

## **Introduction**

I had the pleasure of writing a guest column for *The Seattle Times* for four years from 2000-2004. I pulled them out recently and was stunned at how they could just be run again today. Some of the numbers have changed, some of the companies are now longer here, the conversion of Premera from a non-profit to a for-profit did not happen. Some of the people and jobs have changed, but it was stunning to me that seven years later we are still discussing the same issues. We have different Presidents and different governors.

We finally have a chance with the Affordable Health Act to remedy some of these systemic problems. I will be writing about current health care reform as we go forward. I wanted to share these snapshots so we know why we need reform.

Ultimately, health care reform is a very emotional issue. As Joseph Ross said in his 2002 article in the *Einstein Quarterly*, 2002 in talking about the demise of the 1932 Committee on the Costs of Medical Care: “*The debate became a war of alliances rather than reason. This is best evidenced by Dr. William J. Mayo, one of the founders of the Mayo Clinic who declared his intention to support the AMA and Minority Recommendation No. 1, despite the fact that the Majority Recommendations exactly described the fact that the then current Mayo Clinic.*”

Many warmest thanks to Jim Vesely, then Editorial Page Editor of *The Seattle Times*, who believed in my voice. Working with him for those four years was one of the delights of my life.

I offer this collection in the hopes it sheds light and reason during this debate. Heaven knows we need it.

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## **War of words: A call for new direction for nation's health care**

**by Kathleen O'Connor**  
Special to The Times

Doctors are unionizing, surgeons are leaving Regence Blue Shield and now, you can pay extra money to Virginia Mason to buy time we all used to have with our doctors.

Vice President Al Gore and Sen. Bill Bradley are duking it out on who has the best health-care plan, who they are going to cover, and what it costs.

In Olympia, insurers, consumers, employers and elected officials are duking it out over individual insurance policies. This war of words is only going to get worse. Why? Because, simply put, we do not have a health-care system. We have armed camps. Here are six core facts that contribute to this divisive climate.

### **Fact No. 1: Health care is America's Balkans**

Health care oozes intrigue and shifting alliances. The adage "the enemy of my enemy is my friend" is probably the best way to understand "the system."

Today, doctors and hospitals have a wary alliance against insurers and government programs that cut rates, but they compete for money on other fronts with equipment and services.

Nearly everyone now is fingering the pharmaceutical industry for its profits and costs. But, hardly anyone is looking at whether or not drug costs reduce other costs, such as hospitalizations. Most insurers cannot do a cost benefit analysis because patients are either not in their system long enough to measure the impact or they cannot get access to the medical records in myriad physician offices. Or both.

Employers are relatively predictable wild cards. When the economy is good or the labor market tight, they heap benefits to get and keep employees. During recessions, they cry foul and blame insurers, doctors, hospitals and consumers for rising costs.

The public-health system has specific goals and objectives to promote the health of communities, track epidemics, treat low-income clients (sometimes), and assure our food, restaurants and water are clean. Commercial health insurers and most employers virtually ignore the public health-care system.

We have Medicaid for people with incomes below the poverty level. We have Medicare, for those over 65 or disabled, but it basically only covers hospital costs, some nursing home costs and some home health care. Private Medicare supplemental insurance covers what Medicare does not - doctor visits and sometimes prescription drugs and other costs. Congress decides what Medicare covers. Medicaid is shared by the states and the feds.

Governments often think hospitals, doctors, pharmaceutical companies and insurers are unscrupulously greedy. Their key weapons are rate reductions and reams of regulations.

We have community and neighborhood clinics that serve low-income patients who might not have public or private insurance. They are also largely ignored by insurers and employers. Insurers sell benefits to employers and individuals. Premiums are based on what actuaries tell them about the health patterns of certain groups of people, based on their age, gender and size of groups and sometimes, occupation.

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Like bookies setting odds, actuaries determine the risk - the odds of illness and diseases in these groups - and put a price on it. The smaller the group, usually the higher the cost. This is, in large part, what the fight boils down to over individual policies: who is in whose risk pool.

Insurance premiums have not been covering costs, so rates are rising again. But, even platinum companies like Harvard Pilgrim Community Health are in financial receivership.

And then, the big guns: self-insured employers who are essentially their own insurance companies. Accountable to virtually no one, they offer what they want in the way they want to offer it. Because they are not insurance companies, they do not have to pay state premium taxes the commercial insurers pay. They are also immune from any state legislation on what is in health benefits, such as mammograms, mental health or other so-called "mandated benefits."

Half of all people with insurance through their employer work in these companies.

Consumers? They fit in here somewhere, but now are like refugees simply trying to dodge the cross-fire. They are often vilified as the reason costs are so high, because they don't take care of themselves, use other people's money (employer's) to pay for services and expect doctors to take every last ditch, heroic measure.

Because we do not have a system of care, no incentives exist to work together. When one group gets money, others don't. Each group is pitted against each other for its own economic survival.

### **Fact No. 2: A shoddy return on a big investment**

We pay more for health care than any other country. In return, we have lower life expectancy for men and women, higher maternal and infant death rates and lower rates of childhood immunization than Japan, Germany, Britain, Italy, Canada or France. We remain the only nation in the economic Group of Seven that does not cover all its residents. We spend more than \$1 trillion per year for health care, or nearly 14 percent of our gross domestic product.

### **Fact No. 3: Health care is not undergoing rapid changes**

The only real major changes have been technological, scientific, medical and pharmaceutical/biomedical. In 1932, the Committee on the Cost of Medical Care said U.S. health-care costs were so high because we had too many infectious diseases, too many medical specialists, a disease-oriented system of care vs. prevention and lacked a community-focused health system - all this before wonder drugs and antibiotics, which offered the first cures for diseases.

Now, we have infectious diseases resistant to those drugs, nearly 80 percent of our doctors are specialists and we still do not have a community-focused health system.

We really still have a disease-based system parading in a "prevention" mask. Our "managed care" and "prevention" programs are basically only early diagnosis and screening. If prevention is done, it is largely through some hospitals, community clinics and the public-health system. Most insurers shun prevention programs because they are costly and long term. The average consumer is in a health plan about three years.

Insurers fear other insurers will reap the benefit of their up-front financial investment. They also fear promoting prevention programs for diabetes or asthma. If too many people sign up, it will increase their costs and their premiums, making them less competitive.

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The changes we see are payment fads. These fads drive up our costs because we keep changing courses and adding rules and regulations.

### **Fact No. 4: Rates, regulation and body parts**

Because no vision exists for what a system should do, we substitute cost control for policy directions.

Because our public and private health insurance stem from a disease/fix-it model, we resort to legislation to get coverage for prevention or early diagnosis programs. Groups lobby for mammograms, prostate screenings, alcoholism or mental-health programs, or lobby against "drive-by deliveries."

This body-part approach only serves to pit employers and insurers against consumers and providers and breeds further entrenchment, animosity and distrust. It also diverts attention from what could be done to serve employer, patient, insurer and provider or how to inject responsibility and accountability into a system of care.

### **Fact No. 5: We use health benefits as wages**

We are the only country that uses health benefits as employee compensation. During wage/price freezes after World War II and during the 1970s, employers gave health benefits when they could not give raises. Like giving employees tickets to a ball game - the employees may not have wanted to go, much less buy tickets - but now that they have them, they will use them. The message in this approach is: use it.

Greater use means greater costs. Other nations in the Group of Seven believe it is to their benefit to have a healthy, productive work force and society. Modern health insurance started in Germany before World War I so German companies would have healthy, and therefore, more productive workers.

We nearly adopted that model, but war erupted.

### **Fact No. 6: Health policy - sound bites not vision**

Any discussion about change rapidly arouses the two most visceral ideological camps: single payer vs. medical savings accounts. Any attempt at change, no matter how incremental, is lost in the noise of these two extremes.

Because the spaces between these two camps are littered with special interests - consumer groups, employers, insurers, pharmaceutical manufacturers, hospitals and doctors - no easy way exists to make substantive change.

Addressing one group's solution only serves to alienate one or more of the others. To keep them at bay, and get elected, candidates are often reduced to sound bites they think their voting and donating constituencies will understand.

Seniors vote more than other groups and are well-organized, so we hear much about Medicare. Medicare does not cover prescription drugs, so most candidates will now try to despair of pharmaceutical and insurance costs, without being so extreme as to alienate those affections and cash contributions.

Fifteen years ago, candidates flogged "money-grubbing hospitals," next came "wealthy, overcharging doctors." Villains simply change with the times.

We have a crisis in terms of availability, cost and quality of nursing-home care for our elderly, but it is not as glamorous as rising drug costs or as prone to sound bites. We debate solutions, arguing whose approach is right or wrong. Sound bites, like stereotypes, contain a modicum of truth, but are barriers to a

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rational public discussion of what we should expect from a system, how we can organize it and how best to pay for it.

### **We need to talk**

We need to start from scratch.

We are doing the wrong thing. We have been trying to Rube Goldberg something that is impossible to fix. You can't fix something if you don't know what it is supposed to do.

Just as wars are too important to be left to generals, health care is too important to be left to the industry or government. We need people to decide what a health-care system should do for us and our families and to determine the results we want in our cities, our states and our nation.

We have never done this - as a community, a state or a nation. We need new words, new ideas and new directions. Right now, we are stuck tinkering with dead languages. Tinkering hasn't worked. It will not work.

All politics is local and all health care is local. Workable solutions must come from where we live and work. How things work in Omak and Yakima differ profoundly from how things work in Seattle or Spokane.

We need to share our ideas with each other in our places of worship, workplaces, reading groups, or civic clubs and organizations. We need to hold citizen forums.

If we take off our official hats and ditch our official language, we will find more in common than we imagined - for ourselves, our partners, our children, our parents, our loved ones. We don't need any more task forces that only ask us to respond to another set of tinkers. We need to talk about what health means to our families, our communities, how to get it and then be invested in those changes.

Money must come last. Only after we have decided on what we want can we design ways to pay for it. We have all the pieces. We should pay for it as we do now: employer, consumer, insurer and government. France, Germany and Japan do this. Like us, they have private insurance, public insurance and self-insurance, public-health and community clinics and private hospitals and doctors. They are organized, not socialized.

We'll need a plan to get from here to there. Businesses create strategic plans to reach their goals, but only after they have a vision and mission.

Radical? Certainly. But, so is the Internet. Will this work? Nothing else has - not rate-cutting, not Medicaid, not Medicare, not the marketplace, not the fad of managed care, not even a Patient's Bill of Rights.

But, without a system defined by communities, we will remain Balkanized and be held hostage to intractable groups and the latest cost-control fad.

So, let's start talking. Now.

Guest columnist

## **Health care for the economy**

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By **Kathleen O'Connor**  
Special to The Times

What if health-care reform were a straightforward question of jobs, America's national economic interest and our international competitiveness? It is. Just look.

Here's the quick end of the story first. Administrative expenses devour a 150-percent larger share of America's health-care spending than our competitors in the Economic Group of Eight.

If we reduced this to only 25 percent more on non-care expenses than the worst of our competitors, the American economy would save \$300 billion every year. That's twice the annual tax savings claimed for the Bush tax cuts.

Put another way, these savings happen if our level of administrative efficiency were just 25 percent worse than most of the rest of the world. If we achieved equal efficiency, we'd save \$400 billion a year.

Best of all, these savings wouldn't reduce spending on care delivery or medicines, leaving our quality of care and technological edge unaffected.

How many jobs would \$300 billion savings create? How much more competitive would our products be?

How much more productive would we be as a nation, if we had generally healthier people who did not live in fear of losing their health-care benefits or of facing medical bankruptcy?

Health-care cost is the albatross hanging on the neck of the American economy. If companies have 10 to 20 percent annual health-care increases, they certainly aren't going to give raises or add new jobs.

We spend 14 percent of our gross domestic product on health care, but we don't cover everyone. Our competitors spend about half that and manage to cover all their people. We spend \$1.4 trillion, or nearly \$5,000 for every man, woman and child, and leave over 40 million hard-working Americans without coverage. In return for that investment, we ranked 37th in the world for our health outcomes, below Singapore, Chile, Cyprus and Costa Rica, according to the World Health Organization in 2001.

Actually, we don't spend \$1.4 trillion on health care; only about \$825 billion actually goes for patient care. Take a look.

About 31 cents of every American health-care dollar goes for administration. Another 10 cents goes for other "non-care" expenses. That's a total of 41 cents for non-care expenses, according to a study in the *New England Journal of Medicine* in August. (This does not include medical-malpractice costs, which would add another 4 or 5 cents). The worst case among our competitors is about 15 cents per dollar for non-care expenses. That means the part of our health-care dollar spent on bureaucracy is two and a half times more than our competitors. Put another way, we are 250 percent less efficient.

So, if our administrative costs were reduced to 20 cents per dollar (versus 15 cents elsewhere), we'd save \$300 billion every year. If we equaled the administrative efficiency of our competitors, we'd save \$400 billion a year. The \$825 billion we currently spend for patient care would remain unchanged.

This is theoretical, of course. Much of our political establishment and many deep-pocket special interests have huge stakes in the status quo. These savings are not an abstraction. All our economic peers and competitors can do this.

But what happens when we try to discuss this? The knee-jerk "socialized medicine!" mantra. That universal coverage means "socialized medicine" is hogwash.

Most of our competitors give more control for private-sector care providers than we do and they rank higher in health outcomes. Even Canada. Our health care could just as easily be called "privatized socialism" because private entities (versus the government) dictate which doctors we can see, how much they can charge and the kinds of medicines they can prescribe. Does that happen in Canada, France, Germany or Japan? Of course not.

This private-sector bureaucracy is the major culprit and significant reason for the economic strains on our businesses and our provider practices.

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Think about it. More jobs are going overseas through "outsourcing." We have lost 2.5 million manufacturing jobs since 2000. With 25 to 30 percent of their payroll going for health insurance, companies will do more outsourcing. Higher health-care costs mean more job creation over there — not here.

What's happening here? Loss of domestic jobs and no wage increases because of health-care costs. Our products are also less competitive, with a larger share of costs going to health care than is the case with our competitors.

When we talk about health care, all we do is talk in ideologically driven terms rather than focus on what is economically viable. Change is summarily dismissed as "socialized medicine," which derails the real debate.

How long will we accept name-calling to protect the status quo? Are you better off with your health care than you were 10 years ago? Are you better off economically than you were five years ago? It's time we changed the terms of the game.

Guest columnist

### **Balancing the budget on the voiceless, the sick**

By **Kathleen O'Connor**  
Special to The Times

State after state is doing the same thing: balancing their budgets off the backs of the poor, the frail and the old.

Missouri cut 32,600 adults from Med-icaid this year and cut some women's health services, such as postpartum care. Kansas reduced home health services. The Mississippi Legislature at one point proposed balancing the budget by cutting 13,000 Medicaid nursing home beds and even overrode the governor's veto, until they reached a compromise after session. They are back now in special session.

The irony is that for every Medicaid dollar cut, the states also lose the dollar federal match.

In Washington, we moved 28,000 immigrants off Medicaid this year to save money. They were offered coverage under the state's Basic Health Plan (BHP), where they share more of the cost, but even that is in jeopardy in 2003 when the state's deficit will be worse.

Medicaid is the fastest-growing part of every state's budget — increasing by 20-30 percent. But, hey, most of these people don't vote or donate to political campaigns.

What are we cutting? Of the 28,000 people we removed from Medicaid this year, 25,000 are children. They don't vote.

And if you are in a Mississippi nursing home, where patients suffer from dementia and require total care, you can bet they don't vote, much less donate. Exactly where will these people go? Or do we care?

Unless changes are made in the existing federal law, 900,000 children nationally will join the ranks of the uninsured. But, hey, children don't vote. If their health interferes with their learning, so what? The fact that literacy has a direct relationship to juvenile delinquency must not factor into these decisions. Besides, the kids will end up in the corrections budget, not Medicaid.

What is ludicrous is the assumption that the "safety net" can serve those without insurance. We have over 700,000 people in this state now without insurance. Who is going to serve them? Hospital emergency rooms? No way near enough space, time and staff, and way, way too expensive.

Physicians? Forget it. Many aren't taking new Medicaid or Medicare patients right now. Their margins are so low they can't afford to treat uninsured patients. So, no room in that inn.

We also face a \$300-million shortfall in the account that funds the Basic Health Plan. Where will people go if slots in BHP are lost? Certainly not to Medicaid. Add to this the looming \$2-billion shortfall in the

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state's general fund revenues over the next biennium. This is not only not a pretty picture, it is a brutal one.

So we do the shell game: education, public safety or health care. Your child's school, prisons, or your mom's health care? These are the choices we are forcing ourselves to make. We have locked ourselves into making these either-or choices.

The real tragedy is lack of leadership. Everyone simply says there is not enough money and voters don't want taxes. Everyone is frozen like deer in the headlights of this speeding cost semi-truck, because choices are too hard. We need a new voice.

What really needs to be said is that these are not acceptable choices. We need to have health security, not just social security. We need to be able to protect those in our society who cannot help themselves. Or, we can put our elders on ice floes and wave goodbye.

We are balancing the budget off the poor, the frail and the old. They don't have a voice, don't donate, and many can't vote. Do we really not care what happens to them?

I don't want to live in a society that balances its budget by sacrificing the most vulnerable. But that is exactly what we are doing, state by state across this once great country.

Yes, there are competing needs. So, let's start with setting explicit priorities for what we want as a state and a nation and then collectively figure out how to get there. We have let politics become us vs. them. We have demonized government and each other and have lost sight of what we want as a community and a society. We blame the poor for being so, yet depend on them to take jobs most of us don't want. We don't put people in insane asylums anymore, because the asylums were inhumane; we simply put them on the street and avoid the alleys they sleep in.

We want quality education, but how can you have quality education when children are unhealthy and fail to learn? Are we willing to build more and more jails to house children who become crooks because we never invested in them when they were young?

We're citizens of the same state and the same country, but partisan politics has made us into enemies. We are reasonable people who simply have different points of view. We must start rowing together now to save this ship of state. Otherwise, we will simply be deciding to toss the poor, the frail and the old in the water first, before we turn on each other and sink the boat while fighting to control the rudder.

Guest columnist

### **Where health-care dollars go**

By **Kathleen O'Connor**  
Special to The Times

While businesses and individuals are paying more and more for often fewer health-care benefits, we thought we would take a look at where some of those health care dollars go.

Last year, over \$1.136 million of your health-care-premium dollars went to Herbert Randle Brereton (Gubby) Barlow, president and CEO of Premera Blue Cross. That salary was up from \$1.074 million the year before, even though his income from "all other compensation," presumably retirement and other non-cash items, was down \$65,000 from 2000.

In fact, if Premera were a publicly traded company, Barlow's salary would make him the 13th most highly paid executive in the state, based on cash compensation, as ranked by Washington CEO's "Top 50 Highest Paid Executives" (September 2001).

As of July 2001, Premera was not even the largest insurer. Regence Blue Shield had 1,103,991 members plus another 268,450 from self-insured plans, for a total of 1,372,441. Premera had 903,487 members, plus another 82,497 from self-insured employers for a total of 985,984 members. Premera has 386,000 fewer members than Regence, yet still can afford to have almost double executive salaries?

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Why is this interesting? First, Premera has indicated it wants to convert to for-profit status. Second, their salaries are not just different, they are wildly different from the other health plans.

Mary McWilliams, CEO of Regence, earned a puny \$421,861 in 2001, up from \$317,686 in 2000. Cheryl Scott, CEO at Group Health Cooperative, received \$553,170 in 2001, up from \$483,888 in 2000. But, she just announced she will take a 20-percent cut, so she's down to \$442,536 now, in league with Regence. With this salary, she would rank No. 50 and knock Steve Gillis of Corixa off the executive compensation list.

The figures are based solely on the cash compensation of the executives and exclude stock options and other non-cash compensation, which is why Bill Gates is not in the top 13. He receives only \$639,000 in cash compensation, which places him at No. 25 in terms of compensation of the Top 50.

In nearly every category of comparison, Premera executives are paid nearly twice — or more than twice — what their colleagues are paid at Regence and Group Health. Here are a few examples rounded to the nearest thousands, according to annual reports filed with the Office of the Insurance Commissioner:

### **• Corporate counsel:**

*Premera*, Yoram Milo \$731,000;

*Group Health*, Rick Dale Woods \$264,000;

*Regence*, Joanne Long \$166,000;

### **• Medical director:**

*Premera*, John Castiglia \$447,000;

*Regence* Jeffrey Robertson \$241,000;

### **• Chief actuary:**

*Premera*, Andrew Bao-Hwa Wang \$694,500;

*Regence*, Robert Rueder \$184,000;

### **• Vice president sales and marketing:**

*Premera*, Corbin Marion Butler \$556,000;

*Group Health*, Maureen McLaughlin \$271,000;

*Regence*, Martin Andrews \$209,000.

In light of the fact that Premera has declared its intention to convert to a for-profit organization, I think those overseeing the conversion should ask why there are such large discrepancies in salaries between these organizations and their peers. As a nonprofit, Premera has enjoyed huge tax breaks compared to commercial businesses.

As employers, you may wish to ask how Premera calculates its premium increases. Insurers are required by law to hold three months' anticipated claims payments in reserves. The challenge facing insurers is having an adequate reserve. However, what they can't do is have too much money lying around, or the insurance commissioner can't justify their requests for premium rate increases.

It seems to me, when physicians in our state are no longer taking new Medicare and Medicaid patients; when physician practices are in meltdown; when our employers are dropping coverage, cutting benefits and dependents because the cost of health insurance is greater than they can bear during this recession, that at some point we need to ask where our health-care dollars go. It would be one thing if these salaries were within maybe \$100,000, but these salaries do not seem to be anywhere near the industry norm in this state.

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And if these insurance companies work with "outlying" doctors whose practice patterns are significantly different from their colleagues', it seems to me, we need to ask ourselves where is their responsibility to the community that pays the premiums that helped fuel those salaries.

When Blue Cross in California converted from a not-for-profit health plan to a for-profit, it offered the state \$100 million in return for the taxes it had not had to pay all those years as a nonprofit. The state of California took a look at what it thought the benefit was to the health plan and said no deal and made Blue Cross fork over \$3.2 billion, which was put into two different foundations to address health-care access and services for the people of California. Closer to home, in 1997, the Northwest Health Foundation in Portland was formed with \$58 million when one of Oregon's nonprofit health plans was sold to a for-profit health plan.

As Premera moves through this conversion, it behooves us all to see that we are returned an equivalent value for the many tax-exempt benefits it has reaped from the businesses and individuals in this community that have kept it so very well in business these many years.

Guest columnist

### **Premera's for-profit conversion unnecessary, unwise**

By **Kathleen O'Connor**

Special to The Times

If you look at newspapers around the state, you'll see large ads about how Premera Blue Cross' proposed conversion to a for-profit company and establishment of two new charitable foundations with \$500 million in assets will really make our state a healthier place.

I beg to disagree.

We need this conversion like we need another earthquake.

Look at what Premera has done in the past 12 months alone:

- Dropped its Medicaid and Basic Health Plan lines of business and turned them over to Molina Healthcare, a for-profit health plan headquartered in California;
- Quit processing some Medicare claims;
- Was threatened with termination by Providence Health Care in Eastern Washington (and they're still in hardball negotiations);
- And had a bitter negotiation battle with Multicare Health System in Pierce County that worked out, but had another bitter negotiation with state employees that did not.

Local company with local interests, as its CEO is fond of saying? This is hardly Mister Rogers. And if the company is not willing to negotiate acceptable rates with a group as large as the state employees, whom will it negotiate with?

Premera leadership says these negotiations and coverage decisions are unrelated. Perhaps so. But perhaps what they are related to is making more profit so Premera can pour more Washington and Alaska dollars into LifeWise Health Plan of Arizona, a Premera subsidy that is now offering its first line of health insurance in Arizona.

In its first 2002 filing with Arizona's Office of Insurance, LifeWise listed assets of \$10.5 million. Where did that money come from? More than \$5 million came from the Medical Services Corporation (MSC) in Spokane. Premera was formed after the 1998 partnership of MSC and Blue Cross of Washington and Alaska.

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And the corporate leadership for that Arizona company? It's the same Washington and Alaska executive team that heads Premera. The only new executive listed in Arizona is Cliff Klima, president and CEO of LifeWise of Arizona.

Premera's ads suggest its proposed charitable foundations can help address Washington's and Alaska's unmet health-care needs, such as nurse training.

Do we have a nursing shortage? Yes. Do we have a shortage of other health professionals? Yes. Do we need more services for low-income folks? Sure we do. Is the conversion the way to solve these problems? No. Will the conversion give us a healthier future? No.

Of the 14 Blue Cross Blue Shield plans that have converted to for-profit status, 10 have been devoured by Wellpoint and/or Anthem — major national for-profit insurers.

Would they care a whit about Washington state or Alaska, if they purchased a new for-profit Premera? Ask any of their stockholders, who care more about return on investment, or their service representatives the next time you are on hold.

So if you are a grocer in Yakima, or an orchardist in Chelan, will a for-profit Premera care about your community?

If Premera is dropping Medicaid, Basic Health Plan and state employees — and playing hardball with Multicare and Providence Health Care — what makes anyone think it cares about the marketplace, the businesses or the people in Washington and Alaska?

Sure, we have a nursing shortage, but there are other ways to solve it than depending on money from Premera's proposed foundations.

The director of nursing at the Veterans Administration in Seattle had a great idea some years ago. She went to low-income human-services programs, and found some women who wanted to make a difference. She covered their education to become licensed practical nurses, then hired them at the VA. After a few years, she helped them go back to school with scholarships to study to be registered nurses.

Then there's a colleague in Florida who wants to start a vocational village where unemployed people could live and work together, help each other with cooking and day care, and get grants to go to school for a nursing degree or other allied health profession.

There are ways to solve the shortage problem or ways to cover the low income. This conversion is not the solution.

Guest columnist

### **We can corral health costs by keying on prevention**

By **Kathleen O'Connor**

Special to The Times

Several years ago, I sat next to a veterinarian from Yakima. His specialty was the care and treatment of beef and dairy herds. When I asked him if ranchers had health insurance for those herds, he simply replied: "No. We have to rely on prevention to avoid the high costs of treating sick animals."

It seems that ranchers and dairy farmers have figured out something we haven't. It's cheaper and better to focus on disease prevention than disease intervention.

What would a health-care system look like if we had that same goal? Right now we have a business-to-business enterprise in which employers buy insurance and insurers sell it. Our health-care benefits depend on the job we hold. In most cases, we have health care only when we have a job. Losing our jobs usually means losing our health insurance.

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In Everett, one out of 10 babies leaves the hospital without a pediatrician. In Chelan, the most common reason children miss school is because of toothaches.

We will pay billions of dollars to fix what is wrong with us, yet we do not invest in the most important asset this country has: the people who fuel this economy. We will spend in excess of \$30,000 to rescue one low-birth-weight baby, usually with taxpayer dollars, but not \$5,000 for the prenatal care and delivery that in most cases would have prevented a low-birth-weight delivery.

We spend over \$1 trillion a year on health care — the same size as the federal budget. And what do we get in return? We are ranked 37th in the world for the quality of our health outcomes and 32nd for the quality of our child survival.

We can continue our entrenched arguments like the Hatfields and the McCoys about whether our health-care system should be privatized or socialized. But that misses the point. We need to have a health-care system that has a goal and promotes the health and well-being of our people.

Cattle are immunized, appropriately fed, sheltered in storms and monitored when pregnant. These herds are an investment. Are people no less?

But we don't worry about maintaining the health and well-being of our people and hardly the health of our communities. We argue about cost and who is causing it, then blame the sick for being so. We have prolonged life by 20 years with new technologies and medicines, but as Bastyr University Associate Dean Pamela Snider says, we have not prolonged health.

If we are going to discuss what we need from a health-care system, as we must do, then we need to start with prevention. It is the best investment we can make. We all need to insist on this for ourselves, our families, our friends, our colleagues and our communities.

The journey of a thousand miles begins with the first step. When we make the first step toward changing our health-care system, then this is that best first step. Otherwise, I am afraid, our cattle will still get better care.

Kathleen O’Connor

Guest columnist

### **Health Care in Need of a Fix**

Unless there is systemic change, the system is like the Titanic, headed for an iceberg

**By Kathleen O’Connor**

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From the so-called “Sons of Jackson Hole Groups” to the latest Blue Cross Blue Shield initiative, we are drowning in calls for new studies on healthcare costs and access. We don’t need new studies. We need systemic change.

Why? Because we don’t have a healthcare system: we have a business to business enterprise.

Employers buy health insurance and insurers sell it. Twenty percent of everyone under age 65 has no health insurance. That’s our healthcare system.

While we have Medicaid and Medicare, they are not linked in any systematic way to employers. Medicaid varies from state to state; it is not a standard plan with standard benefits.

Medicare covers acute hospital and some Skilled Nursing Facility costs, but otherwise covers virtually nothing that contemporary seniors need—prescription drugs and long-term care.

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We also have the public health system, but it's woefully under-funded and totally divorced from private commercial insurance.

When a cost crisis trots along, we resort to three standard solutions: cut benefits, cut dependents and cut rates. Sometimes we do all three. This is the healthcare shipwreck.

Employers use benefits to attract and retain employees. In fat times, they throw benefits at employees; then cut benefits or increase cost sharing when times are thin. In lean times, we end up with even more uninsured as businesses lay off employees.

The safety net we had 10 years ago is vaporware. Provider rates are so low in some states that many clinics won't take Medicaid patients. In my state, a frightening number of primary care doctors no longer take new Medicare patients.

When healthcare costs increase, different regulatory or marketplace solutions erupt to quell those costs. Here's the jargon soup we have supped on so far: DRG, RBRVS, PPO, HMO, POS and now DC, as in Defined Contribution. These "solutions" did nothing but shift costs from one sector to another.

No common language or world view—must less trust—exists among the crew and passengers on this healthcare Titanic. Businesses don't trust hospitals and physicians, because they can't get timely or consistently reliable information from them. Consequently, businesses make independent decisions for their own economic good or resort to hardball tactics like The Leapfrog Group initiative.

Employers are largely unconcerned about rates paid to providers because they consider doctors' and hospitals' inability to manage within these rates as simply bad management. So when they hear the ship has sprung a major rate leak, they have no incentive to listen.

Patients don't know whom to trust anymore. It takes months to see doctors, their doctors often change when networks change. When they get to the physician's office, they are lucky if they have more than 10 minutes with the physician they have waited weeks and sometime months to see. Hospital care is so stretched, patients fear for their lives. They don't understand their hospital bill, much less an EOB. And we wonder why liability is so high.

Everyone is so busy blaming, cutting and shifting that we never discuss what is at the heart of the problem: we have a total and complete lack of vision about what a healthcare system should be and do.

You can't build a ship if you don't know it's supposed to float. Which is why our healthcare Titanic system is heading for a shipwreck. We did not build the current system with an end view in mind. We built an employer-based system of insurance with public program props.

We are stuck with a business to business model in which healthcare benefits depend on where we work. We put the sick, elderly and poor into public programs, then wonder why those programs cost so much.

Healthcare as an employee benefit creates a 'use it or lose it' mentality and increases costs. I remember the wage/price freeze in the '70s when we were given full dental and mental coverage in lieu of wages. Everyone I knew rushed out to get crowns and find a shrink.

We can't fix something unless we know what it is supposed to do. We have never as a society discussed what we want from a system of care. We backed into health insurance unintentionally and have proceeded willy-nilly buffeted by the latest acronym.

What we need to do is define what we want a system of healthcare to do and the health outcomes we want. Then and only then can we have goals and outcome expectations, truly have a system of care with

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sustainable financing. Then and only then will be able to work together to reach those goals and be able to assure the economic viability of our businesses, hospitals, clinics and patients and the health and well being of our people and communities.

Then and only then can we have what is totally lacking now: accountability and responsibility.

Guest columnist

### **The health-care shipwreck**

**By Kathleen O'Connor**

Special to The Times

We can argue as much as we like about single payer, the marketplace and universal coverage or we can sit down and talk about our impending health-care shipwreck. Front pages from Chicago, D.C. and Seattle are the same: depleted Medicaid budgets; more uninsured and unemployed; meltdown in mental-health care clinics and hospitals.

At 14 percent of the GDP, health care is the Titanic of the American economy, but its lower holds of Medicaid and public programs are being sliced wide open by budget cuts and rate reductions. And like the Titanic, it is not just these lower holds that will be flooded. Take a look.

#### **Storm warnings**

- American health care is a business-to-business enterprise. Employers buy it; insurers sell it and consumers get services from doctors and hospitals that are paid by their employers' health-insurance premiums. Because health insurance is tied to jobs, when people lose their job they lose their health insurance.

With the second-highest rate of unemployment in the country, it stands to reason that we could have the second-highest rate of uninsured in the country. This means people will either go without insurance, or qualify for Medicaid. But Medicaid is now cutting existing programs. Now, even people who qualify for these programs can't get on them, because the state (along with 35-36 others) has no money. More uninsured.

- Health premiums are rising at 11 percent to 50 percent. These increases will continue over the next couple of years. They are unsustainable for employers, especially small employers, and for individuals — especially during a recession.

To deal with these increases, employers will do one of three things, if not all three: drop dependents from coverage; reduce benefits; and have the employee pay more for premiums, co-payments and deductibles. Some may drop health-care benefits altogether. More uninsured and underinsured.

- Clinic, pharmacy and hospital margins are the lowest they have ever been. Virtually no health-care safety net/charity care exists. Many doctors will simply not take Medicaid patients or new Medicare patients because the rates are too low. No place to care for more uninsured and underinsured.

- Legislators will do nothing helpful. They will either pass a pharmacy formulary dictating generics or discounts; cut rates and add co-payments; and/or cut programs rather than address the systemic flaws. Republicans and Democrats will blame each other for the lack of solutions.

- People will no longer take jobs in nursing homes and home health care because of low wages, leading to tragically low quality of care for frail and vulnerable elderly. More abuse and neglect of frail seniors.

#### **The shipwreck**

Here's what the shipwreck looks like: more chronically mentally ill people on the streets who are incapable of taking medications independently. They therefore resort to listening to the voices in their heads telling them that medicines aren't necessary, or that it is OK to steal a sandwich.

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Because they cannot manage independently, more will be hawking on street corners, and slowly die from exposure and malnutrition. Or, they will end up in jail because they acted out. Jail is also actually cheaper than a mental-health facility. A moral shell game and cost shift.

Forget finding a doctor when one of your parents moves to the state to be nearer to you. Most physicians aren't taking new Medicare patients and many are not taking Medicaid even if the person is eligible for services. Just because you have insurance doesn't mean you will get services. Your doctor could leave the state or retire early in disgust.

In Everett alone, one in 10 babies leaves the hospital without having a pediatrician. These children have no regular physician to look after their growth and development. The single best investment that any country can make is the health and well-being of their children. We don't. We are rated 32nd for the quality of child survival. This will get worse. More children will not receive adequate health or dental care, will fail to thrive, be poor learners and grow up without the foundation and chance for quality education. Poor education and low literacy rates are the leading indicator for juvenile delinquency.

### **The shore**

We don't need more commissions. We need to sit down and talk together about what we are going to do to keep this shipwreck from happening. We need to do it with the public who receives the services, the employers who provide the coverage and the providers and safety-net agencies that are stuck with the consequences.

We did just that last month in Seattle. We found that when we sat down together to solve a problem, we actually could find ways to work together for common solutions. This is not the time for legislative dictate; it is time for public engagement to figure out how we can work together to assure the health and well-being of our people, of our businesses and of our community.

Guest columnist

## **The health-care shipwreck II**

By **Kathleen O'Connor**

Special to The Times

Let's not kid ourselves about the impending state and federal health-care budget cuts. Here is what they mean:

- No more interpreter services for clinics and hospitals; they won't take people who speak different languages — too many liability issues without informed consent.
- Cuts of \$70 million from already underfunded nursing homes.
- Cuts in Medicaid? Already physicians aren't taking patients who have Medicaid. So, here come more uninsured.
- Cuts in mental health? Well, we are used to seeing people on the street, what are a few more? But, who pays for the lawsuits when they go off their meds and act out?
- More uninsured? We live with them already, what do a few more matter? ER rooms can take them.
- No more subsidized child care? So what? Guess they just leave the kid in the car while they're working. Or home alone.
- No more parenting classes or programs to teach basic job skills? They should have learned that growing up, as well as anger management.

The rate and program cuts coming from Olympia and D.C. are horrific. Why? Because it is not just money. We are balancing the budget on the backs of people who don't have a voice — immigrants who

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do the jobs we don't want to do, from bathing our frail aging seniors who can no longer care for themselves, to harvesting our crops; the truly chronically mentally ill so they can go ... where?

We are cutting millions from nursing homes, already so underfunded and understaffed that the home where my mother was living never got around to cleaning her toilet or calling me when she refused her medicine.

Someone has to say this: This state is in meltdown. We have the first- or second-highest unemployment in the country, a see-saw contest with Oregon. Boeing has left. It has not just lost a contract. The dot-coms are gone. Developers have overbuilt. We have over 30 counties with 10 percent or more unemployment. Our traditional industries are largely gone — timber, fish, aluminum, Boeing, apples. And, we cannot change the demographics of our aging population. Greater age means greater use. Greater use means greater costs.

This can't be fixed by tweaks to the current system. As my colleague Cynthia Voortman is fond of saying, "We are just putting a Band-Aid on gangrene."

And that is exactly what we are doing — putting Band-Aids on an invasive, virulent gangrene that can't be cured by mandates or dictates, by legislation or regulation — because of the systemic flaws in our health-care system. We have a business-to-business model of health care: health care as a form of employee compensation. Employers buy it, insurers sell it. This model has just run headlong into the economic crisis facing our businesses, communities and our state. Federal budget reductions just get loaded on top to further spread the infection.

Extraordinary circumstances have set in motion extraordinary change. When we are closing parks, cutting millions from nursing homes and closing institutional care for our most chronically mentally ill just to balance our budget, we have crossed a moral chasm as a state and as a society.

Olympia is overwhelmed by the magnitude of the problems and is held hostage to all the different and conflicting lobbies circling the capital. They need our help. We cannot expect special interests to offer solutions. We need to build a system together that sustains businesses that offer insurance, providers that offer the care and the patients who receive it.

We cannot improve quality when there are more people for fewer providers who get inadequate funding to cover their services. Neither business, government nor individuals can sustain the cost increases and eroding access and quality.

This is not time for business as usual. Independent solutions can't work. It's time we defined a goal for our health-care system and outlined what we expect from a system of care for ourselves, our families, our businesses and our community. Because, without a goal, we will simply continue to dance our death dance as we throw away care services for our seniors, children and access to affordable health care for the businesses and people who fuel what is left of this economy.

So, it is up to us. The question is, are we up to it?

Guest columnist

### **State's health-care arena pits poor against the weak**

**By Kathleen O'Connor**

Special to The Seattle Times

They're back. But, where's the crowd? After not being able to buy an individual health-insurance policy in Washington state for over two years, the policies are back on the market. But folks aren't beating down the doors.

Anywhere from 690,000 to 920,000 people in our state have no health insurance - roughly the equivalent of everyone in Snohomish County on the low side or the combined population of Kitsap and Pierce

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counties on the high side. But only 14,000 people have bought individual policies since they became available again some six months ago.

By the end of April, nearly 22,000 people had applied for individual policies and completed the lengthy health screening that was part of the deal to get individual policies back on the market. Over 1,700 did not pass the screen and were referred to the Washington State Health Insurance Pool (WSHIP) - a high-risk program for those who cannot get health insurance elsewhere. But only 240 people have enrolled in WSHIP since January and 144 had to leave the pool because they were too healthy. Another 667 have simply left and gone. Who knows where?

The good news in all this, however, is that now all counties have choices in insurance. They all have the Basic Health Plan, WSHIP and at least one commercial carrier. Ten counties have the choice of only one commercial product: Premera.

While people seem to want insurance, their interest dwindles, presumably, when they learn about the costs. Regence Blue Shield, for example, has received over 25,000 phone calls about its policies, but only 8,000 people requested applications. Their experience is no different from the other plans. In short, we have these individual policies back, but they are simply out of financial reach.

Individual policyholders faced rate increases of 21 percent in 2000; this year, rate increases range from 18 percent to 22 percent. Which means rates can be as high as \$360 a month for a non-smoking, 60-year-old male. So, while individual policies are back, they are not affordable.

Now, with the erosion of state funding, the Basic Health Plan (BHP) is not an option for low-income people.

And now, the employers and insurers want the people in the WSHIP to pay larger premium increases.

This means we still have anywhere from 600,000 to 900,000 people without health insurance. They dangle above a fragile health-care infrastructure that is near collapse in some counties. And still no call to action from Olympia.

I have come to the reluctant conclusion that we have so divided ourselves in this state with initiatives that we have lost our sense of what is a good state, a moral state. We have lost our bearings, our moral compass.

We pit teachers against state employees; we pit the young against the old and we pit the poor and the disabled against transportation or education, take your pick. We have let the mob decide by initiative, like the mob decided about which gladiator would live or die - thumbs up, thumbs down.

How so? When it comes to maternity care in the individual market, one compromise was pregnancy - pre-natal care would be covered (the cheap part), but not delivery (the expensive part) if the birth happened before the pre-existing term expired. Which might explain, in part, why 42 percent of the WSHIP applicants in February were under the diagnosis of pregnancy.

The WSHIP Board is now facing resistance from insurers and the business community over premium assessments. The plans want the individual members to pay more of the premium dollar rather than increasing their assessment. They are concerned now that because only the sick and disabled are now in WSHIP - the very group these same people wanted out of the commercial market - that the rates are going to be higher. They think the people in the pool, rather than them, should pay more.

We have once again taken the poorest and sickest among us, and huddled them into smaller and smaller groups, so they are essentially voiceless in an industry that depends on the loudest shout. How have we

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gone so wrong that we think it is acceptable to pit the poorest and most vulnerable against each other? Tell me how that makes us a better state or society?

The silence from Olympia is deafening. Vox populi vox dei. But even Rome fell.

Guest columnist

# **Health care's death dance**

**By Kathleen O'Connor**

Special to The Seattle Times

I had lunch in January with a very nice man whose manufacturing company employs 100 people. His health-care costs increased 30 percent a year for the past two years. He is getting another 30-percent increase this year even though his employees have had no major medical claims.

Health costs in the Department of Social and Health Services (DSHS) have grown from 23 percent to over 40 percent of its budget in 12 years. Now blood is on the floor for the department's proposed cuts: \$6.3 million for some nursing home programs; eliminate CHORE services for \$3.8 million; eliminate voluntary CHORE services - \$3.28 million; cut \$3.72 million from Adult Day Health; reduce residential beds in secure crisis residential centers for children by 50 percent for \$5.1 million; eliminate children crisis residential centers for \$6.6 million; downsize in-patient mental-health services, for \$12 million.

I will stop here. This represents less than one page of the five-page total of a proposed \$350 million in cuts. Unlike a business, DSHS can't raise its rates to cover its costs.

One rainy day, when I worked at the University of Washington's Institute on Aging, a woman called who had two young children. She was a full-time mother and caregiver for her live-in parents-in-law, one of whom had Alzheimer's disease. She called us that rainy February afternoon because, she said, if she didn't find some help, she was afraid she was going to hurt someone because she was exhausted from unrelenting caregiver demands.

Senior Services of King County alone stands to lose \$350,000 for the 300 elderly in its adult day-health programs. What happens when these doors close? Who stays home from work to care for mom? Do the caregivers send parents or spouses to nursing homes? If the family can't afford a nursing home, then the state pays for it. There is no savings in this. We are cannibalizing ourselves.

Why is this happening? Declining revenues, earmarked spending from an initiative process that is totally unaccountable for balancing a budget, and fear. No one wants to say the obvious: You can't have a balanced budget without balanced income and spending. But no one is saying anything meaningful about initiatives, other than whining. Leadership is about changing minds, not reading polls, but I gather we have forgotten that.

Dennis Braddock, secretary of the Department of Health and Human Services, says flat out there is no way these cuts can be made without causing further problems.

Let's take mental-health services. In-patient care at Western State and Eastern State hospitals for the chronically mentally ill is about \$360 a day per patient. The state plans to pay about \$170 a day for care in the community. Where? Nursing homes cost about \$110 per day and are desperately understaffed. They don't specialize in mental illness. Group homes? No one wants them in their neighborhood. They won't be ready in time to meet these immediate needs anyway.

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How will these patients even find housing? How do they find a doctor? Who is going to manage their medications? How are they going to manage their money? How can the state even keep track of them?

State health costs are only going to increase, Braddock says, unless we get a prescription-drug program for Medicare soon. Low-income elderly with large prescription-drug costs are already "spending down" their assets to become eligible for Medicaid, which covers drugs. This adds to state health-care costs. In the industry, this is called a "death spiral." And, we're in it.

You would think we would get the message.

Since World War II, health care has been a business-to-business enterprise - employers buy it and insurers sell it. Employers hire predominantly healthy people, which insurers like. Government programs were created to care for the sick and the poor, which means the sick and the poor are covered by tax dollars.

Because health care is a business-to-business enterprise, not a community enterprise, we have never asked what a healthy community should be. In fact, as Anita Boser of the Employers' Health Purchasing Co-op says, we have never asked what problem we are trying to solve other than controlling costs. Now, we must. Our rate, regulation and body-part approach to health care has failed us big time. Our only solutions are rate and program cuts. They no longer work.

If I were Czarina of Health Care, I would first create a FEMA for families to help mitigate these cuts or use some reserves to put them off for a year. Then I would get communities - neighborhood by neighborhood - to brain-storm what they need for themselves and their families, like businesses use in strategic planning. We have never done this. We have always assumed only existing structures and revenues.

Then, we could take what we found at the community level to the county level and compare notes - sort of like a constitutional convention with elected freeholders - and finally move up to the state level. We would have people from the schools, the police, store owners, Rotarians, Kiwanis, artists, faith communities, employers, health-care professionals - public and private - but no associations with agendas.

Washington is in a unique position to do this, given the gravity of the proposed cuts, the tradition of innovative community leadership and the regional federal headquarters that could help with necessary waivers. Once we have identified what we need, we can decide who can do what part of the job and the sources of revenue, existing or new, that would be necessary to make this work.

We already know about how much it costs. Best of all, we would have a system that people own because they helped design it. Even better, it would have accountability and responsibility because everyone would know their role and could work toward a common goal rather than pointing fingers. Who's going to pay for this? Foundations and federal grants.

Some communities are actually already doing this - Lake Chelan Community Hospital and CHOICE Regional Health Network based in Olympia.

"If you don't know where you're going, you could end up in the wrong place," someone once said. We are at that wrong place. We must decide where we should be going and find a way to get there.

We can do it. It just takes political will. So let's have a FEMA for families right now to stave off the worst, then make a commitment and timeline to craft a new path to health rather than lingering in the inevitable death dance we're in.

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Guest columnist

## Drug-discount program won't help the poor

By Kathleen O'Connor

Special to The Seattle Times

We all know about the road to Heaven's opposite being paved with good intentions. Well, that's what we have with the governor's proposed AWARDS program for prescription drugs. It is a token program that is a bandage on a gaping wound.

It helps the middle income, not the poor. It takes the discount from those in the food chain who are least able to afford it - pharmacies, especially small, rural mom-and-pop pharmacies. It is being implemented by rules rather than by a thorough legislative review and discussion. In fact, only one hearing was held on this issue - in Kent in December. It can be implemented quickly because no "new spending" is required.

Worst of all, it does not address the problem of offering affordable prescription drugs to truly low-income seniors. It may be step one in a multiple-step dance, but it is a bad first step that creates adversaries unnecessarily.

### *Here's how it works*

AWARDS is a discount program. Just like an AARP or Safeway card, it offers the cardholder a discount. No income test is required to participate in the program - all you have to do is sign up if you are over 55 and don't have other prescription drug coverage (for information online, see [www.wa.gov/hca](http://www.wa.gov/hca)). Over 3,000 people have signed up so far. The rules were effective Jan. 15 and the program will be up and running March 1.

While there is no doubt this is a benefit for seniors and others who have no prescription coverage, including the uninsured, the fact remains that it is simply a discount program. And, the discount comes out of the hides of only one group: pharmacists.

At the hearing in December, over 90 people protested the program - seniors as well as pharmacists. But, it is still being implemented. Two lawsuits have been filed: one to prevent its immediate implementation (dismissed), and another that challenges the authority of the governor to implement this through rules.

### *Let's do the numbers*

Discounts are nice, but they don't solve the problem. My mother is 82 years old. She receives \$905 a month from Social Security - hers and half of my father's after he died. Luckily, my father had some retirement and some investments. She can afford the \$76 a month she pays for Fossamax; a 20-percent discount would be frosting on the cake.

But, Social Security income is also based on pre-retirement income. So, those who worked at the poorest-paying jobs and who may or may not have additional retirement income or ever owned their own home are paying for rent and food out of their Social Security checks. If it were not for being able to receive half of my father's Social Security, my mother's Social Security check would have been close to \$450 a month. Some women live on as little as \$400 a month from Social Security.

What doesn't get purchased when \$76 of \$450 goes to Fossamax? Or maybe you don't take Fossamax and fall and break a hip.

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Maybe someone can do without an osteoporosis drug; after all, it is not life threatening like diabetes. Take the case of the 76-year-old man whose diabetic medications, including insulin, syringes and testing supplies, come to \$650 per month. The AWARDS program means he will only have to spend, maybe, \$520 a month to stay alive, depending on whether they include syringes and testing supplies in the discount.

### ***Leadership by lament***

With laments of "it's the best we can do and offer a balanced budget," the governor's office said its hands are tied. They say that because of the Initiative 601 spending limits and the other state initiatives, they cannot propose money for new programs when there is not enough money for existing ones.

Are these choices what the people really intended when they voted for I-601 or to give teachers raises? Leadership would get out there and say these are not acceptable choices. We, as a state, are better than this - better than being forced to choose between roads and adult day health care. Someone needs to say this.

That's really why the AWARDS program is so bad. It caves in to the "we don't have any choice" victim approach to public policy. It tries to ramrod a solution rather than engage us in a public dialogue that might have produced viable alternatives. It asks only one group to finance the discounts - pharmacies. Worst of all, the true victims - the low-income elderly - still can't afford their medications.

Several bills will be forthcoming in Olympia on prescription medications. Let's hope they address the inequities and inadequacy of the AWARDS program.

Guest columnist

## **Our health care is great, just don't get sick**

**By Kathleen O'Connor**

Special to The Seattle Times

We have some of the world's best medicine and the finest technologies. We enjoy some of the world's finest physicians, nurses and health-care professionals. People come from all over the world to get care here - the University of Washington Medical Center; Virginia Mason; Children's Hospital and Medical Center - not to mention Harborview, Swedish and Fred Hutchinson Cancer Research Center. I cannot even begin to name the physicians and clinics that provide some of the best health-care services money can buy.

But our medical infrastructure is being gouged by inadequate and misdirected funding.

Here's what happened. The federal government set limits on what it would pay doctors and hospitals. They ratcheted down rates for hospitals and doctors and skilled nursing facilities and almost everything they could to control Medicare costs. The feds and the state jointly pay for Medicaid, so it is subject to rates set here for hospitals, doctors and long-term care facilities for Medicaid patients.

Add to this the squeeze from managed care. While the government was clamping down on one end, the commercial insurers were doing the same on the other end at the behest of employers. Ironically, managed care ended up increasing costs over time, because of its administrative complexity. Physicians

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and hospitals added people to manage the rules and regulations. Even insurers' administrative costs rose to 15 percent in four years.

While provider cash flow was going down, their overheads were going up. Now, less than 50 percent of every dollar they receive actually goes to patient care, according to a study by the Washington State Medical Association. These practices were also harmed by their participation in managed-care contracts in which they assumed part of the financial risk of patient care. Management is impossible without good data, and neither health plans nor providers had adequate timely information to make good management decisions.

Providers were also hit hard when the rest of the economy took off. The labor market tightened and it became increasingly difficult to get some entry-level positions. Especially hard hit are home health care and long-term care services that rely on entry-level workers to care for the elderly and disabled.

Initiative 601 put a 2 percent lid on what can be spent from state revenues. Additionally, Initiative 695 eliminated the car-license tax, which was a major source of public health funding. Over the next three years, 39 counties will lose \$32 million in public health and services.

The teachers' salary increase takes money out of the general fund, which means the 2 percent increase comes from a smaller revenue base. So the 2 percent is off a smaller pie.

What this all means is with the top funding priorities being transportation and education, major cuts are proposed in health and human services - nearly \$300 million - to keep a balanced budget. But, the safety net hospitals and doctors offered is largely no longer there. Hospitals only have about 1 percent operating margin - they can hardly be expected to absorb more charity care. Thirteen hospitals have had negative margins for nearly four years.

Because of the state initiatives, not only are programs being cut, but rates for Medicaid services - which are already about half of the commercial insurance rates - are being reduced as well in order to try to find ways to pay for services.

The irony is that we do not have to make these choices. We have funds that could help us navigate our way through these funding messes without dumping frail, elderly people into the night.

One thing is for sure in Olympia. Everyone says they have never seen it worse. Now is the time to seriously reconsider what we have done. The governor's meeting with some health-care representatives on Jan. 29 is a step in the right direction.

Guest columnist

### **The travesty of choosing roads or public health**

**By Kathleen O'Connor**  
Special to The Seattle Times

In this time of some unprecedented economic growth and prosperity, we are forced into making choices about whether we will fix transportation systems or assure that our elderly have access to home care, adult health care and other services.

We are making choices between programs for children and seniors when we have funds to meet both needs. Why? Because we have become hostage to an initiative process that makes public policy.

## **KATHLEEN O'CONNOR: SELECTED COLUMNS, *The Seattle Times* 2000-2004**

Gov. Gary Locke's new, biennial, "Moving Washington Forward" budget does so at the expense of the poorest and most vulnerable-- the destitute, the elderly and the chronically mentally ill. We are better than this as a state and a community. Well-intentioned people have voted for programs without realizing the consequences of their decisions at their polling places.

With spending cap initiative I-601, we are limited in what we can spend on state programs. In reality, transportation and education were seen to be higher public priorities over health and social services. The choice became either/or because we are locked into simplistic formulas.

What no one meant to happen, I am sure, is that by giving other issues the highest priorities, we are ripping away services away from our most vulnerable residents.

The governor's proposed budget would mean a \$270 million cut in services for the elderly, the poor and the chronically mentally ill.

Home health agencies will close. Some already have. Others are reducing staff which means frail elderly people will go without services.

Reductions of \$12 million are proposed by moving mental health patients from in-patient care to out-patient settings, when we already know that is not the best care choice for many patients. Our correction facilities have already become the provider of last resort for people with chronic mental illnesses. What we will save in state mental health services we will either shift to the cities and the counties or the jails.

Cuts of 40 percent are proposed in funds that hospitals rely on to help care for the uninsured. Hospitals are at their lowest operating margins in years because of managed care and Medicare cutbacks. Ditto for the doctors whose practices verge on insolvency.

We need a joint, public education campaign led by the governor and the Legislature - by the Republicans and the Democrats - spelling out the need to change the state's I-601 spending limit.

As parents, we have all had to give the lesson to our children that actions have consequences. Legislators know what those consequences are and it is their responsibility as elected leaders to carry messages to their constituents about the consequences of the initiative process and what it means for social and health services in this state.

We need to adjust the 601 spending limits so we are not forced to make choices between children, seniors and transportation. Or give to teachers automatic pay increases while we ignore those who care for parents who can no longer bathe themselves, or dress, or who are ravaged by Alzheimer's or Parkinson's disease - conditions not of their choice or the result of personal irresponsibility.

It's time for elected officials who have to make the final choices to step up to the plate and let the electorate know the monster it has created and put it to rest.

If they can campaign for office, then they can campaign for the good of the state.

Guest columnist

## **Health care's strange bedfellows needed here**

**By Kathleen O'Connor**

Special to The Seattle Times

Strange bedfellows breezed into town recently with a workable solution to expand insurance options for the uninsured. No less than the heads of the Health Insurance Association of America (HIAA) and Families USA, formerly arch enemies who are now tromping around the country showing how they found mutually agreeable ways to get affordable health insurance for the 43 million uninsured Americans.

We need that kind of risk-taking leadership here. We were a leader in finding ways to offer affordable, accessible, public and private health care solutions. The state's Basic Health Plan is a landmark program, as is the Employers' Health Care Purchasing Co-op. Not to mention other interesting alternatives, like the First Choice and Cost-Co Health Insurance option. But now, we have few innovations and virtually no leadership at a time when existing health care services are desperately under funded.

Initiative 601 and the new initiatives mean we don't have enough money in the state budget to pay for existing programs. So, programs have to be cut. This means the poor and the vulnerable will be hit big time.

### ***The Charred Landscape***

Flexibility in the health care market is gone. Managed care eroded the providers' financial infrastructure. Federal and state payments cut providers' income so there are no funds to cover the uninsured. We pay caregivers a pittance, which means they would rather flip burgers than help bathe and dress our elderly or disabled sons and daughters. Which means we will have a crisis in long-term care at home or in institutions.

Health insurance premiums are raising their ugly double-digit heads again for employers, especially small employers.

Individual policies are back, but with a 13-page health status questionnaire to screen the new applicants. We have no idea what the results of that screen and the new rates will be.

Healthy Options is basically dead. Come January 1, the largest managed care plans won't continue their Medicaid managed care patients because the rates they get from the state are too low. This means over 100,000 Medicaid patients will be on their own again to navigate an incomprehensible system. The managed care plans that will still take them could be overloaded with patients and/or will provide services with payment rates from the state that may or may not cover their costs.

Add to this, the state Department of Health's intent to cut the AIDS Health Network budget by some \$600,000, the DSHS decision to drop adult dental, and their decision to close some hospital mental health services and let the patients fend for themselves in unsupervised out-patient settings. Not to mention the fray over who takes the rate discounts so seniors can have affordable prescription drugs.

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All this is on top of a precarious medical financial infrastructure. Physician practices are losing money because of low reimbursements from commercial insurers and public payers. Many counted on a volume of managed care that never materialized and have closed their doors. Rural communities are especially hard hit.

And then, the issue of trust. Everyone is vilifying everyone else for costs and rates. All are in danger for carpal tunnel from the finger pointing alone.

Who is doing something about this? No one. Not the governor. Not a divided state Legislature. We need some leadership here.

We need leadership that gives voice to our needs and can articulate our vision of what a system of health care should do. What goals do we want to reach?

We need leadership that is not government driven, but offers a fresh approach like the attempt being carved out by HIAA and Families USA. We need a voice that advocates a system of care that works for consumers, providers and employers, as well as the cities and counties that have to meet the needs of those who rely on the safety net.

It doesn't take rocket science to do this. We have never sat down to figure out how we can get all the various parts to work together. Right now not only is our system riddled with holes and gaps and lacks, it is just as riddled with redundancy, duplication and often needless and costly competition.

We can't rely on stakeholders because they have stakes in the outcome. We may or may not need more money. But, more than money right now, we need to say what we want the money to do and define our expectations.

If HIAA and Families USA can find common ground, can we not risk a systematic public dialog to define what we want a health care system to do and build a path to get there?

So, what will it take to get some action here? If the governor wants to be a leader, now would be a good time. And, this would be a good issue. Lives are at stake.

**Guest columnist**

### **A lame health-insurance plan**

**by Kathleen O'Connor**  
Special to The Times

Tomorrow, the Washington State Health Insurance Pool (WSHIP) Board will meet at the Westin Hotel in Seattle to continue its work to restore individual private insurance policies in the state. Their work has gone very wrong.

The deal that was cut to get insurers back into the market will take the sickest 8 percent and put them into a special pool funded by all insurers so the cost burden would not fall just on the three insurers that offered individual policies. But under current thinking, individuals in the pool will be subject to a system that grades applicants by rate of disease and weight.

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What we did not know at the time the pool arrangement was made, is that the cost burden has changed. In fact, Premera and Regence made profits of \$2.575 million and \$3.104 million, respectively, on their individual policies in 1999, with the same group of people they always had.

What we did not know then is that this board is planning to create a point system based on an applicant's risk of disease and body weight. Equally troublesome is that some board members believe the board is not always subject to open-meeting and public-disclosure laws because of its private funding. And, the group developing the health rating system is the very group that gave us "drive-by deliveries" - the 24-hour limit on maternity stays - overturned by every state legislature and Congress.

A point system placed on individuals seeking insurance because they were laid off, or their dot-com went under, or simply took early retirement is an invitation to chaos. An insurance rating system based on how risky you are to get a disease is a battlefield. Battles will rage in Olympia as consumer groups and support groups fight over the points allocated for each disease. Court challenges will be made by those whose disease scored too high. This is a recipe for disaster. Then, we will once again be back to square one after squandering thousands and thousands of dollars that could have gone to patient care.

We do all this because three companies said they were not making money. We caved in to the demands of those who do the bulk of the business. It's time to change the rules of the game.

Three insurers - Premera, Regence and Group Health - dominate the market. If you tally up all their products and affiliations, these three plans account for 58 percent of the health-care marketplace. This does not breed innovation. Group Health has the smallest market share of the three at roughly 18 percent. PacifiCare, at fourth, isn't even close at 6.03 percent. We let the big insurers dictate the terms and conditions of this legislation rather than challenge their chokehold.

What we are doing is simply wrong, very wrong. Why? Because we are creating standards that apply to only one class of people - the self-employed, early retirees or dependents who have been dropped from the group market. We are holding individuals to vastly different and largely unjustifiable standards. Group insurance is not based on premiums by the pound or asthma or diabetes or genes.

If we let this board create a premium by point system and think that will solve the marketplace problem, we are naive. We have already sacrificed our elderly and our poor. Who else are we willing to give up?

If we go down this road, the governor, the attorney general and the Legislature must aggressively find ways out of this near monopolistic chokehold and put real competition in the marketplace.

Alternatives exist. We can expand the small-business market so individuals could be their own group. Or, say that every group of 99 or less would be eligible for group rates. We can insist that anyone who wants to offer group insurance in the state must offer an individual product in all parts of the state as part of the price of doing business.

We must claim ownership of our health care and not leave the rules of the game to the industry. We must claim ownership from the bottom up, not the top down. If all health care is local and all politics is local, then building this system must emerge from where we live and work and grow, from local to county discussions, to state discussions. If we know what we want, then we can work together to get it. This is not rocket science. We are just told it is.

We need health care that helps us sustain health, not penalizes us with points for potential diseases, or pound points, or health benefits mandated by the loudest lobby.

## KATHLEEN O'CONNOR: SELECTED COLUMNS, *The Seattle Times* 2000-2004

Guest columnist

### Cut off: HMOs trim elderly for profit

by Kathleen O'Connor

Special to the Seattle Times

It's simple economics. Medicare HMOs (Health Maintenance Organizations) are not making enough money. They whine they can't make money given what Medicare pays. So, they dump seniors and try to con the governor and others into suing the Health Care Financing Administration (HCFA) that oversees Medicare to get better rates.

But these plans knew the rates from the get-go.

First Choice is dropping 3,200 seniors. PacifiCare will ditch 1,500 in Walla Walla, but keep its other 61,500 members. Premera will toss 6,000 in Western Washington, but keep 13,000 seniors in Eastern Washington. Aetna will drop 10,700 members and Regence Blue Shield, 8,000.

Only Group Health announced no changes for its 62,000-member HMO.

Nearly 30,000 Washington seniors have to find new plans - more than 700,000 nationally.

Here's why:

Medicare HMOs used to be managed care's cash cow. In the 1980s, HMOs promised the government they could reduce Medicare costs. HCFA would give the plans a flat fee each month for every senior who enrolled. In return, the HMO would manage all the Medicare benefits plus whatever additional benefits they wanted to include. The plans got 95 percent of the fee-for-service rates in their communities. The HMOs would see that seniors got Medicare Part A and B services. They could keep any savings they made.

Touting they could manage Medicare better than the government, plans across the country threw virtually irresistible packages to gobble up the lucrative senior market: zero premiums, prescription drugs, whatever it took.

And, sign up they did. But, now they are being as quickly dumped for lack of enrollment.

In King County, each Medicare HMO is paid roughly \$492.23 per person each month for Medicare Parts A and B, or nearly \$6,000 per year per person depending on age, gender or disability. Group Health or PacifiCare, with about 60,000 seniors each, receive nearly \$360 million a year.

The trick is having enough members. That's where Regence, Premera, First Choice and others got caught. First Choice had the fewest members at 3,200 and gets about \$20 million a year. But, it doesn't take too many cancer and chemo cases at roughly \$100,000 each to run up the tab and eat up the profit. It would take many such cases to use up the annual \$360 million a Group Health or a PacifiCare receive. They can absorb the costs of a few very sick members and not lose money, much less their shirts.

But, Medicare HMO members are healthy: 84 percent say they have no limits on their daily activities. Nearly 81 percent of all Medicare HMO members report excellent health; only 20 percent say their health is poor or fair.

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Medicare spending per person has remained pretty constant. Only 5 percent have costs in excess of \$25,000 per year. In fact, HCFA spends \$1,000 or less on 52 percent of all beneficiaries each year. This 52 percent represents 45 percent of all Medicare spending.

So, while the HMOs are getting the cream of the crop in terms of health, they somehow cannot make money? Our HMOs now say they aren't getting paid as much as other states. Foul. They knew this all along.

Yes, rates vary. In King County, a Medicare HMO receives about \$492.23 each month. In Pierce County, its \$465.97; in Walla Walla \$442.01 and in Spokane, it's \$477.10. So, now it's easy to see why Premera kept Spokane and PacifiCare dumped Walla Walla.

That Dade County, Florida, plans get \$809.90 or LA plans get \$673.86 per member per month has nothing to do with what our plans accepted. They knew these differences when they signed their contracts. Medicare HMOs are optional programs. No one forced them to do this. Some just didn't get enough members.

That's the bottom line. Calling out the guard in a proposed lawsuit against HCFA is a straw dog. These plans don't have enough members to make enough money. It's that simple.

What this public/private partnership tells us is that partnerships work as long as they make money.

The problem is structure. Medicare is more than 30 years old - an entire generation. Life expectancy when Medicare began was 65, the age of eligibility. Medicare A and B cover hospital costs and outpatient care. They don't cover prescriptions; long-term nursing home care; adequate home health care; as well as many other things. When it was created in the '60s, Medicare focused on the disabling medical costs seniors faced then: hospital costs. But our health landscape changed.

Few could have anticipated our longevity burst. The current Medicare generation experienced one of the largest explosions in life expectancy in world history - virtually a 20- to 30-year addition to the previous generation. We have been trying to make a horse-and-buggy benefit design keep pace with unprecedented medical and technological advances that enable us to live longer with more chronic care needs. Now, the average Medicare beneficiary is a 75- to 80-year-old woman with three or more chronic diseases.

The original model can't meet today's needs. But, instead of facing that issue head on, we design experiments that work as long as the private sector makes money. And, we create reams of rules to assure consumers are not being fleeced, yet ignore the health-status demographics of our society. Present policies simply chart new directions for a sinking ship.

What we must do as a community and a society is define what we want a health-care system to do. We cannot count on Congress or HCFA to call the shots and make decisions for the good of country or community. They are locked into meeting local constituent needs.

That means it's up to us. We have to tell our elected officials not just what does not work. We have to tell them what we want.

And that is? A health-care system that supports the health and well-being of all Americans, that provides a safety net for those who need it, that assures an aggressive oversight and appeals process and a system of care that is not dependent on the latest payment fad. We deserve this not only for our seniors, but for all Americans.

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Medicare HMOs are the canary in the coal mine. As Medicare goes, so goes the nation. Because of its size and influence, whatever it does will be copied by the commercial plans that follow the path of least resistance.

And, don't listen to anyone who says, "who's going to pay for it?" We are all paying for it now. Just ask any senior who has to change plans. Unless and until we say what we want - a system that supports the health and well-being of our seniors and the health and well-being of our communities and our nation, then we will remain stuck with a crippled system that is more concerned about cash than care.

If there were ever a time to start a community dialogue about what a health-care system should do and how to marshal existing resources to make it work, now is that time.

This discussion will be more profitable and less expensive than yet another tax-supported lawsuit against yet another tax-funded agency to fiddle with yet more complicated formulas. Better ways exist.

But, without goals, health care will remain a mess.

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Guest columnist

### **Rolling snake eyes with health care**

by **Kathleen O'Connor**

Special to The Times

Not being a gambler, I nevertheless joined friends at a casino. I took \$10. After five minutes and five lost dollars, I quit blackjack to try craps.

I thought craps was a simple roll of dice. Roll a 7 or 11 and you got money. But no, craps is laden with rules - use one hand; keep your hands inside the table; double your money if you place chips in a certain box, and so on. I stopped listening, shook my head and laughed about so many rules over a simple toss of two cubes.

I lost \$10, but physician groups are losing more, much, much more in the benefit-management crapshoot. One clinic has lost \$16 million in the past two years. It is not alone.

#### **Rules of the game**

United Physician Service, Kitsap Physician Service, Medalia and Cascade Healthcare Alliance are in receivership or out of business. But it's not just them. Over 70 percent of such medical groups in California verge on insolvency. Even the national managed-care flagship, ranked No. 1 in the nation, Harvard Pilgrim Health in Boston, is in receivership.

Why? These groups accepted financial risk for patient care in the new managed-care marketplace. But too many options exist with no information systems or other infrastructure to support the complexity, much less manage it efficiently.

What this means is the plans and the medical groups and hospitals that contract with them do not know for sure if the patient is really eligible for services, if the patient was referred to the right doctor or the right hospital. Even though care is provided, the doctors may not know until months later what they will get paid - or whether they will get paid.

## **KATHLEEN O'CONNOR: SELECTED COLUMNS, *The Seattle Times* 2000-2004**

Take my former assistant. She went to her primary-care doctor, who referred her to a specialist. He sent her to the hospital for surgery. Six months later, "Karen" got a bill for \$6,000. The letter said she went to the wrong hospital. Her primary-care doctor sent her to a doctor who was not in the approved network. He sent her to the hospital he is affiliated with. That hospital was not in the approved network. Karen got the bill. Happens every day.

Deciphering health-care benefits is a crapshoot. Each insurer has many different plans, with different rules on co-payments, deductibles, premiums, physician and hospital networks and payment options. I spent three hours one Sunday with a very savvy friend who works in health care, trying to figure out her annual costs if she used the POS (point of service) vs. the HMO option vs. the PPO (preferred provider organization) option. Neither of us could decipher these choices. And, if this was a problem for us, imagine a physician's office.

Take The Everett Clinic, one of the most highly regarded group practices in the state. It contracts with Regence, Group Health, Premera, First Choice and Aetna, and others. Each of these plans has many different products, each with a different list of approved doctors and hospitals. Then, they have options within options - HMO, fee for service product, PPO, POS and Medicare HMOs - all with their own separate rules and payment structures.

The Everett Clinic employs 75 people full time just to analyze these rules and regulations.

"We used to have 15 plans we worked with, but are now down to 7 or 8 because of mergers, but these plans have as many benefit options as Carter's has pills," says Richard Cooper, CEO of the Everett Clinic, and 20-year industry veteran.

"We have 175 physicians. We used to have 3.5 employees per doctor to help support the practice. We now have 5.5. Nearly a quarter of them spend their time deciphering eligibility, referrals, authorizations and various billing and insurance-related issues. The IRS has 14,000 pages of tax regulations. Medicare alone has 146,000."

### **Plague of plans**

Managed care is a crapshoot with manufactured rules decipherable only by those who design them.

Physician groups are bleeding financially from arcane and microscopic differences. By deluding ourselves that choice is good, we have created a work force that does nothing but decipher rules that change every year with every contract.

Health plans say employers and patients want choice; that they compete in the marketplace based on the benefits, coverage and cost-sharing options they offer. But more choice means more complexity. More complexity means more costs.

If I cannot figure out a friend's options, or if the Everett Clinic has to hire 75 people just to decipher who is covered for what, then things are out of control. We have already lost Medalia, United Physicians and Cascade - say what you want about management mistakes. We are drowning in complexity that serves no beneficial health-care or financial purpose.

It would be cheaper and better if we all had fewer and clearer choices. Let plans compete on the quality of care and customer service instead of benefit design. Then we, as patients, could understand our choices and use the system wisely. And our doctors and hospitals would have half a chance of understanding the rules and staying solvent.

Until then, it's a crapshoot. And we are all losing.

# KATHLEEN O'CONNOR: SELECTED COLUMNS, *The Seattle Times* 2000-2004

Guest columnist

## Rx for prescription drugs

by Kathleen O'Connor  
Special to The Seattle Times

TV ads show buses trucking seniors to Canada to buy drugs they can't afford here. Others show buses trucking Canadian seniors here for services they can't get there.

Prescription-drug ads burst from magazine pages and TV commercials on the latest drugs.

Politicians rail against drug costs for seniors and lament our costs in comparison to Mexico's or Canada's.

This is the climate of charges and counter charges that surrounds the debate over the costs of prescription drugs in America.

While I waited for a prescription to be filled recently, a woman in her 80s brought in her prescription. When told the cost would be \$100 a month, she stood there and wept, then turned and left empty-handed.

She is not alone. Nearly 40 percent of all seniors have no prescription benefit. Most Medi-gap (supplemental) policies with a prescription benefit have a \$250 deductible, 50 percent co-payment and a yearly maximum that ranges from \$1,250 to \$3,000 before it reaches a maximum - totally inadequate for today's needs. Seniors use medications more than any other group.

The older the person, the more likely she needs medications. The average 75- to 80-year-old Medicare beneficiary is a woman with three or more chronic diseases. If her husband has died, her income is reduced by half. Some live on as little as \$400 per month with Social Security as their only income. She can't even afford AARP's \$8 membership fee.

### Peeling the onion

Simply put, the seniors who don't have drug coverage can't get discounts and rebates nearly everyone else gets. This makes them the only group that pays full fare for prescriptions. Most employees get discounts. Seniors with supplemental insurance get discounts. People on Medicaid get discounts.

This most vulnerable group pays 83 percent more for medications than nearly everyone else. Drug costs are going up for everyone.

According to the William M. Mercer 1999 Annual Employers Survey, drug costs were up 7.3 percent, ahead of physician and hospital costs (5 percent to 6 percent), but on par with most employers' premium increases (6 percent to 7 percent). When Medicare is added, drug costs have double-digit increases.

Pharmaceutical companies rank No. 1 of 37 industries in terms of return on revenue, surpassing all other Fortune 500 companies in 1998. Yet, they also invest more in research and development than any other industry.

When it comes to costs, hospitals are the Goliath: \$401.3 billion in 1999. Physicians were next at \$241.5 billion. Prescriptions ranked third at \$100.6 billion. Followed by nursing-home care at \$90.1 billion. Not a nickel-and-dime industry.

## **KATHLEEN O'CONNOR: SELECTED COLUMNS, *The Seattle Times* 2000-2004**

The only thing rising faster than drugs and insurance premiums are some insurance executives' salaries. Premera gave a whopping 61 percent increase to its retiring executive and then raised its individual insurance rates by 24 percent after a bill they promoted passed the Legislature. Ten other Premera executives got 28 percent increases.

Group Health's executive got a 20 percent increase.

### **Who calls the shots?**

Congress defines what Medicare covers. The Health Care Financing Administration (HCFA), which manages Medicare, decides what they will pay. But, not quite. Congress also sets payment rates, which set rate changes on hospitals, doctors, home health care, and nursing homes. Drugs are not a Medicare benefit, so they were not included.

The private insurance industry historically has taken care of pharmaceuticals in their supplemental policies. And did they ever use drugs to their advantage. Most early Medicare HMOs threw in prescriptions and the promise of "zero" premiums to dominate the senior market. When that backfired financially, they dumped prescriptions or dumped the HMO, leaving millions of seniors stranded from Seattle to Los Angeles and Orlando.

While drug costs have been increasing, even HCFA says the growth in pharmaceutical spending is expected to ease as fewer new drugs come onto the market and consumers' cost-sharing starts to stabilize.

Yet, the pressure to cover drugs is immense and fraught with hyperbole.

Candidates voice outrage that we pay more for drugs than Mexico, Canada or Europeans while they simultaneously bash socialized medicine. And, if we think the government wants to put the reins on the pharmaceutical industry by rate regulation, we're kidding ourselves.

Between 1992 and 1997, pharmaceutical earnings grew nearly 11 percent a year, which outdid the S&P 500 index by 90 percent. Hamstring the pharmaceutical industry when we need the hot economy to keep Medicare from being insolvent? Not a chance.

And to solve the problem?

More than five proposals now exist in Congress to add a drug benefit to Medicare, with more sure to come. Solutions fall into three camps calling for radical Medicare reform:

- Marketplace, private insurance and consumer choice;
- Government subsidies and management;
- And one that gets Congress off the hook completely and passes the quagmire to the states to solve.

Virtually all proposals include an income test - a first for Medicare and a gigantic hurdle. Almost all include stop-loss insurance in case someone made a really big mistake about costs.

So, if a drug benefit is added to Medicare, where will the money come from to pay for it?

Payroll taxes that go into the trust fund now? Employers will revolt. The surplus? Only if the economy stays hot.

## **KATHLEEN O'CONNOR: SELECTED COLUMNS, *The Seattle Times* 2000-2004**

We're gambling big time. No one has a clue how this will work, yet everyone is making political hay just as they did with the last attempt at Medicare reform in 1989 which was reversed a year later.

When it comes to proposals, Washington's Sen. Slade Gorton has one as well that takes the cake. Gorton blames drug companies for charging more here than in Canada and Mexico: 95 cents a pill for Prozac in Mexico compared with \$2.21 a pill here.

Gorton seeks to amend a 60-year-old congressional act that prohibits manufacturers from undermining American businesses by selling the same product overseas at discounts.

The average Mexican earns \$7,700 a year compared with our \$30,200 per-capita average. That means we pay 2.3 times what they pay in Mexico for Prozac yet we earn nearly four times as much.

This is exactly the problem in this election year. We are all outraged at the cost differences. And, where does that get us? Nowhere.

### **Solving the wrong problem**

The current, sweeping solutions are virtually doomed to failure. An income test for Medicare is bound to rebound. Controlling prices by rate regulations is only blindly following already flawed public policy. Framing the issue as marketplace vs. government-run health care only serves to divide us. And, we are rushing for solutions in an election year, so we have the rare opportunity to foul up big time.

None of the solutions we rushed to in the past has worked. Remember the promise of managed care? Well, we got it. Who likes it? Does it work? We dropped Medicare reform 10 years ago like a hot potato because we rushed to do the wrong thing.

Solutions exist. We don't have to overhaul all of Medicare to find them. We need to focus on the problem: How can we get affordable medications for a vulnerable group of seniors who are the only ones paying full fare?

We need to ask this of an independent commission that includes employers, pharmaceutical companies, consumers, policy officials, clergy and others. All sorts of examples exist: purchasing pools, discounts and other arrangements. We do this for Medicaid. We do this for employers.

Given our track record for other Medicare or health-care reform, these sweeping proposals are doomed because they have more to do with getting elected than helping that woman at the pharmacy.

We need to get the solutions out of the hands of an election-year Congress trapped between campaign contributions and the senior vote.

So, create an independent commission in which all the stakeholders can find common-sense solutions to a problem that is more than solvable - and, much, much more than TV ads fighting over which country sends more buses of seniors to the other.

## KATHLEEN O'CONNOR: SELECTED COLUMNS, *The Seattle Times* 2000-2004

Guest columnist

### Why health-care insurers keep changing the rules

by Kathleen O'Connor  
Special to The Times

Premera Blue Cross, the state's second-largest health insurer with nearly 756,000 members and over 7,000 employers, has quietly been converting some of its business from nonprofit to for-profit status.

Why should you care? Read on.

In November 1998, Premera created Premera Healthcare, Inc. (PHI), a wholly owned, for-profit subsidiary of the Washington-Alaska Group Services, Inc. (WAGS), another wholly-owned, for-profit subsidiary of Premera Blue Cross.

In January, PHI applied to the state insurance commissioner to issue 50,000 shares of stock to capitalize the subsidiary, which already had \$10,000 in capital. The Washington-Alaska Group was the sole shareholder.

Add to this Premera's new CEO starting in July, who served as the chief financial officer of HealthNet and who participated in the conversion of Blue Cross of California from nonprofit to for-profit.

It is not just Premera. Regence wants a for-profit subsidiary as well. Regence, created as a holding company for the four separate nonprofit Regence Blue Shield organizations in Washington, Idaho, Oregon and Utah, has filed to create a new for-profit operational company for joint data management, which will be funded by these four nonprofit organizations in the form of stock. As the state's largest insurer, Regence has over 888,000 insured members and another 195,000 who are with employers who self-insure. Boeing ranks as its largest client.

So, what's the big deal? As nonprofit organizations, Premera Blue Cross and Regence Blue Shield, worth \$220 million and \$500 million, respectively, have enjoyed tax advantages not available to for-profit corporations. If they convert, in whole or in part, what returns do we as taxpayers get for our subsidy of these organizations?

#### Not chump change

When Blue Cross of California transferred a majority of its stocks into a for-profit subsidiary, the state cried foul and Blue Cross had to pony up \$3.2 billion.

But Washington state has no law governing these conversions. The state's Holding Company Act covers property, casualty and life insurers, but HMOs and health-care service contractors, such as Premera and Regence, are not covered by that law. This means, at the present time, HMOs and health care service contractors can do what they want with their assets and transfer whatever they want from their nonprofit business into for-profit corporations without answering to anyone.

#### The track record

California is not alone in demanding payment. And, the payments are substantial. Colorado obtained \$155 million from Blue Cross/Blue Shield of Colorado. Connecticut got \$41.5 million. Blue Cross/Blue Shield of Kentucky settled for \$45 million. New Hampshire Blue Cross set aside \$80 million for health care because of its conversion. Virginia recaptured \$175 million in charitable assets for the state. The list goes on.

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Over 20 states now have, or are considering, laws to regulate these conversions and require payments to the public for the advantages the insurers have enjoyed as nonprofit corporations.

Most of these settlements came about after years of lawsuits and litigation. Missouri alone waged a six-year fight with its Blue Cross. Texas and Illinois are fighting mergers and suing for assets. Delaware's conversion stalled after the state got involved. Blue Cross/Blue Shield of Kansas has backed away from its conversion once the state attorney general opposed the move. You would think these plans would learn the lesson.

### **Who wins? Who loses?**

Nonprofit organizations are licensed as such because they are seen as serving the public good. Consequently, they are not required to pay most state and federal taxes.

Unlike a nonprofit organization, for-profit shares can be sold for the benefit of individuals and used for executive compensation and bonuses, as well as capital generation.

The potential gain from these conversions is for the new company and its shareholders, not the public.

The loss to the people of the state is the money we would have had if those revenues and assets were taxable like other corporations. So, if these nonprofits want to change the rules of the game after years of nonprofit status, what do they owe the people of the state? Premera Blue Cross has been a nonprofit for 55 years. Regence for 83 years. What is the value of our public subsidy of these organizations?

### **Call a moratorium**

A bill to protect the public interest and regulate these conversions never made it out of committee in Olympia. The Holding Act has not been amended. Interim studies, however, have been proposed. These studies are essential, but what is even more important is being sure we get a return on our investment, especially at a time when Initiative 695 has reduced funds for public health programs.

We need a moratorium on any conversions until we can be assured the public good is being met and that the public, not just corporations, will get a return on its investments.

Guest columnist

## **Insurance not just for healthy, wealthy**

**by Kathleen O'Connor**

Special to The Times

Hidden behind the gibberish of insurance terms like pre-existing conditions, guaranteed issue and portability, is the fight to restore insurance options for individuals. Because insurers could stem their financial losses in the one market they could close, they simply stopped offering new individual policies. Now, 600,000 people - roughly the population of Seattle - have no chance of buying insurance in 31 of our 39 counties. And 250,000 people with individual policies live in fear of losing theirs.

Insurers say they are losing money because people jump between policies, or buy insurance, then use it to pay for maternity care or a knee replacement and leave. Insurers say this leaves them holding the financial bag because premiums didn't cover their costs.

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But this is equally true of the commercial market, which insurers cannot afford to lose. Employers act just like individuals. They buy a plan, use it, and when it becomes too expensive, they drop it and shop around for another insurer. If individuals are culpable in how they behave, so are employers.

So the issue is not behavior. It is the bottom line and who is in whose risk pool.

### **The Dark Ages**

Like medieval walled cities, insurance risk pools are designed to exclude the dangerous and protect those inside. They assume those inside are familiar and safe, and that outsiders, if taken in, will either contaminate them and/or use up resources and drain the treasury.

So large employers, like Boeing or Washington State, have their own risk pools, small businesses have theirs and some businesses band together to get better prices for their members.

Safety-net programs, such as Medicaid for the poor and Medicare for the elderly and disabled, have taken those who tend to use more services out of the commercial market and put them into separate pools.

The 250,000 individual policyholders are grouped into yet another pool, but are easy prey. They number relatively few and have no organized voice. The 600,000 waiting to get insurance also have no organized voice or rallying point.

Each group tries to protect itself by keeping others out. But because each of us acts in our own economic self-interest, we build more walled cities and have unintentionally created morally suspect choices.

### **Moral choices**

It's not that insurers don't want an individual market. They just want one that is more predictable and healthy.

So now, to open up the individual market, a health screening is proposed for new applicants. If someone has a chronic disease or health problem, they will be routed to the Washington State Health Insurance Pool (formerly, high-risk pool) where their costs will be partially subsidized. And the pre-existing condition term will be extended to nine or 12 months rather than the current three. This compromise may be the only way to get an affordable individual market now.

But, what this all means is that those programs we once created as safety nets have become the moral equivalent of leper colonies. We put the old and disabled here, the poor over there, take those who can afford it in part and put them into the Basic Health Plan and ban the sick to yet another colony.

All this to hold down the costs of the commercial market. And who of us is to know when we or someone we love will become disabled, poor, sick or old?

Shame on us.

### **Feet to the fire**

We are close to compromise on the individual market. So compromise we must, now. But after these proposals pass, we must find another way. We are morally bound to find solutions other than casting people into leper colonies based on income, age or health status. After all, who among us would choose to have multiple sclerosis, diabetes, leukemia or cancer?

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If we take the course to give options to 600,000 people, then we must find ways to stop dividing the insurance market so it is not just for the wealthy and healthy. We are better than that as individuals, as a society, as a state.

If we do this, and reluctantly, I think we must, then it is the absolute duty of each of us to demand that the governor appoint an interim citizen task force to find less morally culpable solutions. Many suggestions have emerged, but cannot be dealt with in the haste of a 90-day session. Options exist. It does not take rocket science; it does take political will.

There is no one bad guy to blame. No malevolent intent created this "system." We are all responsible for what has emerged from a self-interest driven system. But now is the time to say this is wrong.

Martin Niemeuller, a Protestant minister, said it best when talking about the insidiousness of the Nazis: "When they came for the Jews, I was not a Jew, so I said nothing. ... When they came for me, there was no one left to protest."

So, which pool are you in now?

Guest columnist

### **Gore vs. Bush on health:**

**System has become captive to political ideologies**

**By Kathleen O'Connor**

Special to The Seattle Times

If there is one clear choice in this election, it is health care. At stake is the future direction of American health care.

Republican candidate George W. Bush relies on medical savings accounts at the commercial, Medicare and long-term care levels. Democratic candidate Al Gore leverages existing programs to expand coverage.

Here's how their proposals work and what they would mean.

#### ***Bush's proposals***

Bush wants individuals to make health-care decisions. He would let all employers offer annual tax credits of \$1,000 per individual and \$2,000 per family to cover up to 90 percent of their health-insurance costs via medical savings accounts (MSAs).

MSAs work like 401(k) retirement accounts. Money in the form of a "defined contribution" from an employer is deposited annually in a restricted account. Employees would pay a hefty penalty if they used the money for anything other than health care.

MSAs let employers give employees the premium money they would have paid, so the employee makes health plan and coverage purchasing decisions. The employer gets the best of both worlds--employees assume responsibility for their health-care costs and coverage, yet employers keep their pre-tax deductions for employee health care.

Bush wants to overhaul Medicare to make it similar to the Federal Employee Health Benefit Plan in which employees have a wide range of options from which to choose. This would move Medicare to an MSA or

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"premium support" model and expand the choices that seniors would have for the Medicare market, as well as expand Medicare+Choice program options.

He proposes giving block-grant money to states so they have the option of covering prescription-drug costs while his Medicare overhaul is under way. No federal prescription-drug program would exist under his proposal until the overhaul is completed in 2004. He also wants to create a commercial prescription-drug option seniors could buy.

He wants to make the cost of long-term care insurance fully tax deductible, have a personal tax exemption for home caregivers and let medical savings accounts be used for long-term care services as well as medical services.

### ***Results***

Relying on MSAs for commercial insurance will require major legislative changes because rules for health insurance are regulated at the federal level for those large employers that self-insure (called ERISA for the Employee Retirement Income Security Act) and within the individual state for those employers who have to buy commercial insurance. Here, Microsoft, Weyerhaeuser and Boeing are ERISA companies. Roberto's Hair Salon, Fremont Dock and Hale's Ales and many dot-coms have to buy health-insurance packages subject to state rules and regulations, not federal.

For Bush's plan to work, legislation would have to be changed at the federal level and within each and every state in the nation. Major questions on MSAs remain unanswered. If employers give the premium money to the employee, will it be taxed, which it is not now? If so, who gets taxed? Employer or employee? If individuals assume responsibility for their own health-care purchasing, will they be subject to an individual health screening that does not now apply to them within their employer-based group product? Where do employees get catastrophic coverage or re-insurance?

Bush's proposals for tax credits and expanding options for small business owners through multi-state associations are workable. He is to be credited for expanding tax credits to caregivers and for deducting long-term care insurance as well. But, Gore proposes something similar.

Bush's proposal for a separate prescription benefit option for seniors will not work. Why? Because only the most seriously ill people would want it and would actually use it, which ironically makes it too expensive for most people to buy or the government to pay for. Even the insurance industry has no interest.

Bush has moved the current problem of prescription drug coverage from the federal to the state level, by allocating block grants to pay for prescription drugs for seniors whose drugs cost more than \$6,000 per year. This means each state would have to staff up for a new program and Medicare would have to create an entirely new bureaucracy to manage something temporary.

His Medicare+Choice expansion will increase costs because more choices mean more administrative complexity in managing all the different rules, regulations, deductibles, co-payment, premium sharing, coverage options and claim forms. More choices mean more administrative costs.

Bush's approach would fundamentally re-structure the health-care marketplace, move it away from an insurance-based model because MSAs are basically not insurance products. MSAs also offer the real danger of taking the healthiest and wealthiest out of the commercial insurance market and leave only the most infirm, which would increase costs for those least able to afford it.

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### *Gore's proposals*

Gore proposes covering people one category at a time. He would expand small-businesses' options by promoting purchasing cooperatives, such as are now available here in the Employers Health Care Purchasing Co-op, among others. These co-ops offer big business benefits at more affordable rates. He also proposes a 25 percent tax credit for each employee and a 25 percent tax credit for individuals between the ages of 55 and 65 so they can buy into Medicare. Bush has almost similar proposals.

Gore wants to expand the CHIP (Children's Health Insurance Program), raise the eligibility level to \$41,000 for a family of four and cover their parents. Like Bush, he would reduce its regulations.

In Medicare, he would add a non-deductible prescription-drug benefit with a premium of 50 percent of the drug-benefit costs and an annual maximum of \$2,000 which increases to \$5,000 by 2008. It will cover one half of prescription drug costs up to \$5,000 annually and includes catastrophic protection. Seniors with incomes under \$11,000 per year would have no premiums or co-payments.

He proposes a \$3,000 tax credit for volunteer caregivers of an elderly parent or spouse, which is similar to what Bush proposes.

Gore also proposes covering mental-health services for children, which Bush does not address, and wants to expand state Medicaid services to make it easier for states to cover home and community-based services. Bush would let MSAs handle that.

### *Results*

Gore's health-care proposals are the most comprehensive, least intrusive and require no major legislative or regulatory changes, except for Medicare prescription drugs, which is a struggle for everyone. Gore offers a way to expand coverage and leaves the MSA pilot project intact while some operational questions can be answered. Gore's plans are founded on the employer-based model through which 70 percent of all Americans have insurance.

### *That's the choice.*

The fact remains, however, we spend more on health care than anyone else in the economic Group of Seven industrialized countries. We have worse outcomes in terms of life expectancy and the death rates of infants and mothers. And, 42 million people are uninsured.

We have let health policy become captive to our political ideologies of MSAs, personal responsibility, managed care, single payer, or whatever. Our ideologies have trapped us into fruitless debates of what is right or wrong vs. what we want, what will work and how to get there.

Instead of holding health policy hostage to elections, we could actually build on some work that has already been done. The President could re-structure the Medicare Commission (Thomas Breaux-Commission) and expand its mission to look at the entire system, not just Medicare.

Instead of relying solely on Congress, the dialogue could include others such as Families USA and Health Insurance Association of America which have been in preliminary conversations. If these two often ideologically opposed groups can take steps toward common ground, then Congress and the President should be able to do the same. It does not take rocket science to create a system, it takes broad participation and political will. And, a vision of what a system of care should do.

