

# CHAPTER 1

## HEALTH CARE'S GAME-AND-BLAME BATTLEFIELD

America's health care oozes intrigue and shifting alliances. "The enemy of my enemy is my friend" is the hallmark of our health care system. It has birthed adversaries instead of allies, it has made monsters out of otherwise decent people, and it has forced providers, insurance companies, pharmaceutical companies, government and patients to demonize each other for their own economic survival.

With degrees in Japanese and comparative governments, I am trained to look at systems and find ways to understand, compare, and contrast different political, economic, and cultural systems. After years of working in the health care industry, I have concluded it is as alien to most Americans as any foreign country in terms of who the players are, what they do, why they act the way they do, and how the money works.

I cover a lot of complex material very fast and at a macro level. This is not intended to be the definitive book that documents every fact and figure in the industry to prove that I know what

I'm talking about. If it were, you would not read it, and this is a book that needs to be read. I have references in back for those who are insistent for those details. I am only too pleased to provide them.

## **THE BASICS**

America's health care is a business-to-business enterprise. Employers buy health insurance from insurance companies who put a price on benefits and sell them to employers. The prices are based on what doctors and hospitals charge, plus the administrative costs of the insurers and the overhead and profits for all the participants along the way. Because we have a business-to-business model, there is no accountability for outcomes. We are stuck with the conflicting goals of each individual group.

The business-to-business model has created an irreparably flawed, fragmented system of employer-based costs and benefits. We lack an integrated system of care. We have redundancies and duplications as well as gaps, deficiencies, and needs. We have no common health care goal as a community or as a country.

Over 70 percent of all people with health care insurance get it through their employer. Employers want to offer health insurance for their employees at the best possible price. This has created, in good part, some consumer attitudes that they are entitled to have something for nothing, because their employer started out covering all

their health care costs. When costs get out of line, employers put out bids and get new estimates so they kind find yet other ways to control costs.

Consequently, our health care policy focuses solely on costs. We simply redesign benefits and bounce employees and companies from insurer to insurer, none of whom want to undertake prevention because there is no economic incentive to do so.

Because we have no goal, and because our health care is a business-to-business model, we have perverse incentives that pit otherwise reasonable people against each other for their very survival. Let's see how this plays out.

## **A FIELD GUIDE TO ALLIES AND ADVERSARIES**

Health care wars erupt periodically when costs start going up as they are again now. But, when we try to lower costs in one area, we usually drive up costs in another. Our old traditional way of paying for health care was to simply pay what doctors and hospitals charged. This is called “fee-for-service,” but this approach has absolutely no brakes on costs. Hospitals would keep you as long as the physician thought necessary and charged what they needed to cover their costs. Doctors were paid every time they saw a patient. They could set their own rates and see their patients for as long and as frequently as they thought necessary.

Federal payment programs and managed care changed all that thus unleashing the most recent and evolving health care cost-control war.

### **THE DUKES AND THEIR FIEFDOMS: HOSPITALS**

The health care dollar goes primarily to hospitals. In a one trillion-dollar a year industry, hospitals get the lion's share of the health care dollar. In 1999, that meant \$391 billion or roughly one-third of \$1,171 trillion total 1999 health care expenditures went to hospitals.

Hospitals used to get their money by the number of days a patient stayed in the hospital. Congress changed that in the 1980s when health care costs skyrocketed at 10 percent to 22 percent each year, hammering business, state and federal budgets in the middle of a recession. Congress tried to control what it could first: Medicare hospital costs. This began the move away from an unbridled fee-for-service approach to paying on a cost-per-disease approach.

At the same time, employers saw health care emerge as their second largest expense after payroll. General Motors, for instance, paid as much for health care as it did for steel. So, employers began to pressure private insurers to lower their health care costs.

For its part, Congress decided that Medicare would pay hospitals a flat fee per diagnosis (DRG) rather than costs per day. Hospitals got one fee for heart attack, another for stroke, yet another for cancer or diabetes. Unfortunately, these fees

did not originally take into account age, sex, or general health of the patient. They made no distinction between an overweight eighty-five-year-old man who had smoked for thirty years and was on oxygen and a fifty-five year-old man who played golf, jogged, and had no other health problems. So, if hospitals had younger generally healthy people who had only one disease, they made out like bandits. If they had older, poorer people with several health conditions, they sank. Rural hospitals sank first.

Medicare represents about 35 percent of all hospital revenues. So hospital administrators were frantically scouring the health care landscape to replace what had been a very lucrative revenue stream.

What to do? They began marketing. They went after women in droves. “Birthing Centers” erupted all over the country. Why? Because women make 75 percent of all health care decisions. If a woman is happy with her maternity experience, she will organize all the family health care around that hospital and the doctors who admit to that hospital. It was a great marketing ploy, even though many maternity centers are “loss leaders” if they don’t deliver enough babies.

Hospitals also realized that if they relied solely on inpatient care to generate revenues, they were doomed. So they began developing new surgery options that did not require the patient to stay overnight. These same-day, outpatient (ambulatory)

surgery centers were outside of Federal Diagnostic Related Group (DRG) regulations, so they generated unregulated income to replace some of the income they were losing from government rate-setting.

Equipment for diagnostics tests also sprang up to generate new revenues to help replace revenue loses with in-patient care. They bought MRIs, CAT scans, and other diagnostic equipment so the hospital could generate new revenue streams. Consequently, there is pressure to use these services so they will create revenue as well as pay off their investment.

These very things that create income for hospitals now also create conflict with physicians. Just say “Certificate of Need” (a sometimes state-required licensing review to permit expansion of health care facilities and services) in some communities and the verbal grenades start flying, as both hospitals and doctors try to justify and make their case about why they should be able to provide the services. The outcomes of Certificate of Need decisions have major income consequences because income depends on whose application is approved or denied.

Physicians figured that if patients no longer needed to stay overnight in the hospital, then they could do same-day surgery as easily as hospitals. And, if the hospitals could have diagnostic equipment, then why can't physician offices? And so the war was on.

Doctors and hospitals who were at one time largely partners now compete for many of the same services to generate revenues, which means duplication is rampant.

On the other side of the kingdom, while the Feds were budgeting what they would pay hospitals and lowering the rates, employers began to join with insurers to push hospital costs down. They designed a new way to pay for health care in the form of Preferred Provider Organizations (PPOs) and some HMOs. So while the Feds were changing the revenue streams to the hospitals and doctors, the commercial insurance markets started changing the revenue streams as well. Basically, they were offering a “discount on volume” approach to lower employers’ costs.

Insurers went around to doctors and hospitals and promised them a deal—you take lower rates and team up with us, and we will move more patients your way. In other words, what you sacrifice in high rates will be made up to you through volume.

So, while Medicare was whacking away on one stream, insurers and employers were whacking away at another. And, then along came managed care ratcheting down the rates and contracts even more and putting increased pressure on the hospitals to find other sources of revenues. And the game goes on, leaving consumers afraid for their lives in short hospital stays, leaving hospitals with sicker patients, and leaving everyone worrying as much about money as about patient care.

**THE KNIGHTS: DOCTORS**

After Congress figured rate control and budgeting worked for the hospital goose, it tried a similar approach with the physician gander and began limiting Medicare payments to physicians as well. They tried to adjust physician fees to compensate for large differences in pay rates between specialists—the high-rate guys, such as cardiologists and neurosurgeons—and the low-rate guys—primary care doctors and pediatricians. (A formula known as RBRVS—Resource Based Relative Value System).

So the same scenario played out with physicians as it did with hospitals—rate control on one hand and the discount on volume deal from the commercial insurers on the other. The problem is, there are vastly more doctors than hospitals. And because they had no idea which insurer would win in the new health care marketplace, the doctors joined every plan that came along, which meant they were essentially competing against themselves.

Physicians also faced the same dilemma as the hospitals: how to replace revenue that was not coming back. So, like the hospitals they also began buying equipment and offering tests at their clinics for patient convenience. They started increasing their volume of patient visits and procedures. Some even began offering outpatient surgery.

The rate controls, which were initially used to control costs, unintentionally created internecine

warfare that increased costs. At \$250,000-plus for an MRI or CAT scan machine, lots of users are needed to pay for these investments at both the physician clinics and the hospitals.

Consequently, advertising, marketing, and promotional campaigns blossomed to lure consumers to use one facility rather than another to pay off the costs of their investments. These campaigns promote use, and use means economic survival. More use also means higher costs for the system as a whole.

In short, competition in health care increases costs, because it promotes use and more use means more costs. So, what works to produce financially viable physician offices and hospitals ironically drives up costs for the system as a whole, because the system depends on using services to pay for overhead, infrastructure, and profits.

As to where your health care dollar goes, physician and clinic visits account for a little over 22 percent of all health care costs. Of that 22 cents of the health care dollar, only 11 cents actually gets to primary care.

### **THE MERCHANTS: PHARMACEUTICAL COMPANIES**

Charging money to everyone, the pharmaceutical industry rakes in the dough. Pharmaceutical products are blamed for increasing health care costs, for direct-to-consumer advertising, for being the world's leader in charging the highest

prices for pharmaceutical products, and for boasting this nation's highest profit.

Interestingly enough, no one blames hospitals, medical clinics, health insurers, Tylenol, Bayer, or Pepto Bismol for the direct-to-consumer advertising they have been doing for years. The FDA simply did not allow drug companies to do so until 1997.

While pharmaceutical firms, hospitals and doctors were often staunch allies, especially when it came to the role of government and rate regulation, a rift has emerged among them. The new biotechnology products and some other new drugs stand to take money away from doctors and hospitals because patients won't have to go to the doctor as often or to the hospital as frequently. These new medications that feed pharmaceutical profits literally have the potential to directly reduce the income that hospitals and doctors receive for patient care.

For example, rheumatoid arthritis afflicts about two million people. Its annual impact alone on health care costs is staggering—nine million annual physician visits and 250,000 hospitalizations which adds up to \$5 billion worth of health care visits. Enbrel, a relatively new drug developed for rheumatoid arthritis, costs a patient about \$12,000 to \$15,000 per year.

Needless to say, doctors and hospitals are probably quietly thrilled everyone is pointing fingers at drug companies now, because if some of these

drugs really work on many major diseases, doctors and hospitals may face yet another declining revenue stream. However, some new studies show pharmaceutical costs are also increasing physician costs (and income), because consumers have to go to a physician to get a new prescription. Many new medications also require more frequent monitoring with regular blood tests and overall health check-ups.

Ironically, hardly anyone in the health care industry has the information systems in place to do a cost-benefit analysis of the impact not only of these medications, but of nearly every other medical/surgical strategy as well. So, almost everyone does Spin City without any data at all to prove or disprove the health and/or financial impact of various approaches.

The fact remains, pharmaceutical companies not only have the highest profits in health care, they have the highest profits of any industry in the U.S. In 1999 alone, their profits as a percentage of revenue were 18.6 percent—ranking higher than commercial banks, the second top performing industry at 15.8 percent and computer peripherals at 12.1 percent. Pharmaceutical manufacturers are clearly for-profit and are demonized for that profit. What is not said is that nearly every other sector of the health care industry—physician practices, medical technology, medical suppliers—is also for-profit, with the exception of some health plans, and hospitals which remain largely not-for-profit enterprises.

The big advantage for pharmaceuticals, unlike almost every other health care service and product, is that they have remained outside the clutches of Medicare. This makes them the only major player not subject to rate policies set by the federal government. The fight about Medicare and prescription drugs, therefore, is a two-fold battle. One is cost. The other is rate control. The pharmaceutical mantra is “no rate control.” And, as the miserly merchant, they are not bargaining.

### **THE INQUISITORS: THE INSURERS**

If a vote were taken on the villain of health care, it would probably be a draw between insurers and pharmaceutical companies. Insurers are still ahead because of their ever-present and pervasive role. They control the services people get, how they get them, how they pay for them, and how much they pay for them. They largely own patients’ personal health care information, such as the results of lab tests that are paid for by health insurance premium dollars.

Like banks, they compete against each other for business, but unite in a flash as an industry when trouble like the Patients’ Bills of Rights trots by.

Insurers are both for-profit and not-for-profit. Managed care can be for-profit or not. The traditional fee-for-service insurers (indemnity) are for-profit. Some not-for-profits, such as Blue Cross and Blue Shield, have been turning themselves into for-profit enterprises. It’s a shape-shifting

landscape. Few behavioral differences exist between profit and not-for-profit because the not-for-profit mimic the behavior of the for-profits so they can survive in the same marketplace.

Like a tinker peddling wares, insurers sell products to tempt employers to buy what they have to offer. An insurer can have a multitude of products. A Blue Cross/Blue Shield plan wants IBM's business. So, it will offer a variety of packages and products designed to offer a choice of services at an affordable price for IBM's employees. Their offers can range from the fee-for-service model—use-it-and-we'll-pay-for-it—to the managed care model—use it only under these conditions.

The trouble with the fee-for-service model is that there are no financial brakes. The trouble with the managed care model is it has too many rules and regulations about who you can use as a doctor, or how long you can stay in a hospital, or which drugs a doctor can prescribe. Virtually no one understands them. Even if someone did, it wouldn't matter. The contracts, networks, and rules change every year as plans are constantly tweaked to control costs.

The managed care model has ended up doing the opposite of what it was supposed to do. It drove up costs because it required fleets of people to stay on top of the different rules and regulations of all the different plans. One multi-specialty clinic in California with 135 physicians, for example, added 25 people full time just to verify the

different regulations of 35 different insurance contracts with their different benefits, hospitals and physician networks, as well as patient eligibility. Administrative complexity adds cost.

Managed care raised its ugly head in the mid-90s as the marketplace solution to the Clinton health proposal. It was going to save money by focusing on prevention and by compiling complex health care information on computers to save administrative costs. Not only did that fail to materialize, it fell flat on its face. Insurers have lost millions, if not billions, on failed information systems, dot.coms, eHealth solutions, and now Internet applications.

Prevention? No insurer wants to touch it. Why? Because the average person is in a health plan at best for three years. Plans don't want to make the necessary up-front investment when other plans will reap the financial reward of that investment. So prevention programs are basically early diagnosis and screening. Not bad, but not enough.

The economic incentives for health plans are to get as many healthy people as possible. If it is not always possible to get healthy people, the benefits can be designed to exclude things that are used frequently by sick people, such as prescription drugs.

Health plans blame consumer groups and the state and federal governments for their cost increases because they pass laws that require insurers to cover such things as mammograms or prostate screenings, mental health, or extended stays for

maternity care. They blame consumers for being irresponsible users of health care services and causing cost increases because they don't pay for services directly out of their own pockets.

The plans blame doctors for wanting too much money. Ditto for hospitals. They finger the pharmaceutical industry now as the cost-increase villain. The only group insurers don't throw rocks at are employers who buy their benefits and products.

What is not broadly known outside the health care industry is that nearly half of the "health insurers" in this country are "self-insuring" employers, not insurance companies. Businesses, such as General Motors or Microsoft or Medtronic and even many state governments, decided there was little sense in giving an insurance company their premium money when they could keep that money themselves and hire someone else to do the administrative work, such as processing claims.

This way, not only do they get to keep the money the insurer would receive, they also don't have to pay the state the premium taxes commercial insurance companies must pay (since they are General Motors and Microsoft and not insurers like Blue Cross or Aetna). Self-funded employee benefit packages are largely invisible to the employees, in most cases, because many of these employers contract with commercial insurers to offer the benefit package the employer has asked them to design.

Why does this matter? Simple. Different rules apply to different groups. The self-insurers are governed by ERISA (Employee Retirement Income Security Act) and, therefore, the Feds. They are not accountable to or governed by the insurance laws in each individual state. What this means is that every player on the health care playing field plays by different rules—one group for the self-insured and fifty different rules in fifty different states for commercial insurance.

What this means is, if Kansas finally decides to require insurers to cover contraceptives, that law does not apply to any of the companies in Kansas that self-insure. And, if the Patient Bill of Rights passes Congress, it will wreak havoc, however, on those states that have already passed Patients' Bills of Rights, because they will have to change their bills to match the Feds' bill.

In terms of an industry profile, three associations exist: the American Association of Health Plans (AAHP) whose members are 52 percent non-profit and 48 percent for-profit and cover 125-140 million people in their HMO and PPO members; the Health Insurance Association of America (HIAA) which has 294 members that have products from individual healthcare insurance, to HMOs, PPOs and individual disability and long-term care products for over 100 million Americans and are largely for-profit; and the Blue Cross/Blue Shield Association of America, whose members are also members of HIAA and AAHP.

**THE KEEPERS OF THE GATE: PUBLIC INSURANCE**

Medicare and Medicaid are public insurance programs paid for by our tax dollars. Medicare and Medicaid are the largest public health insurance programs in the country and were passed into law in 1965 to assure the elderly, poor, and disabled would have some assistance in paying for their health care costs. Medicare is paid for by payroll taxes on employer and employee. It covers only hospital costs, some nursing home care and some other associated costs. Outpatient care and other medical costs are covered by Part B, which is private supplemental insurance with some government subsidy. Over 70 percent of all Americans think Medicare covers nursing home care. It does not. Nor does it cover prescription drugs outside the hospital.

While Medicare has the same benefits in every state, the rates for hospitals and doctors vary county by county, across each and every state. Doctors in California, Arkansas and New York are paid differently for doing the same thing. These rates, however, are not tied to the cost of living, but rather are tied to the historical rates (called usual and customary rates—UCR) hospitals and doctors charged in those counties and states.

When it came to Medicare HMOs, the managed care plans were paid a flat fee per month at 95 percent of the fee for service rates in their communities. Managed care plans dropped their Medicare HMOs in droves recently because they

said these rates are no longer adequate to provide health care services.

Congress sets the rates for Medicare as well as determines the rates hospitals, doctors, home health care, nursing homes and even medical equipment will be paid.

Congress also decides what services Medicare covers. It literally took an act of Congress to cover mammograms and prostate screenings, for example—just as it will take an act of Congress to add a pharmaceutical benefit.

Medicaid is a shared responsibility between the Feds and each state. The Feds give the states a federal financial match based on the level of poverty an individual state says it will serve. States can decide if they want to pay above that amount and can get matching funds from the Feds to do so.

When this is described, however, it sounds like people are speaking in tongues. This is what they say—People who are eligible must be at 100 percent or 150 percent, etc. of poverty. What this means is \$19,000 is the poverty level for a family of three. If a family of three earns \$19,000, then they are at 100 percent of poverty. So, if the Feds say anyone at 100 percent of poverty is eligible, then the states can take anyone under that income level. The problem is, some states are richer than others. To make the program work financially, states can limit rates for services so they can cover more people, or they can raise or lower access depending on the percentage of poverty. Medic-

aid ends up pitting state against state and the states against the Feds over eligibility levels and rates of pay.

Medicare is the only government program that is not based on income. Everyone over 65 and some disabled have access to the program, regardless of income, unless they immigrated to the U.S. after age 65 and did not work. So, everyone gets the same benefit no matter how rich or how poor they are.

Public programs tried to work with the private insurance industry to create Medicare and Medicaid HMOs to control costs. That worked for awhile, but now the HMOs say they are not making enough money and are ditching these programs in droves. This leaves the most vulnerable citizens—the poor, the sick, and the disabled—to fend for themselves in an unfathomable system with few choices.

Because Medicare and Medicaid combined constitute more than 40 percent of all health care expenditures (43% in 1999), their policies have a ripple effect throughout the system. It is simply easier for commercial insurers to mimic their rates and regulations than create their own. This explains why physicians, hospitals, pharmaceutical manufacturers, and others focus such an intense effort at the national level over rates, regulations and body parts that are eligible for Medicare and Medicaid coverage.

Medicare covers 39 million elderly and disabled people and paid out benefits of \$129 billion in

Part A and \$81 billion in supplemental payments in 1999 for a total of \$213 billion.

Medicare costs do not include the costs of prescription drugs or long-term nursing home care. Medicare costs are for hospitals (58%); physicians (22%); home health care (6%); and nursing homes (skilled nursing, not custodial care)—5%.

### **THE EMPERORS: EMPLOYERS**

Employers are the Emperors. Remember, American health care is a business-to-business enterprise. The buyers and sellers are businesses. Over 70 percent of all the people who have health care insurance get that insurance through their employer. Therefore, any change in the health care system will have to suit the needs of employers or, at least, not alarm or harm them.

Employers don't want a common or nationwide standard set of health care services and benefits for everyone because they use health insurance as part of their employee compensation packages. They use health care benefits to attract and retain employees. They pay for those premiums out of pre-tax dollars, so what they pay for health insurance also lowers their tax liability. That's the bottom line.

They blame everyone but themselves for costs. And, they talk out of both sides of their mouths simultaneously.

Out of one side, they say they want choices because they use benefits to attract and retain

employees. Out of the other side, they blame those same employees for using the very services they offer. They say employees are irresponsible because they don't have to pay the bulk of the costs. They blame labor for high costs because they make health care premiums and cost sharing part of their contract negotiations. They blame consumers, Congress, and state legislatures for mandated benefit laws.

Businesses are very nervous Nellies now about the Patient Bill of Rights. If a Federal bill passes that lets patients sue their health plans, self-insuring employers know they are one lawsuit away from being called an insurance company and a target for being sued themselves. Ostensibly, they don't care if such laws are passed in state legislatures, because they are exempt from state laws. They fight them anyway just to stop the momentum.

Small employers are at the mercy of commercial insurance companies with standard, off-the-shelf benefit packages. They get pounded by the way insurance risk pools work. (Risk pools are like medieval walled cities. Your costs are based on the health status and risk of those inside. The larger the group, the lower the rates. But more on this later.) They pay a much higher cost per person for health care, especially administrative costs, than their big brother or sister counterparts. But, they follow big business anyway.

In Japan, small businesses rebelled and health insurance became available for everyone because small businesses were sick of paying more for less coverage for their benefits per employee than large employers were paying.

Large employers and small employers pay different health care taxes. Both are able to take their health care premium costs out of their pre-tax dollars, therefore lowering the amount of money on which they have to pay taxes. But large employers do not have to pay state premium taxes that are included in the costs of commercial insurance packages small employers must buy, unless they buy some of the commercial policies as a choice for their employees. Some states have special insurance pools for people who cannot buy insurance because they have a major disease such as cancer or diabetes. These pools are often funded by taxes on insurers. Companies that self-insure do not have to pay into these plans because they are not “insurance companies.”

So, once again, small businesses that cannot self-insure have to pay more for things their bigger siblings don't. Because they think they are all in the same boat because they are all businesses, small businesses have blithely followed the big business path, to their own financial detriment.

Not only are employers the emperors of the battlefield, they have armies of henchmen in their service.

**EMPLOYERS' HENCHMEN**

An entire industry exists to sculpt health care benefits for businesses. Four major armies help employers with healthcare benefits: **employee benefit consulting firms, actuaries, brokers and business coalitions.**

**Employee benefit consulting firms** are the **wizards** who conjure up the benefit packages for employers based on what employers tell them about balancing cost and employee satisfaction. One firm, Milliman USA, probably designs 70 percent of all employee benefits in the country.

Not only do these firms design benefit packages, they also do research on the impact of those benefit designs. They can demonstrate the difference in use and cost by changing a co-payment from \$10 to \$15 and can show there is no difference in outcome if a woman stays twenty-four hours for a maternity delivery rather than two to three days. It is this group that gave us “Drive by Deliveries” and other such wonders and sold them to the employers. Their salaries get factored into the premium dollar.

**Actuaries** are the **bookies**. They bet odds on how many people in a group will get sick and use services and then they put a price on it. So, a small hair salon with largely young females (and therefore at risk of childbearing) will pay a higher price than a gas station and garage with young or old males. Firms that are largely female, such as retail, will pay higher premiums because of potential

maternity costs, than accounting and law firms that are largely male. Ranchers and farmers pay more than accounting firms do, because they are in more physically hazardous industries. Actuaries calculate the odds, put a price on them, and call that “premiums.” Their salaries are included in your health care premium dollar.

**Brokers** are the **sales team**. Like real estate agents, they save the buyer—the employer—the trouble of going out shopping and pricing plans and benefit designs. They ask the employer what they want, then shop around and come back with options. For this, they get a percentage of the sale. Their commissions are included in the premium dollar.

Employers want to keep employees, yet they want to control costs. They were the originators of health care as an employee benefit, even though there were also early union plans. Employers have consistently used health care as a form of employee compensation and in times of wage price freezes they have given employees more health benefits in lieu of wages. Health care is a bottom-line issue for employers—when the labor market is tight, they expand benefits to keep employees. This practice is cheaper than replacing an employee given that the low-end cost to replace an employee is \$14,000. Yet, during recessions, they add co-payments, premium sharing, and lower coverage or drop dependents from coverage.

Multi-state employers are driven wild by the different rules and regulations and networks and benefit options in each and every state. Yet, they resist uniform or standard benefits because they believe it takes away their ability to compete for the best employees.

**Business Coalitions** are **Alliances** employers form to influence the health care marketplace. These coalitions can purchase care directly as they do in Minneapolis, or form lobbying groups, or develop and test pilot projects.

#### **THE NEWEST EMPLOYER BATTLEFIELD STRATEGY:**

##### **THE LEAPFROG GROUP**

Over 80 Fortune 500 companies, including federal and state purchasers of health care, have come together to form The Leapfrog Group ([www.leapfroggroup.org](http://www.leapfroggroup.org)) to use their purchasing power to influence the marketplace and to increase the safety and value of health care for the American public. They have decided on three areas they think need improvement for patient safety in hospitals: 1) computerized order entries for all prescriptions given to a patient in a hospital setting; 2) high volume of high risk surgeries; and 3) staffing of intensive care units. Seven designated pilot sites have been selected. These initiatives were chosen because all the purchasers involved could sign on to them. They are testing this initiative now in seven sites around the country.

Ironically, their efforts are adding costs to the system. The computerized physician order entry, cost one hospital in Boston nearly \$2 million to implement and \$500,000 a year to maintain. One hospital alone in Seattle, has to train 1,900 doctors on how to use the system.

This Leapfrog initiative is indicative of the fracture of our health care system. No one trusts each other, so we have initiatives by edict vs. collaboration. As a further irony, the Leapfrog Group is a spin off of the Business Roundtable, which has as one of its standard goals to oppose mandates. They do not see that their requirements are yet another unfunded mandated benefit coming out of state legislatures or Congress. Yet, what they are asking adds as much cost.

While their intent to improve patient safety is laudable, their approach is indicative of the system's fatal flaw: I'll do what's best for me and damn the consequences for everyone else.

### **THE ZEALOTS: UNIONS**

Unions were the early advocates who brought health insurance to the workplace. They created their own plans, started union clinics, and fought for health insurance coverage for their members. Since the mid-1940s, they have been able to make health insurance a part of the labor contract with their employer. What this means is that strikes around the country include health care benefits as a key point in the negotiations. Boeing caved

on health care demands in the machinists' union and the professional union strikes in 2000.

What has happened is that unions have gone from being advocates for their members who did not have insurance, to now insisting on some of the nation's most generous coverage, i.e., they demand that their members not pay any of their premiums or co-payments and have no deductibles. They consider any change in deductibles or co-payments or premium sharing as a change in salary and terms and conditions of employment, and fight it. These unions may be right, but maybe the issue is pay not co-payments and deductibles. When everyone else has to share, they are not winning allies in these cost-sharing demands.

Taft-Hartley Plans are another form of insurance available for members of labor unions, even though the employee may work for a company that offers health care benefits. So, a large national company, such as Safeway, may offer its employees several different benefit packages, one of which is a union trust, which further muddies the water.

In the health care armed camp, the unions fight employers to get more health care coverage for their members. Because health care is a form of compensation, any union employee participation in cost-sharing is viewed as a lowering of wages, and consequently a change in compensation. However, if there is one group in favor of government intervention in rates and regulations in

health care, it is the unions. Distrustful of employers, doctors, hospitals, and the marketplace in general, unions turn to government as an ally to protect their income, economic well-being, and rights as workers.

### **THE COURT SERVANTS: PUBLIC HEALTH SYSTEM**

The Public Health System can be characterized as the court servants of health care. They make sure we have a strong infrastructure—that our water is clean, that our food is safely handled in restaurants and in packing plants. They track diseases to prevent and contain epidemics. In some cases, they offer services to people who otherwise cannot afford it. They don't have a marketing and public relations budget, so you would never know they are there unless you read the list of restaurant closures in your local paper.

If anyone has a health care agenda, it is the Public Health Service, with goals like *Healthy People 2000* and *Healthy People 2010*. It has goals for smoking cessation and oral health, but the private insurance and commercial sectors pay absolutely no attention to them.

Probably no group has done more to assure the health and well being of all Americans than the public health system. But, virtually no one knows or cares that they are on the health care cost-containment battlefield. They are totally ignored by employers and insurers, because they

are, after all, government, and health care is a business-to-business enterprise.

Their funds come from tax dollars. But unlike Medicare and Medicaid, they have nothing to do either with insurers or employers. They focus on our health infrastructure and go around trying to minimize our health risks.

They collect information on diseases, outbreaks, hospital admissions and deaths and collect and analyze priorities for public health initiatives. They have prevention resources and information that could be used by every employer and insurer across the country, but insurers and employers ignore them.

**Community and Migrant Health Centers** are other public programs designed for people who are on Medicaid or who have no public or private health insurance. These **Florence Nightingales** of our communities, are patted on the head and thanked for being there. Everyone takes them for granted. Like the public health system, they are considered neither ally nor adversary. Worst of all, no one thinks of including these groups into any integrated system of care. Ironically, we could do more for less if they were part of what could be a health care team.

Public health programs funded by federal or state programs have their own separate health care agendas. They are looking at the health of the community, which hardly anyone else does. They are looking at disease patterns, prevention, and

early interventions, which no one else does. They go dutifully marching on, trying to reduce health risk factors, assure health screenings, and lower disease risks, but no one cares, because they are the government. So, all the time and money they spend on diabetes risk reduction, for example, is totally ignored by employers and insurers, because these are, after all, unwashed public servants.

Some businesses think they play essential roles in the community, but businesses will largely only support individual clinics, not the system as a whole. They are publicly funded with federal, state, and local dollars, which means the clinics are at the mercy of Congress, state legislatures and city and county elected officials.

### **THE HIDDEN DANGER: NURSING HOMES**

If there were a stealth danger, it is the nursing home industry. While everyone is putting time and sound bites into lobbying against pharmaceutical companies and insurers, nursing home costs and staffing are the grenade waiting to explode. Fees for nursing home workers are not on par with what these workers can get in other sectors of the economy. Work there is not glamorous and often involves lifting, bathing, and caring for people who are not going to get better. This industry faces a cost and access crisis that will make pharmaceutical costs look like a sunny day in May.

There are not enough nursing beds to meet the needs of our current senior population, not to

mention the boomers. By age 75, most people have one or more chronic diseases and can count on spending about one to three years in some kind of nursing care facility at some point in their lives.

Over 70 percent of all the people in the country think Medicare pays for nursing homes. It does not.

Medicare pays for limited stays in skilled nursing facilities where people go to recoup from an illness or surgery, get better and go someplace else. Medicaid, private insurance or your own funds pay for the kind of nursing home that takes care of people who are not going to get better. These are the people who have Alzheimer's Disease and need personal care, but who are never going to recover from their disease and, therefore, are not eligible for "medical" care.

Because Medicare does not cover long-term nursing home costs, who pays for nursing home care? People either have to pay for it themselves, out of their family budgets or perhaps out of long-term care insurance, or Medicaid pays for it. For Medicaid to cover nursing home costs, however, people have to meet Medicaid's income and asset tests. In short, they must show that they are living at or below the federal poverty level. What is important to think about, is that the services people get are often very different if they are private pay and/or insurance patients or Medicaid patients because of the different rates the facilities receive.

Reams of rules and regulations have been written covering "transfer of assets," which is

what many people have to do so they can qualify for Medicaid. Why would they want to do that? It protects family assets which would rapidly disappear at the \$60,000 or more per year these institutions charge.

Everyone in the industry knows about this lurking crisis, but they are too busy fighting other battles to worry about it right now. Besides, people aren't leaving nursing homes to go to Canada for a better deal on costs, like they ostensibly are doing for prescription drugs.

Nursing homes and home health care agencies are being squeezed to death from rate cuts and a tight labor market. Caring for frail, elderly patients is not always very rewarding, and it is often physically demanding. The duties are the same as childcare—bathing, changing diapers, dressing, overseeing medicines, and having to deal with families who are guilt ridden because they can no longer care for a loved one at home.

### **THE JOANS OF ARC: NURSES**

Nurses are the passionate patient advocates, but while the public loves them, hospitals and doctors fight them, use and abuse them, and have a love hate relationship with them. Doctors don't want the more advanced nurses (ARNPs—nurse practitioners) to do more patient care or get affordable liability insurance, because then nurses would have the distinct ability to really compete with the doctors for patient care. While doctors

fight them at every turn, insurers love them because they are cheaper than doctors.

Hospitals are battering nurses. They don't hire enough with high level skills and many make them work mandatory overtime. They think they can control costs by relying on lower levels of nursing care at times when the patients are sicker than they have ever been because only the sickest patients stay in hospitals. So, at a time when patients have more complex care demands in hospitals, there are fewer qualified nurses to care for them. Those who are there are older—the average hospital nurse is forty-six—and thinking about retiring.

Simply put, there are not enough nurses to go around. Fewer people are going into nursing. Nursing schools are closing. The advanced nurses are older and simply cannot physically lift, turn, and carry patients as needed. Some hospitals are closing doors temporarily for all but emergency surgery and nurses are beginning to strike for better wages and hours.

Marketing wars for nurses are emerging. State-raiding wars are on the horizon which will force states to raise salaries so other states can't steal their nurses. This need for nurses will increase as America ages, since increasing age is the best predictor of increasing hospital use. Fewer and fewer people are choosing nursing as a career, which has all the indicators of a looming care crisis for the baby boomers.

### **THE BROKERS: GOVERNORS**

If there were any group making deals witheveryone, it would be the governors. They preside over their individual state budgets, which include the health care benefit costs for state employees. Consequently, they side with employers when it comes to negotiating with unions. They fight the large employers who do not pay into state government health care programs. They arm wrestle with the Feds over how much they get for Medicaid for their state. They appoint boards that oversee the licensing of hospitals, doctors, nursing homes, and other health care professions and facilities. They wrangle with the unions who want more health care dollars. And they promise the public they will take care of them and provide better benefits and not increase their health care costs. This is a full time job, plus some, while wearing different hats.

If any one group could influence change, it would be this one, but they get caught in the same ideological chasms as Congress in the great divide of Republican and Democrat.

### **THE KNAVES: LAWYERS**

If health plans and pharmaceutical companies are the villains of healthcare, lawyers are the knaves. Universally seen as necessary evils trying to turn the flaws of the system to their own economic advantage, they are uniformly despised. They are targeted as the reason health care costs

keep going up due to lawsuits, malpractice insurance and the fear of lawsuits. Yet everyone hires them to get the bills they want through Congress, to draft model legislation, or to sue the government, insurers, or whomever, whenever some group cannot get its way.

An excellent current example of how these “double agents” work is: States are using the time and money of their own attorney generals to file lawsuits against the federal government—be it HCFA ( now CMS) which manages Medicare or Congress which sets the rates—so they can get more tax dollars to pay more money to private, for-profit insurers so these private insurers can offer more Medicare HMOs in their states for their frail and elderly seniors. Go figure.

On the other hand, they are no better or worse than anyone else in a system that has created so many enemies that use oceans of money in lobbying or advertising to get money they are afraid someone else will get instead of them.

### **THE PONTIUS PILATES: THE PRESIDENT AND CONGRESS**

Elected officials set up the rules of the game but wash their hands of responsibility. They are too busy fighting and blaming each other for this system of care to do anything about it. They have politicized health care by characterizing it as government-run or run by the marketplace. They keep it trapped in ideologically and party-driven mine fields so that no progress can be made toward common solutions.

Republicans and Democrats have had essentially the same solution for years. What it all boils down to is: “Not on my watch you don’t” and campaign contributions. And you and I are left out in the cold.

### **OTHER ALLIES AND ADVERSARIES**

With no intention of paying short shrift to others, space simply does not permit covering all the other parts of the industry—labs, alternative providers, medical equipment companies, software. Information technologies, home health agencies, and even voluntary programs that offer services and education, such as the American Cancer Society. There is just too much to cover to add all the myriad players. My goal is for a wide range of people to read this. Longer books, more thorough books have been written (see Bibliography and Selected Readings). I know there is much more depth. This book is designed to be the industry equivalent of Cliff Notes so people will take the time to read it.

But, wait! We have forgotten someone!

### **THE HUDDLED MASSES: THE PATIENT?**

Patients continue believing they will get the care they need when they need it. Patients today are like Charlie Brown who thinks Lucy really will hold that ball this time and not jerk it away at the very last minute. No one has time for the patient now, however, other than blaming him or her for using services someone else is paying for.

Employers and insurers say patients want the highest levels of care, demand a no-holds-barred status on tests, want all the heroic measures in the world and damn the cost. Doctors say patients want too much of their time and are taking up their time with quack information from the Internet. Hospitals want them in and out as soon as possible, but also want them to use their diagnostic equipment and have babies. Insurers want them if they are healthy. Congress pays attention if they make contributions or can influence voting blocs. Ditto for governors and presidents.

The bodies on this health care battlefield are only too real. They are each and every one of us. We no longer have time with doctors. We are told what doctors can or cannot prescribe, how long we can stay in the hospital, who we can see as physicians, and what services are covered. Doctors are told how long we can stay in a hospital and what medications they can prescribe.

Worse yet, we have forty three million people without any health care insurance—up to nearly 10 million people in ten years and at the height of our greatest economic prosperity.

Of all people with insurance 70 percent have it through their employer. Of those, 50 percent work in companies that self-insure. What this means is that half of all people with insurance have their health rules regulated by the federal government; the other half are regulated by their state.

Patients have few advocates or allies. They simply want access to health care services for themselves and their families without breaking the bank. We are the huddled masses migrating between jobs and risk pools when all we want is safety and comfort for our families and ourselves.

## **WHAT'S AHEAD?**

Our health care system has too many rules for the wrong thing and absolutely no incentives for anyone to work together. The economic survival of one group means harm for another. No amount of tinkering will fix the system's fatal flaws. We must change or we will devour each other and ourselves.

That's the bottom line. Read on for what it means for you, your business, family, and friends.