns an advertising business.

"I'll somehow manage," Gail says, but she admits she is worried. Business has slid the past three or four years. The uncertainty brings great stress and anxiety. "I'll panic. If it's this bad now, what's it going to be in three to four years? What am I going to do (then)?"

She already has put off home repairs because of the increase she just received. She was about to take out a home equity loan to hire a landscaper, but as soon as she saw Kaiser's Christmas premium, she called the landscaper to tell her it was off.

Gail, with her hard-working mid-western values and existing business, has the toughness and resources to muddle through. But she worries about others less well off. "What about people who make a hell of a lot less than I do?" she asks.

She thinks it's no accident that premiums get less affordable as people grow older. Like many HMO patients, she believes Kaiser would like to jettison its older patients, no matter how long they have been with the health care giant. There is no such thing as customer loyalty when money is involved, and keeping aging patients could mean more payout for coverage. "As we get older our bodies start to fall apart. Of course they don't want us," Gail says.

She adds that Kaiser is wreaking havoc on employers as well with exorbitant increases. "My biggest client has Kaiser, and they're freaking out," she says.

Gail is angry now, and wants to know what people can do. "Are there no restrictions placed on these HMOs at all? How is an ordinary person supposed to pay these outrageous fees?"

She is writing letters to legislators. But she wishes the people of California would arouse themselves and take political action. "Should we get a bunch of people to picket?" she asks. But she adds, "we're so apathetic about everything."

Gail would like to see the state step in and freeze rate increases. She would like to see management salaries published. She realizes that calls for such reforms will invite accusations that she is pushing for "socialized medicine." But so what, she asks.

"England and Canada rave about their systems," she says, despite efforts by the U.S. mainstream media to denigrate universal health care. "I'm seriously thinking about moving to Canada."

But Gail is baffled and angry that her own country, her own state can't fix this problem and provide its citizens with one of the most basic services any government ought to provide: health care.

"What is the problem?" Gail asks. "It's corporateering. Why is it so difficult for the greatest nation on earth to get this right?"

## Susan Walker, employed part-time, cancer survivor, Granada Hills, California

For Susan Walker of Granada Hills, health care coverage is not something abstract, an optional expense that she can take or leave. For Susan it is, literally, a matter of life and death. She has had bad luck medically, with heart problems, cancer and other ailments. She has had seven surgeries.

So when she opened her mail in early December and saw the new 2004 rates from Kaiser Permanente, she panicked and then plummeted into a deep pit of depression.

Susan's premium will shoot from $319 to $493. Worse, in her eyes, is the jump in hospital stay to $200 a day. It had been free.

"I don't understand why they did this," says Susan. "The last one was from $249 to $319, so I thought it would go up a little, but not like this. Coverage is vital. It's my safety net, my security blanket. I feel as though it's been completely ripped from me now."

The only moderately good news on her health care premium front this holiday season is the fact that the increases don't affect her children. Her adult daughter is covered through her place of employment and her son, a 17-year-old high school senior, is covered by her ex-husband's plan.

Susan, who is 61, grew up in San Marino and has spent most of her life in southern California. Her health was not an issue until 1986, when she contracted cancer. She beat it, but like all cancer survivors she has had to be cautious; that caution requires constant medical monitoring. She also has had heart problems.

*... I thought it would go up a little, but not like this. Coverage is vital. It's my safety net, my security blanket. I feel as though it's been completely ripped from me now."*

"The hospital fee is really frightening," Susan says. "I've had seven surgeries."

Susan looks around her and does not see any help forthcoming. Because she is not strong enough, she cannot work full time. An administrative assistant, she works 25 hours a week, not enough to qualify under her company's plan.

The cancer and the heart problems give her pre-existing conditions, making a move to a different insurer all but impossible. "I don't know what else to try," Susan says.

The premium increase, along with her general health problems, also has affected her mental health. "I was so distraught, I wanted to get some counseling," Susan says. Then she learned that the co-pay for counseling also is going up, making that, too, unaffordable.

Like the many other patients over 50 who are receiving similar notices from Kaiser Permanente this month, Susan believes the health care giant is attempting to jettison

people as they age. "The older you are, the more you're going to cost them. It's age-ism. It's total discrimination," she says. "You're penalized for being older."
It's more than discrimination: it's also cruel. "We need it (health care) the most," she says. And the entire issue of health is "more nerve-wracking when you get older."

Until now, Susan has remained politically unsophisticated, but that may change. She is not just depressed and worried, she is angry. She cannot understand how Kaiser or any other health care insurer can raise rates arbitrarily. "They're not accountable to their clients?" she asks.

"We need some kind of cap" and other state regulation, Susan says. Without someone keeping insurers in line, "it's only going to get worse."

"If you want me to carry a banner, I'm ready," says this suburban Mom. "I'm ready to start a riot."

## Jonas Weisel, self-employed, Santa Rosa, California

Jonas Weisel seems like an honest enough guy, but lately he's been having trouble getting people to take him seriously. "When I tell them about this, almost nobody believes me," Weisel says.

"This" is his latest notice from Kaiser, which came in the mail in early December. The health care insurer raised his rates from $564 to $955—a jump of 69%.

It does seem incredible, but it happened, and Weisel figures he is not alone. He has done the math. Of Kaiser's 6.2 million members, 350,000 are in individual plans. Of those, 10,000 are in conversion plans. They are people who, like Weisel, have pre-existing conditions. Many if not all of them are receiving through-the-roof rate increases. "Ten thousand people may have gotten this (increase)," Weisel speculates.

These exorbitant health care costs are relatively new for Weisel, 54. A free-lance editor and writer, he, his wife, Meg and their daughter Chelsea were covered for years in a Kaiser group plan through their employer. The owner retired in 1999 and they went to an individual plan. Chelsea, 17, is covered under a personal advantage plan, which has reasonable rates and moderate increases.

For the elder Weisels, the rate boosts under their conversion plan were manageable at first: 22% and then 25%. Then came this year's 69%.

*"The criteria they use to select people for higher rates is flawed," Weisel says. "It doesn't allow for people who don't use (Kaiser's) services. If you are labeled, you are going to be lumped into a conversion plan."*

Why couldn't they, like their daughter, go on a personal advantage plan? Because they have pre-existing conditions. In Weisel's case it is asthma and for Meg it is an intestinal condition. So Kaiser disqualified them from "personal advantage."

This angers Weisel because he and his wife manage their health problems carefully and rarely need a physician. Yet they are being made to pay more because Kaiser actuarials have placed them into a category of people.

"The criteria they use to select people for higher rates is flawed," Weisel says. "It doesn't allow for people who don't use (Kaiser's) services. If you are labeled, you are going to be lumped into a conversion plan."

Weisel believes that Kaiser actuarials are using the same logic that insurers apply to teen-agers who buy car insurance: they have more accidents so you charge them more. Kaiser believes older people use health care more, so you charge them more. But each older person is an individual, he notes and they don't all use health care services excessively.

Weisel, like many people in their 50s and older who are receiving these notices, thinks something else is at play here: "a desire on their part to remove people" from their health care plans.

When that happens, of course, it "it becomes a state problem" as Kaiser and other providers shift the cost of providing older people with health care to the taxpayers.

Asked what he would do to fix health care in California, Weisel bristles. "It's not my job to solve the problem," he says. California, which has turned its innovative and creative energies to create Silicon Valley and other technological and social marvels, should apply that creativity to building a rational, reasonable, and workable fee and insurance structure for health care, he says.

He thinks, however that there is a lack of political will, brought about by the fact that most people, covered through their employers, don't realize the gravity of the situation. "Most people are oblivious because they belong to a group (plan)," Weisel says.

As to politicians, "it's not their problem. It's not anybody's problem unless they're paying it themselves."

The self-employed, Weisel adds, are increasingly choosing to go without medical insurance altogether or opt for major medical—a dangerous state of affairs for them personally and for the state's and nation's economy if it happens across the country, as Weisel believes is happening.

"Everyone feels like this is such a complicated problem" Weisel says. "No one is willing to solve their piece of it. It's become this complex problem that doesn't have a solution. It doesn't have to be that way."

# Appendix 2: Town Hall Summaries

### *San Francisco—March 2, 2002*

Michael Finney of KGO-TV (ABC) moderated the prototype Town Hall on February 20th. The 1-hour program aired March 2nd 2002at 7 PM to a viewership of approximately 1.2 million. 40 stakeholders, including, Daniel Zingale of the Department of Managed Health Care, State Senator Liz Figueroa (D-Fremont), Lee Blitch of the San Francisco Chamber of Commerce, Steve Thompson of the California Medical Society, hospital administrators, nurses and consumers helped kicked-off the Town Hall series in San Francisco.

### *Los Angeles—July 26, 2002*

Adelphia Communication's Bill Rosendahl moderated the 90-minute Los Angeles Town Hall, which aired on a repeat basis to 1.6 million homes in Los Angeles County during the month of July. The California Channel subsequently aired the Adelphia Town Hall on Thursday, September 5, reaching nearly 6 million homes statewide. This event featured 45 Los Angeles regional and statewide voices, including the president of the Los Angeles Chamber of Commerce, several Latino organizations, three state legislators, uninsured consumers and County Supervisor Zev Yaroslavsky.

### *San Diego—November 15, 2002*

During the week of November 11th,The Foundation for Taxpayer and Consumer Rights (FTCR) worked with San Diego's KGTV (ABC) on a 3-day health care series that culminated in a Town Hall event at the County Administration Center, moderated by KGTV's Lee Ann Kim. Segments of the event, which hosted more than 100 San Diego consumers, hospital CEOs, clinic directors, small business owners and others, were aired that night on KGTV. The event was taped and aired in full on the County Television Network on December 12, reaching 725,000 subscribers. In addition to the town hall, the Foundation for Taxpayer and Consumer Rights (FTCR) worked with KGTV to produce two health care investigative stories on HMO arbitration and abusive practices that aired on Thursday, November 14th. Also on that evening, FTCR organized a live, 2-hour, on-air phone bank of health care experts in the KGTV studio that responded to over 500 consumer health care questions.

### *KPCC Southern California Public Radio—February 6, 2003*

FTCR and the California Health Consensus Project participated in a live 1-hour KPCC radio town hall hosted by Larry Mantel that featured call-in listeners and guests Jerry Flanagan of FTCR, Dr. Michael Cousineau of the USC Keck School of Medicine, Michael Tanner of the CATO institute, Tom Epstein of Blue Shield of California, and Steve

Thompson of the California Medical Association. KPCC is an NPR affiliate station based in Pasadena, California.

### *Leisure World of Orange County—March 19, 2003*

Leisure World, a retirement community in Southern California, is the first municipality in the nation exclusively for senior citizens. Leisure World has 18,000 residents with an average age of 77, and a minimum age requirement of 55. In attendance at the town hall were Don R. McCanne, retired physician and national board member of Physicians for a National Health Plan; Felix Schwarz, Executive Director of Health Care Council of Orange County; Bea Levin, a retired Orange County nurse; Ted Rosenbaum, Political Coordinator for People for a National Health Plan; small business owners Howard Meek and Marilyn Meek; and 60 retiree. The event, aired on the Channel 6 cable television station, focused on the impact of Medicare and Medicaid privatization on senior consumers. Consensus discussions elements included the need to create a state-run health care bulk purchasing program as an alternative to the private health care market.

### *California Connected—April 22, 2003 & May 29, 2003*

FTCR worked with the award-winning weekly PBS television news magazine, California Connected, to develop two cutting edge health care programs modeled on our successful town halls. The first 1-hour program aired statewide on April 17th and provided point-of-view interviews with each of the major stakeholder groups: consumers, business owners, health professionals and health insurers. The second 45-minute show, aired state-wide on May 29th, brought together 15 leading voices in health care reform for an all-day "pizza session" where reform advocates, businesses owners and consumers worked with a dispute resolution counselor to develop an outline for universal health care reform. Produced through a unique collaboration of KCET-Los Angeles, KPBS-San Diego, KQED-San Francisco and KVIE-Sacramento, California Connected is seen throughout the entire state.

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