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THURSDAY, FEBRUARY 6, 2003

"AIR TALK," STATION KPCC, 89.3

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BE IT REMEMBERED that on Thursday, February 6, 2003, commencing at an undisclosed time, at KPCC Radio, FM 89.3, Southern California Public Radio, 1570 East Colorado Boulevard, Pasadena, California 91106, the following proceedings were conducted and transmitted.

P R O C E E D I N G S

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MR. MANTLE: This is Air Talk on 89.3, KPCC. Very good morning to you. I'm Larry Mantle.

Well, it's no secret that the American health care system has some very serious problems. Costs in virtually all areas are going up. Concerns about doctors trying to be able to make a living and pay off their huge student debt loads are a problem. Hospitals are closing around the United States. Public health care is in a crisis, particularly here in Los Angeles County.

During the course of this hour we're going to talk about a possible state model here in California that might be able to insure a greater percentage of Californians, bring down the costs, and find some ways of being able to provide necessary services in a more, I guess you would say, economical and consistent way.

To talk with us about various proposals for

providing universal health care is Jerry Flanagan -- he's the Northern California director and consumer advocate at the Foundation for Taxpayer and Consumer Rights -- and Dr. Michael Cousineau, associate professor at the USC School of Policy Planning and Development, where he holds a joint appointment in preventive medicine.

Gentlemen, great to have you both with us in studio to kick off our conversation.

Let me begin by asking you, Professor Cousineau, to talk about the momentum that seems to be building for some kind of universal health care plan, because it seems like after the Clinton administration came out of the box trying to take on national health care that it just became too much of a hot potato after that fell apart. Now it seems people are warming to the idea of debating this again.

MR. COUSINEAU: I think we're finding ourselves increasingly boxed into a corner where we find universal coverage is really our only option. Everybody's beginning to see the value of it, in part because more and more people are beginning to suffer the consequences of a system that doesn't cover everybody, particularly the elderly, people who can't get prescription drug coverage. There are a lot of cracks in our system that seem to be getting wider and wider. More people are falling through

those cracks.

With changes in the economy, more small businesses, more people unemployed, businesses that are having a very difficult time making a profit end up cutting off health benefits as a result. And so there are fewer and fewer places where the system is sort of holding on to ourselves and keeping ourselves healthy.

So I think we're seeing that maybe universal coverage is an option that maybe has a lot of value. More people, I think, are coming to that agreement.

MR. MANTLE: We even have a nonprofit health insurer, Bruce Bodaken, chief executive of Blue Shield of California, who came out and argued that California should come up with a universal plan and essentially require employers to provide insurance. It's not a single-payer, government-administered plan, but nonetheless, for the head of one of the state's biggest insurance companies to argue, "We've got to get everybody covered" is a bit of a notable item.

MR. COUSINEAU: Absolutely, and it does show, you know, the breadth of change that people, both in the industry as well as consumers, are beginning to experience and share as a result of these changes.

MR. MANTLE: Jerry Flanagan, typically when we've heard universal health care talked about, the most

prominent model presented is this so-called single-payer plan. That's where the government essentially sets the prices, the government is the payer for health care coverage, everyone essentially is insured by the government entity, and it's a similar model to what you see in Canada or in Great Britain, for example.

It seems now that we have a proliferation, though, of other models in addition to this single-payer plan. And share with us why that is. Is single-payer just an extremely difficult political sell? Is there a lot of skepticism that this is something that government could do well?

MR. FLANAGAN: Well, as you identified at the top of the hour there, there's a crisis in health care unlike we've seen in the last decade, what brought about the Clinton plan in '92 that ultimately self-destructed. Employers are suffering the same fate as consumers; they're paying more for the coverage they provide to their employees. Consumers are paying more out of pocket. As a result, people are proposing a whole range of legislative proposals.

Certainly one of the long-term concerns with a single-payer or government-run system where insurers would not be the system is sort of the practicality of implementing it. Imagine the government running the

coordination of doctors to patients and getting prescriptions on time. There's a lot of folks that are worried that that wouldn't be an efficient model.

MR. MANTLE: They visited the DMV, and the idea of the State running the medical system is kind of scary.

MR. FLANAGAN: We've all stood in those lines. But there is certainly a reason why you want to look toward that model. It's because insurers right now, health insurers for profit and even the nonprofits, are spending a big chunk of every premium dollar, from ten to 40 percent, on things that aren't health care, on things that are salaries for CEOs, advertising, and administrative costs.

And remember, HMOs were created back in '75 and really became popular in the '90s as a mechanism for controlling costs. Well, now they're the middleman; that's increasing costs. So it makes sense for employers, for consumers of all classes, to say are they really value added, and how do we make them value added, and one of the ways to do that is to, well, remove them from the system. But even the simple political analysis of how do you remove a major employer in the state and put those folks out of work -- so single-payer is a good model. We think there may have to be a transitional phase in which you make the HMOs compete against a State pool to show that

they actually can save costs.

MR. MANTLE: Well, it seems to me another problem is for all the faults of HMOs and insurers, people do at least have some choice in the matter, and so if they feel that the gate-keeping of their HMO or their insurance company is too stringent, they can say, "Well, I'll pay more money to go and get a plan where there's less gate-keeping." But if you only have the option of the government providing it and they have a consistent standard of gate-keeping, you know, then you're more limited, it would seem.

MR. FLANAGAN: It's certainly the case -- that's one of the issues a lot of consumers -- and if you look at the polls, people are concerned about a government-run system because of that simple single choice, and Americans, Californias, want to have a choice.

However, keep in mind, though, in this system, because of mergers over the last couple of years, 137 HMO mergers, there isn't a lot of choice. There's regional monopolies. There's four or five large insurers that control the market. They all have the same products and they all charge the same costs and they all take huge sections of every premium dollar out to pay high CEO salaries and pay for administration, so the -- it's a bit of a fallacy in terms of there's really no choice.

MR. MANTLE: That there's really a big free market. Well, and the other thing is even if there's single-payer, in fairness, you could still have supplemental insurance that people with greater means could choose to subscribe to get more intensive services than are provided under the government contract.

MR. FLANAGAN: Certainly. One of the -- yeah. There's a lot of different calculations and structures that have been proposed in single-payer, and there isn't one single-payer model. One of them would be that you would have a basic benefits package, and then folks could go outside of that and buy in the private market, if one still existed under such a program, additional insurance, sort of the Cadillac insurance for immediate prescriptions, nongeneric drugs, and doctor visits whenever they want them.

MR. MANTLE: As you look, Michael Cousineau, at the single-payer model, what do you see as the pros and cons of the government being the provider?

MR. COUSINEAU: Well, I think we have to separate people's sense of wanting choice of provider -- physicians, hospitals, and nurses -- from their choice of a plan of insurance.

If you ask most people, I don't think they care that much about, you know, if they're in Blue Cross or

Aetna or something else, but they do care about having some choice of physician, and that I think we could build into -- you know, the Canadian system is a good example of where, in fact, you have a single payer, but, in fact, you have multiple physicians and hospitals from which people can choose. And that's important, to try to preserve and try to build in our system -- I think we could actually create a single payer in which we create more choice than less choice than we have right now. Right now, you know, you're going to an HMO; you're pretty much locked in.

Kaiser, for example, has done a very good job of bringing people into the system and then creating a way for people to choose their own doctor and change doctors within the system if they want. So I think that -- you know, that's a model that we already have in California, a thing we can build on. And it's important for people to understand that you're not necessarily limiting choice to the single payer.

I think the most difficult challenge we have is politically. You know, we're talking about one-sixth of the economy, sort of, you know, moving that around in big shovelfuls to try to make some changes, and that's going to be difficult to do politically. And I think that I do support some sense of a transition plan that, you know, moves us in that direction.

I am concerned about some level of, you know, allowing the groups to compete with, if you will, the State plan, because I am concerned that a lot of the insurance industries will end up sort of figuring out how to game the system and select the healthiest people, and then the State system ends up with -- you know, that's what we have right now, for example, in house insurance and fire insurance with the State pool.

MR. MANTLE: The FAIR plan, you're talking about.

MR. COUSINEAU: The FAIR plan; right.

MR. MANTLE: Yeah.

MR. COUSINEAU: And there's a lot of problems in that as a result, so we have to be careful about how we do that.

MR. MANTLE: So the model you're thinking of -- would it look something like somewhat like Medicare, where everybody would have basic services, but then you could have supplemental insurance if you desired?

MR. COUSINEAU: Yes. I think the supplemental plans have to be also fairly well thought out. The supplemental plans right now in Medicare are very, very expensive. It's not uncommon for people that right now are fully covered under Medicare Part A and Part B to be paying up to $1,000 a month for two people to get

supplemental plans, so then you've got to say, "Gee, is it worth it?" But I do think there needs to be -- there is a role and a place for supplemental plans in this system.

MR. MANTLE: Let me bring into the conversation research analyst for the CATO Institute Michael Tanner. He directs research on new market-based approaches to health, welfare, and other entitlements that stress individual responsibility rather than being under governmental control.

Michael Tanner, thank you for joining us on Air Talk.

MR. TANNER: It's a pleasure.

MR. MANTLE: Understandably, given the CATO Institute's perspective and your orientation, you would not be by any means a fan of a single-payer plan and having the government be the payer and the contractor for medical services, but are there private-sector models that you think would work much better than what we have now?

MR. TANNER: Well, I think that the current system we have is clearly flawed. We link health insurance with employment in a way that puts a burden on employers that they then pass on either by not providing benefits or by passing on the costs to their employees. It means that if you lose your job, you lose your insurance. It massively contributes to the problem of the

uninsured in this country, and it limits choice because your employer selects who your insurer is. They lock you into an HMO or whatever, and you really don't have an option to go elsewhere, because that's the way you're getting it under the current system.

So I think what we really need to do is try to move away from the existing model and then decide whether or not we want to go to a system in which the government essentially manages and controls the health care system, or a system in which individuals are given more power and more ability to control the system for themselves. And I would certainly much rather see us go into a system in which we can subsidize for low-income people if they need it. The government can essentially print checks, but it is not managing the health care system.

MR. MANTLE: Is there enough money in the health care system for insurers to be able to make a profit and for costs to be contained to keep premiums at a reasonable rate and services at the level they should be at?

MR. TANNER: Well, it all depends on what people want in terms of health care. And the problem with the American public is they tend to want contradictory things. They want all the health care they want with the newest, most modern technologies, every drug advancement that's out there; they want it today, with no wait; they want it

with the doctor of their choice; and then they don't want it to cost anything. And unfortunately, those things -- you can't have all of them at once.

MR. MANTLE: Do you want to comment on that, Jerry Flanagan?

MR. FLANAGAN: I would. To answer your question in terms of providing care and controlling costs, one of the things we're looking at as an in-between point between the current system that's clearly not working and a single-payer system, as a transition point, would be a public utility model that essentially would control costs through a commission, keep profiteering down, but also make sure that efficient providers and doctors are making enough money to provide the services. There's a great --

MR. MANTLE: Al Gore proposed this model.

MR. FLANAGAN: This proposal has been around for quite some time. Catholic Healthcare West back in 1992 put something onto the table, and it's something that's been discussed for years.

You know, we've had a public utility or used to have a public utility that provided almost universal access for phone service back in the '20s, and AT&T and the Bell folks would tell you they got there through a public utility model, private industry providing universal access. Why can't they do that for health care?

MR. MANTLE: Well, there's a difference, though, and that is that under public utilities, a monopoly is allowed to operate and gain the advantage of a monopoly subject to opening up their books to justify their rates and to justify that they're providing a competent service. But here you would have competing companies, so would that not make it more complicated, more difficult to have essentially a Public Utilities Commission for health care?

MR. FLANAGAN: As a matter of fact, there's a great model for this in Maryland. Since 1971 the Maryland Cost Control Commission has had essentially a public utility model for hospitals in which a commission sets a range of rates for services that a hospital provides. They're competing, and efficient hospitals that fall in that range make a profit; those that go beyond it, don't, and then they have to compete against a more efficient model. So there is certainly a way to do it, and it's not that difficult.

As a matter of fact, we have all the abilities in terms of the State running a program and oversight and retaining private insurers and making them compete against a diverse public pool that's run by the State, an insurance pool, that will help bring those costs down. So it's certainly -- a great model's out there. And you know, we're excited.

I think right now the most important thing to remember is that it's never been the policy of universal health care that's kept us from passing it; it's been the politics.

MR. MANTLE: But how do you deal with the issue that Professor Cousineau raised, which is that the State is going to end up with the poorest and the sickest in their pool, that the private insurers, even under this utility commission model, are going to end up with the healthier and wealthier?

MR. FLANAGAN: Well, and we'll talk about this later in the hour, I believe, on the pay-or-play model, that would indicate a State pool for employers that don't provide health care. Remember, the State already has a very large pool that's under the CalPERS program, the California State employees, several million employees, and if you add to that Medicare and Medi-Cal growing the size of the risk pool, then you have --

MR. MANTLE: And the uninsured and the indigent uninsured.

MR. FLANAGAN: And -- well, under a pay-or-play model, though, you have to remember, though, you only get a benefit if you're employed --

MR. MANTLE: Okay.

MR. FLANAGAN: -- depending on how the process

would work, but yeah, that's certainly correct. You want to have the State pool to be large and diverse. And if you have a minimum benefits package that is required by the State to provide and the employer to provide, then there's a competition on a fair playing field of benefits.

MR. MANTLE: When we come back I want to ask Michael Tanner of CATO about the option of removing profit from health care, making it a nonprofit industry, I guess what Kaiser Permanente does here in California -- they're a nonprofit HMO -- and whether that might provide additional resources to be able to keep premiums from their rapid rate of escalation.

We're joining you in conversation on the topic of universal health care. Does it make sense for California to look at taking a leading position in providing insurance coverage for all Californians to broaden the pool of those insured, try and keep cost containment on premiums, while providing a high-quality service? This is Air Talk on 89.3, KPCC.

(Station break for advertisements.)

MR. MANTLE: Joining us on Air Talk is Tom Epstein, who is with Blue Shield of California, the third largest health plan; it's a not-for-profit based in San Francisco. Tom is vice president of public affairs overseeing communications.

And the head of Blue Shield of California announced just before the end of last year that he was in favor of a universal health plan for California which would require employers to provide health care benefits so that everyone who is employed would end up being covered. Tom Epstein, thank you very much for joining us.

MR. EPSTEIN: Thanks for inviting me.

MR. MANTLE: First of all, I'm curious about the argument that some make that if you remove profit from the equation of providing health care in California, that that will provide a variety of resources not currently available to provide high-quality care and to keep premiums down. As a nonprofit that you represent, do you think that argument makes sense?

MR. EPSTEIN: We're a nonprofit, but we also have to compete in the real world against for-profit companies, so we all are advantaged by the competition that comes from having for-profit competitors. We have to be able to convince Californians to buy our products, and we have to go up against these other companies, and I think that there is an advantage to that competition.

Nonetheless, we aren't driven by a quarterly return to investors, so we're able to think longer term and 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.

MR. MANTLE: Are there advantages that for-profits have over HMOs like Kaiser or over Blue Shield?

MR. EPSTEIN: They have the ability to raise more capital to make investments in computers and other things that allow them to be more efficient. They're able to -- if they're nationally based, they can attract national accounts that enable them to grow larger. We, being a California-based company, don't really have as many national accounts. We're mostly focused on people who life in California. So yeah, there are some advantages that the big for-profits have.

MR. MANTLE: What would the advantage be to those who were subscribers to Blue Shield if there were universal health care in California?

MR. EPSTEIN: We're proposing a six-part plan that I want to run through really quickly. We think that employers should have to either provide coverage for their employees or pay into a pool to cover those who they choose not to -- who they don't cover in their own company, although we would exempt some of the smallest businesses from that.

We also think that individuals should pay to buy

insurance if they're not covered by an employer. If they're self-employed, they -- and they can afford to buy coverage, we think they ought to.

We also think that everyone who is eligible for a public program ought to be enrolled in that public program, whether it be Medi-Cal or Healthy Families.

We think very importantly that everyone should be guaranteed the right to insurance irrespective of their medical condition so you can't be denied coverage if you have a preexisting condition.

We also think there should be an essential benefits package, one that provides a solid level of medical benefits that everyone needs to handle probably 90 percent of all the conditions that they come up with.

And we also think that those who can't afford this coverage and smaller employors who can't afford to provide it should be subsidized and that we should do this through a very broad-based tax, something that everybody pays to do.

We call this whole package universal coverage and universal responsibility, because everybody bears a part of the responsibility for providing coverage.

MR. MANTLE: Michael Cousineau, what are your thoughts on this Blue Shield plan that they're presenting? Does it make sense as an option for California?

MR. COUSINEAU: There's a lot that makes a lot of sense here. And I -- you know, the elements of this system have been discussed for many years in California, as well as nationally, and you know, I think putting it on the table from the industry is very significant.

Certainly the concept of universal coverage and sort of rethinking the tax part of it is the most troubling and most difficult part politically, but it is possible to think this thing through, and it's also difficult right now, given both the politics of California and also the looming State budget, which makes it difficult to think about new taxes, but I think they're right, and as well as the other proposal, Sheila Kuehl's proposal for a single payer, and the utility model and several others that have come forward all have some very similar elements, and I think as you pointed out earlier, does show that -- you know, that the -- I hate to say it this way, but the ice is beginning to crack as a way to try to solve this problem. So I think there's a lot here of a lot of merit.

MR. MANTLE: Tom Epstein, thank you very much for joining us from Blue Shield of California and talking about your company's proposal.

Jerry Flanagan, you wanted to respond to what Tom was saying.

MR. FLANAGAN: Just very briefly, and I'm glad Tom was able to join us today. We're happy to have Bruce Bodaken, CEO of Blue Shield, in the universal health care debate. I think it's really important that they are taking some leadership.

The one problem that we have with this proposal, similar to what we have with the pay-or-play in its current manifestation, is that if you're going to require people to buy something, you also have to then put efficiency standards on the seller. It's sort of like if GM said, "Everyone has to buy a car from me, but don't ask me how much I'm going to charge for it."

Tom said that everyone bears responsibility. The insurers also bear responsibility. They have to allow the State to say, "Here is a range of what you can charge for the product." They have to bow to cost efficiency standards. They have to have their rates that they charge reviewed. And if you do that, then you can actually greatly increase the pool.

MR. MANTLE: Well, let's bring Michael Tanner of the CATO Institute into this conversation. Michael Tanner, your thoughts on what Jerry Flanagan was just saying, that you need to have that level of government oversight?

MR. TANNER: Well, I'm bothered by several

aspects of the proposal. I think it's a very costly proposal. And I think that when you start trying to limit various prices at various levels and trying to get into that, you run the grave risk of ending up back with what you had in the utility crisis, where prices could be raised at one level and not at the other and you create shortages within.

I'm also concerned about the whole idea of trying to -- when you have a mandate for what insurance is, you then have to define what satisfies that mandate. And the experience has been that at that level, the special interests begin to weigh in and demand that their services be covered.

If you just look at the history of State-mandated benefits, or back when the Clinton health care plan was being debated, living here in Washington, you could see the advertisements running on TV every day that it's not real real health care if you don't cover mental health or chiropracty or dental care. One day you would have the osteopaths running ads saying that the chiropractors shouldn't be in, and the next day the chiropractors would be running ads saying they should be in. Ultimately the decisions on what constitutes insurance becomes a political question that's decided by the most powerful special interests, not by the health

needs of the consumer.

I think we're much better off if we give consumers more control over their money and more choices so that they can craft the type of insurance plan that most fits their needs, not the needs of whatever interest lobbies best.

MR. MANTLE: I think, though, the difficulty for so many of us is we look at health care in California; there are these competing HMOs and insurance companies, some for profit, some nonprofit; and we look in the for-profit arena, particularly at what seemed to be big profits that are being made and very high salaries that are being paid to the top executives, and you look at HMOs as a result of doctors saying they're being squeezed too much and starting to reimburse doctors more in response to that. In the meantime, premiums then are going up as a result of these other pressures in the system. And I think it seems to many Californians like if competition alone is going to do it, why isn't it doing it?

MR. TANNER: Because you have very little competition. 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. But if you took profit out of the

system, it would come at the cost of efficiency and innovation and a lot of trade-offs involved in that, and the savings, while initially would be great, would not survive the long run.

If you look at nonprofits or even at government systems like Medicare, where there's no profit involved at all, the costs are still rising very rapidly simply because the costs of health care innovations -- we have more treatments available; we have more drugs available; we have more things that the public demands. And as long as they're demanding, that's going to keep driving costs.

MR. MANTLE: But you see with Medicare, for example, you look at the administrative costs associated with Medicare, and it appears to be just a fraction of the administrative costs associated with HMOs, nongovernment HMOs. Why is that?

MR. TANNER: Well, 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. They're able to substitute other things. For example, they don't have a billing service or a collection service in the same way; they collect money from the taxpayers, so some of that cost is put off through the IRS and so on. If you actually look at costs across the entire government health care system

as allocated, it's still less than the private sector, but it's still much greater than reported.

But it's not simply administrative costs that are involved. There's a whole rationing issue. The fact is that most health care decisions are based on rationing, who's going to decide who's going to get care. Under a government system, the government rations it. Under a single-payer system, the government rations it. Under insurance systems, HMOs and so on ration it.

We need to move back to a consumer-based system in which consumers decide how much health care they want and how they're going to pay for it.

MR. MANTLE: We're talking with Michael Tanner of the CATO Institute, where he's research analyst focusing on market-based approaches to health, welfare, and other entitlement programs.

With us in studio, Dr. Michael Cousineau, associate professor at the USC Keck School of Medicine, and Jerry Flanagan, consumer advocate and Northern California director for the Foundation for Taxpayer and Consumer Rights.

Universal health care in California. Might it be a reality? What kind of model might be used? We'll continue our conversation and take your phone calls at 866-893-KPCC. Is there a model that you find most

compelling among the various proposals that we're discussing? 866-893-KPCC. This is Air Talk.

(Station break for advertisements.)

MR. MANTLE: This is Larry Mantle. We're discussing various proposals for universal health care in California, the argument being that if you can extend the pool of people insured, still have some kind of a system of cost control in place, that you could keep services at a healthy level and at the same time bring down the costs of providing medical services.

Clearly there's a big problem with the way health care is provided not just in California, but nationally, and so that's really heated up the debate over how best to serve consumers and at the same time provide for innovation, hopefully have some kind of competition that might spur better health care services, and provide patient choice, as well. We're at 866-893-KPCC. We look forward to having you join us.

Steve Thompson is the vice president of government relations for the California Medical Association. Steve, thank you very much for being with us on Air Talk.

MR. THOMPSON: Thank you.

MR. MANTLE: Share with us physicians' thoughts on the process. We've had physician complaints that

reimbursements were horribly low and that under capitation contracts that doctors were having a hard time even, you know, keeping their practices open and paying off student loans and the like. It seems like HMOs have responded for the most part, but now premiums are starting to go through the roof as a result of that. What do doctors think about the solution?

MR. THOMPSON: Well, first of all, it's important to define what the problem is. And as I listened to the previous discussion, you know, there were a whole bunch of different ideas dealing with different parts of what's wrong with the health care system.

The enduring problem in California, from the standpoint of the California Medical Association, is the gross number of uninsured, which has endured through good times and bad times. We have seven million uninsured Californians; 5.6 million of those uninsured are working people or dependents of working people. And in spite of numerous proposals over the past ten years, we haven't been able to dent that number.

So the first issue that we believe should be addressed in terms of major health reform is how to cover as many of the uninsured as possible. In that regard, we support an employer mandate.

Is an employer mandate a solution to the cost

problem? Absolutely not. Everybody believes we ought to have universal coverage. Most people think that the benefits should be broad and expanded, particularly when they become patients. And so the question of cost is vitally important.

So we believe that costs should be shared by government for people that are eligible for current government programs. And I must tell you in California, between Medi-Cal, the Healthy Families program, and Medicare, 11 million Californians receive their primary health insurance through government-sponsored programs. So government has stepped up to the plate, but it has not solved the problem.

MR. MANTLE: Do you think that a single-payer plan, where the government administers the health care system -- does that at all make sense? Certainly I know the nurses' associations have become strong advocates of single-payer.

MR. THOMPSON: Well, a single-payer plan has different perceptions depending on who talks about it. Medicare is a single-payer plan and yet allows choice of either fee for service or Medicare managed care plans. So the question is should there be a single financing mechanism. Maybe in the long run, but we believe that right now that's not politically viable.

Therefore, we have supported an employer mandate, an employer mandate that would allow small employers, where it's not efficient to provide health insurance at the workplace, to join a purchasing pool, and for employers and employees to pay into that purchasing pool, and if those employees are currently eligible for government programs, to bill the federal government for half the cost.

It's estimated that there are over two million Californians that are eligible for Medi-Cal and Healthy Families that don't enroll, that they become cost burdens entirely on the safety net funded primarily through County government and State funds, and that we're basically turning money back to New York, New Jersey, and other states that have taken advantage of it.

So we think the first step is to try to cover that 5.6 million employed and dependent uninsured at the workplace, to try to use pluralistic cost financing for that, and to provide significant choices.

We agree with the gentleman from the CATO Institute that there needs to be more consumer choice in the current system, and that choice should at least involve how to use dollars on an ambulatory basis. We certainly don't think consumer choice has any part to play if you're going in for heart surgery or in the hospital,

but it does have a big role to play on selection and use of ambulatory services.

So in addition to the current models, the HMO, the PPO, or even the indemnity model, which are the three basic health plan choices, we think concepts such as the medical savings account that allows individuals to select ambulatory services make infinite sense.

MR. MANTLE: All right. Steve Thompson, joining us from the California Medical Association, where he's vice president of government relations.

Your thoughts, Michael Cousineau, on the plan that CMA is talking about?

MR. COUSINEAU: Well, as Mr. Thompson said, they are supporting the pay-or-play approach and with the employer mandate, and I agree with Steve that covering the, you know, seven million uninsured is critical. And I think that's really what we're talking about. The question is how you do it.

And the public programs that he mentioned can play a bigger role right now in beginning to close that gap, and right now the complexity in the, you know, seven or eight different programs that are out there is actually a barrier to many people even getting enrolled now. And what I know the physicians and the hospitals and others are concerned about is continued deterioration of those

programs as a result of the State budget that's going to reduce reimbursement rates to physicians and possibly hospitals that's going to probably push even more people out of the system.

So I'm concerned about holding on to what we've got, and I agree that we do have to close that gap, and I think the employer mandate right now, at least in the short term, is a good way to do that.

MR. MANTLE: Jerry Flanagan?

MR. FLANAGAN: Well, I agree with 98 percent of the stuff that Steve Thompson was talking about. And I guess just like with the Bodaken proposal, Blue Shield, if you're going to mandate that someone buy something, you also have to mandate on the seller that they have a controlled price. If you don't, then there's no way the small employers are going to be able to afford the coverage for the employees, which means they'll have to pass the costs on to the employees, and the effect will be for consumers is what I'm worried about, is they'll be paying more out of pocket.

MR. MANTLE: I thought Steve Thompson, though, was talking about a much larger pool that smaller employers would be able to buy into so they get the buying power of a bigger organization.

MR. FLANAGAN: That's true. So they could buy

into the State pool. But for those that are outside of that mechanism -- many employers, obviously, already provide benefits right now; it's unlikely that they would choose a State pool, at least initially, and they would be subjected to increased premium costs and pass those on to employees without controlling HMO profits.

Just one point on the former gentleman, Mr. Tanner. One thing we've really discovered, doing a series of town halls around the state, is that people want more control about how the dollars in health care are spent, making the decisions not politically, but as a society. Where are the problem areas? What are we going to do with the money we have?

The other thing that's resoundingly clear is that there's enough money in health care right now to insure everyone in the state, but we're spending it very inefficiently. So a system that deals with grabbing the money in health care and putting it in places where it's best used will make sure that everyone in the state pays less for health care, because when everyone's insured, the cost is cheaper for everyone.

MR. MANTLE: We'll continue our conversation on universal health care proposals for the Golden State. We're talking with Michael Cousineau, associate professor at the USC Keck School of Medicine; Jerry Flanagan of the

Foundation for Taxpayer and Consumer Rights; Michael Tanner of the CATO Institute; and we've also been talking with Tom Epstein of Blue Shield of California; and Steve Thompson of the California Medical Association.

We'll take your phone calls as we continue on 89.3, KPCC, Southern California Public Radio, broadcasting from studios at Pasadena City College.

(Station break for advertisements.)

MR. MANTLE: Universal health care for California is our topic today on Air Talk.

Alex in Glendale, welcome to Air Talk.

CALLER ALEX: Oh, thank you so much, Larry. I've really got a fire in my belly about this topic. I'm so glad that you're talking about it.

MR. MANTLE: Good.

CALLER ALEX: I really want to talk about choice, because I think this is -- it's really a function of how much you're able to pay and then having doctors -- if the doctors are able to take you.

I was lucky, because I lived in Texas and was teaching in Texas for a short time last year, and when I came back, our fees here had gone up 40 percent; right? So I really saw that, because I came in and back out.

Also, when I was in Texas I was in Blue Cross and paying a very high premium, but I couldn't get a

doctor to take me because they would ask me, "Well, are you going to be a long-term patient?" And I couldn't say yes, because I was on a short contract. And they said, "Well, we can't take you." So then I ended up also going to emergent care and paying them, you know, over a hundred just to get a normal checkup.

So I think it's disingenuous to talk about choice and talk about consumer choice when you're paying over $200, someone who's in very good health, who's never had any health problems.

And I was very lucky. When I was a kid, I lived in England and I saw how universal health care worked there. And not only does it pay for prescription and operations and such, but even my great aunt, who was very elderly and had gone in to have something done, once she came back, they also sent out, I think, young med students who would go around and check on people, make sure they were doing okay.

And I think if we thought about things like subsidizing schooling for doctors, if they go somewhere and do service in the inner city or something, we could forgive their debt. And I think this would go a long way toward helping the problem of their incredible debt and their thinking, you know, "We have to make all this money because we owe $200,000 in school loans," or something.

So I really --

MR. MANTLE: Okay.

CALLER ALEX: -- hope that -- could I ask you, also, because -- I'll get off the phone.

MR. MANTLE: Sure.

CALLER ALEX: Could you tell us if we want to work for universal health care as a volunteer, whatever, who can we -- you know, where can we go on the net or what can we do? Who can we talk to?

MR. MANTLE: Okay. Jerry Flanagan, I think, would be the guy to talk to about that.

MR. FLANAGAN: Yeah. I would be pleased to talk with you. You can go to us on the web at www.consumerwatchdog, all one word, .org, and there is an option there to sign up as a volunteer. And you can also contact me through that website, and we're certainly looking for folks that want to work on this issue, so I'd be glad to talk with you.

MR. MANTLE: And Michael Cousineau?

MR. COUSINEAU: There is a new program sponsored by the Robert Wood Johnson Foundation called Covering the Uninsured Week. I believe they have a web page, as well, if you go to the Robert Wood Johnson Foundation, and they're hooked to something called Families USA in Washington, D.C., that also hosts several proposals and

ideas for universal coverage.

MR. MANTLE: Michael Tanner of the CATO Institute, your response to Alex's call that there really isn't choice even today?

Michael, are you there?

MR. TANNER: Yeah. I agree that there is far less consumer choice than we would like. Most people get their insurance through their employer and their employer limits them to a single plan, so about 40 percent of people don't have a choice of plan. But there are still ways around that, which there are not available under national health care schemes.

The caller talked about England. They've made a decision under their universal budgets over there that their national health care plan, for example, will not pay for kidney dialysis on patients over the age of 55. So if you're over the age of 55 and you can't get private insurance -- about a third of Britains are privately insured to avoid this -- you simply are going to die, because they've decided that's not where they want to expend their health care resources, and they've made that as a political decision and you're locked into it. So I'm not sure that that sort of universal budgeting, global budgets, is what we want to go to in this country.

MR. MANTLE: All right. Either of you gentlemen

want to respond to that?

MR. COUSINEAU: I think the key, again, 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.

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 and --

MR. MANTLE: Well, I just want to say, though, you know, we made that assumption in Los Angeles County about going to an outpatient clinic basis, that that was going to save all this money from emergency room care, only to find that there were a variety of other cultural barriers to care beyond access to clinics. So the study may indicate that while you'd have people going in for preventive care, but people actually doing it is another thing.

MR. COUSINEAU: Yeah, and I think that the one

Steve raised earlier was really interesting, Steve Thompson of the CMA. By having a State pool that your employer tells you about and helps to overcome those cultural barriers and we create it as a -- not as a strange and somewhat questionable program for the poor folks, but it's a program run by the State that has great benefits and it's something that we support as a society, then it makes it easier to overcome those barriers.

MR. MANTLE: Let's talk next with Wise in Long Beach. Good to have you with us on Air Talk.

CALLER WISE: Hello?

MR. MANTLE: Hi, Wise.

CALLER WISE: Hi. How you doing?

MR. MANTLE: Good.

CALLER WISE: Okay. I have a situation where I'm born with a congenital heart defect, and I'm a very productive member of society. I'm college educated, but I find myself being discriminated against because of my health condition when they find out I do have it. So what happens is I get pushed out of a job.

If we had universal health coverage, I can have a job that I enjoy without being discriminated against and be more of a productive member of the society. And I feel like I don't have that. I'm constantly following health insurance companies or jobs that have insurance rather

than something I really want to do.

MR. MANTLE: How many Wises do you think are out there, Michael Cousineau?

MR. COUSINEAU: Many, many, many. And you know, because of HIPAA, some recent federal changes, it's more difficult for some companies to discriminate against people such as him and for people who are employed.

But I've heard from brokers that 40 to 50 percent of people who come to them saying, "I want to buy health insurance in the private market" are not able -- they cannot actually sell them because they can't find a carrier to actually sell insurance to them because of a preexisting condition, even not only talking about a person with a congenital condition as the caller, but someone with a case as simple as, "I've been to the doctor once or twice in the past year." Based on that, people are being denied purchase of health insurance.

So underwriting reform, health care reform, has to occur very quickly. We're precluding people right now from the market who want coverage.

MR. MANTLE: Real quickly, because we're short on time, Shawna, who I understand is a nurse, thank you for joining us on Air Talk.

CALLER SHAWNA: Hi. Thank you. I'll try and --

MR. MANTLE: Yeah. Be really brief, please.

CALLER SHAWNA: Yes. I'd just like to suggest that those people looking into what to do next look at the government's two experiments in universal coverage, one being IHS, Indian Health Service -- which I am an American Indian who participates in that -- and also Medicare. Because any nurse pretty much will tell you that when DRGs, Diagnostic Related Groups, came in with Medicare, that changed everything, and the compassion in health care went out the window, because the DRGs began to be the way that doctors practiced medicine because that was the only way they could get reimbursed. And then the insurance companies accepted that.

So when the government gets involved in saying, you know, "We're going to say who we cover and how we cover it" -- I actually participated in comments to the Commission on reviewing the RN-to-patient ratios and made the same comment. When you're looking at universal health care, will you please look at the government's experiments in those. Really look at them.

MR. MANTLE: Okay. So you're not a fan, obviously, of how the government has administered the two programs that you mentioned, and I think there's a fair amount of skepticism about the government's ability to do it, and that probably makes the single-payer model the most difficult politically to sell to the public, despite

the fact those that favor it are very passionate in favor of the single-payer model.

I thank you very much for your call, Shawna. Thank you for being with us.

Michael Tanner of the CATO Institute, thank you, sir, for spending this hour with us on Air Talk, and we look forward to talking with you in the future, as undoubtedly this debate isn't going anywhere. We'll be talking about it in the future, certainly.

MR. TANNER: Anytime.

MR. MANTLE: Thank you so much.

Dr. Michael Cousineau of the USC Keck School of Medicine, thank you very much for being with us, sir. We appreciate -- you've done this before, and we know we'll be talking with you again, as well.

MR. COUSINEAU: Thank you.

MR. MANTLE: And thank you, Jerry Flanagan, of the Foundation for Taxpayer and Consumer Rights.

MR. FLANAGAN: My pleasure.

MR. MANTLE: I appreciate your joining us.

(Closing credits not transcribed.)

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) ss:
COUNTY OF SOLANO)

I, DENISE L. DOUCETTE, CSR 5963, RDR, CLVS, FAPR, a Notary Public commissioned in the County of Solano, State of California, hereby certify that the foregoing Pages 1 through 41, inclusive, represent a full, complete, and true transcription of audiotaped proceedings represented to me to be a radio broadcast conducted on Thursday, February 6, 2003, by KPCC, 89.3 FM, Southern California Public Radio, 1570 East Colorado Boulevard, Pasadena, California 91106, transcribed to the best of my ability to hear and comprehend said audiotape recording.

I further certify that I am not related to any of the parties in the foregoing action or in any way interested in the outcome of the cause herein. I have hereunto set my hand and affixed my seal this 23rd day of March, 2003.

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DENISE L. DOUCETTE, CSR 5963