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Data Update, Spring 2003

Editors' note: The Data Update is regularly reprinted in the International Journal of Health Services Research, edited by former PNHP health policy director Dr. Vicente Navarro. Readers who find this section useful may also be interested in PNHP President Dr. Don McCanne's "Quote of the Day" health policy e-mail listserv (subscribe by sending your e-mail and a few sentence description about yourself to don@mccanne.org). It's an excellent, ongoing health policy tutorial.

Uninsured and Underinsured

• Nearly 75 million U.S. residents, about one-third of the non-elderly population, lacked health insurance for at least part of the last two years. About 25% of the uninsured (over 18 million people) lacked coverage for the entire 24 months of 2001 and 2002; only 10% lacked coverage for 2 months or less. 41 million people were uninsured for all of 2001. About 80% of the uninsured were either employed or had an employed parent (Families USA, 3/5/03).

• 38% of insured individuals experienced at least one problem accessing health services in the past year. Nearly one-fifth (18%) reported that they had postponed seeking medical care, 15% had a problem paying medical bills, 10% did not fill a prescription they needed, 8% were contacted by a collection agency about a bill, and 6% went without needed medical care (Kaiser Commission on Medicaid and the Uninsured, July 2002).

• Among both insured and uninsured people, minorities have consistently worse access to health care than whites. However, ethnic and racial disparities in access to medical care are almost twice as great among *uninsured* working-age Americans than among people with insurance. For instance, only 31% of uninsured Latinos and 36% of uninsured blacks had a regular doctor in 2001, compared with 51% of uninsured whites. Among people with insurance, the gap was much smaller: 67% of Latinos with insurance and 71% of blacks had a regular doctor, compared with 78% of insured whites (Center for the Study of Health System Change, 6/19/02).

• Nursing care matters: Patients recovering from orthopedic or vascular surgery at hospitals with fewer nurses have a greater risk of dying, according to a study of over 230,000 patients cared for at 168 Pennsylvania hospitals. Nurse-patient ratios varied from 8:1 to 4:1. The study found that patients' risk of death (30-day mortality) increased 7% for each additional patient under one nurse's care. Overall, researchers estimated that a nationwide ratio at the upper end of 8:1 compared to a ratio of 4:1 would result in a 31% increase in the mortality rate, or 20,000 additional deaths (Aiken et al, JAMA, 10/23/02).

• Two-thirds of states are cutting Medicaid benefits this year in the face of large deficits, and almost half are freezing or reducing Medicaid payments to providers. Medicaid covers about 47 million

people and the recession is projected to increase enrollment 7.7% this year. States are cutting back on benefits (cutting off eligibility for more than 1 million adults and tens of thousands of children), shelving plans to expand programs to more low-income working families, and increasing co-payments. In Nebraska, for example, the program is shedding 12,000 adults and 16,000 children who don't meet the state's new income criteria. Reducing already-low payments to doctors will limit access to care for many beneficiaries (Kaiser Family Foundation survey, New York Times, 1/14/03).

• 95,000 Bethlehem Steel retirees and their family members lost their health coverage in March. A US bankruptcy court ruled that the firm could terminate their benefits. Retirees have the option (but not the funds) to purchase COBRA health insurance for up to six months by paying the full cost, $492 a month for individual, and $750 a month for family coverage (Philadelphia Inquirer, 3/31/03).

• Only 58% of California physicians are accepting new HMO patients, according to a study by Dr. Kevin Grumbach and colleagues at UCSF. The percentage of specialists accepting HMO patients dropped from 77% to 62% between 1998 and 2001. It is now almost as hard for a privately-insured HMO patient in California to get an appointment with a new doctor as for a Medicaid patient (Center for Health Professions "California Physicians 2002: Practice and Perceptions" December 2002).

• Medicare beneficiaries' average out-of-pocket expenditures on medications increased from $644 in 2000 to $866 in 2002. 5% of beneficiaries are expected to have out-of-pocket drug costs of $4,000 or more this year. The prices of the 50 prescription drugs most frequently used by the elderly – many of them on the market for ten years or more - rose by 7.8%, nearly three times the rate of inflation (2.7%) in 2001. Of the 50 drugs, 42 have been on the market for at least five years, and 20 for more than ten years, yet pharmaceutical companies continue to raise prices on these medications (Kaiser Family Foundation 2/03, Families USA, 6/02).

• One-fifth of seniors in New York State go without needed medications because of high drug costs. A higher proportion (35%) of seniors without drug coverage skip doses of medication or do not fill prescriptions due to high costs. Medicaid provides seniors with the best drug coverage, followed by employer-sponsored plans. Medigap plans provide the least protection with about a third of those with Medicare supplementary plans spending $100 or more a month on prescriptions (Commonwealth Fund release, 12/5/02).

• This is insurance? In Massachusetts, Blue Cross is marketing a new PPO insurance policy with a $5,000 deductible for an individual and a $12,500 deductible for a family. Preventive care is exempted from the deductible (but not co-pays), but emergency care, visits to specialists, and surgery are only covered after the deductible has been met (Boston Globe, 8/9/02).

• The American Association of Retired Persons (AARP) and United Health Group are selling a new plan aimed at people aged 50 to 64. Instead of covering all, or a certain percentage of medical bills, the policy pays a fixed amount for certain health items (e.g. up to $7,856 for a CABG). The reimbursements are set so low that subscribers are at risk of financial ruin in case of illness. "They shouldn't call it health insurance," said one analyst (Washington Post, 2/28/03).

• In 2000, U.S. infant mortality fell to a record low 6.9 deaths per 1,000 live births. However, black infant mortality is more than twice as high as white infant mortality (14.0

vs. 5.7 deaths per 1,000), a wider disparity than 20 years ago. The United States is ranked 23rd among the world's 30 industrialized nations in overall infant mortality (HHS release, 9/12/02).

• The VA is dealing with a growing crisis related to increased demand for services and rising prescription drug prices. While the number of patients the VA cares for increased by nearly half, from 2.7 to 4.5 million, between 1995 and 2002, the budget has increased by only one-quarter, and the number of staff members in the system fell from 205,000 to 183,700. Currently, veterans wait an average of six months for an initial visit at a VA facility. The VA has expanded access in recent years by opening 400 community-based clinics. A 1995 law expanded eligibility to middle-income veterans earning up to about $35,000 who lack service-related disabilities, but new enrollment among this group has been suspended from January through October, 2003. About 164,000 veterans will have to seek care elsewhere or wait to begin treatment. In addition, higher income veterans already in the system will be assessed a $250 fee (Modern Healthcare, 8/12/02, Portland Press Herald, 2/26/03).

• The University of California at Irvine Medical Center announced it would no longer take non-emergency uninsured patients unless they live within 5 miles of the hospital or within 2 miles of its two clinics. The hospital is the primary safety-net provider in Orange County, providing 63% of all indigent outpatient care and 30% of inpatient care. The Center and 25 other hospitals that provide indigent services are seeking increased reimbursement from the county (Modern Healthcare, 8/12/02).

Costs

• Health spending will rise to $3.1 trillion by 2012 (17.7% of GDP), according to estimates by CMS. Without reform, costs are expected to rise 7.3% per year during the next decade, then slow to 6.7% annually by 2012. Medicaid spending is expected to increase more than 8% per year as more people lose private health insurance (Wall Street Journal, 1/7/03).

• U.S. health spending in 2001 was $1.42 trillion (14.1% of GDP, $5035 per capita), up 8.7% from the 2000 figure of $1.31 trillion (13.3% of GDP), according to the Centers for Medicare and Medicaid Services. Estimated costs in 2003 are $1.66 trillion (15.2% of GDP, $5,775 per capita) (Office of the Actuary, CMS; Heffler et al, Health Affairs Web Exclusive, 2/7/03).

• Private health insurance premiums rose 10.5% in 2001, while spending on Medicare and Medicaid increased 7.8% and 10.8%, respectively. Medicaid growth was driven by an increase in enrollment due to the recession, and is projected to have risen even faster, 12.1%, in 2002 (Wall Street Journal, 1/8/03).

• Employers are bracing for a 15% increase in health premiums in 2003, on top of a 12.7% increase in 2002 – the biggest one-year increase since 1990. According to a survey of 2,104 public and private employers, the average family premium increased to $7,954 in 2002, with workers paying 26%, or $2,084. Individual coverage averaged $3,060, with workers paying an average of 15% of the cost. Deductibles also rose: The average PPO, in-network deductible rose from $210 in 2001 to $276 in 2002; the average PPO, out-of-network deductible rose from $407 to $488 over the same period. Only 61% of employees had a choice of more than one HMO in 2001, down from 81% in 1998. The number of small businesses offering coverage dropped from 67% in 2001 to 61% in 2002. The majority of workers are now enrolled in PPOs (52%), followed by HMO's (26%), POS plans (17%), and conventional indemnity plans (5%) (Gabel et al, Health Affairs, Sept/Oct 2002).

• Health spending for people under age 65 who are uninsured for at least one year is about half ($1,253) that of people with private insurance. In addition to receiving less care, uninsured people pay 35% of their medical costs out-of-pocket, compared with 21% for the privately insured. Government paid about $31 billion of the estimated $35 billion in uncompensated care for the uninsured in 2001 (Hadley and Holahan, Health Affairs, 2/12/03 web exclusive, Kaiser Commission on Medicaid and the Uninsured).

• General Motors is the biggest corporate purchaser of health care, with 1.2 million employees, dependents and retirees. GM will spend $4.4 billion on health care in 2003, up from $3.9 billion in 2002. In 2003, the firm is increasing monthly employee-paid premiums for about 160,000 white-collar retirees by an average of $25 a month. Ford is also passing along increased costs to retirees and active employees. Ford's health costs rose 13% in 2002 to $2.7 billion. The company is increasing premiums for workers and retirees enrolled in HMOs by an average of 15%. The firm is also limiting eligibility. For example, a retiree will no longer be able to obtain Ford coverage for step-children. Ford is also raising the deductible for a family in its basic "Ford Medical Plan" from $700 to $1,000, and the cap on out-of-pocket spending from $3,000 to $4,000 (LA Times, 3/7/03, Detroit News 2/20/03).

Labor and Business Unrest Over Rising Costs

• 18,000 GE workers in 23 states struck for two days in January to protest a hike in out-of-pocket health costs for the average worker of $300 to $400 a year. Increased co-pays will especially hurt sick retirees. It was the first strike at the firm in over 30 years. The current three-year contract expires in June; union leaders say they want management and corporate America to address the real problem of the broken healthcare system instead of simply passing on costs to workers. GE's health costs have risen 45% since 1999, from $965 million to $1.4 billion. Still, the firm is one of America's most profitable corporations, with $16 billion in profits projected for this year. The increased cost-sharing by workers would save the firm about $30 million – not much compared to former CEO Jack Welch's $8 million in annual pension benefits. 14,000 GE strikers are members of the International Union of Electrical Workers - Communications Workers of America (IUE-CWA) and the rest are in the United Electrical Radio and Machine Workers of America (Christian Science Monitor, 1/15/03, Toronto Star, 1/16/03, Financial Times, 1/14/03).

Other companies negotiating new contracts this year – and facing potential labor disputes over health care - are the "big three" auto makers GM, Ford, and Daimler-Chrysler (with a combined total of 730,000 active members in the United Auto Workers); Delphi, the largest maker of car parts; Lucent, Verizon, and Qwest communications; Brown and Williamson Tobacco Corp; and tire-makers Goodyear and Bridgestone/Firestone, according to the US Department of Labor.

Last year, a scattering of workers across the country – from Hershey Foods Corp. in Pennsylvania, to a teacher's union in Red Wing, Minnesota, to a Tenet-owned hospital in San Francisco – went on strike over health benefits. Health costs were a major issue in labor disputes at New York City's Metropolitan Transit Authority and at Navistar International Corp. Increased unrest is expected "across corporate America" in 2003 without reform of the health system (LA Times, 1/15/03, New York Times 1/15/03).

Single Payer in Maine Would Save $1 Billion

• A preliminary report by Mathematica, a DC-based consulting firm, found that a single-payer system in Maine would save nearly $1 billion on health costs by 2008. The plan would provide coverage to all Maine residents and reap huge savings by slashing administrative costs. Small businesses, which typically pay over 20% of payroll for health insurance premiums, would benefit under single payer because they would pay less in new taxes than they pay for insurance premiums; about 600 small businesses in Maine have endorsed single payer. The Maine plan does include some cost sharing, including a $50 per day co-pay for hospital care, although it caps annual expenses for families at $2,000. Former state representative Paul Volenik, who co-chairs the Health Security Board with Sen. John Martin, said the Board is asking the Legislature for another year to continue investigating single payer with Mathematica and to devise a more detailed plan (Portland Press Herald, 1/30/03).

Corporate Money and Care

HealthSouth Fraud "Ranks up there with Enron"

• HealthSouth, the giant for-profit operator of rehabilitation hospitals and clinics, overstated its earnings by at least $1.4 billion from 1999 to mid-2002, and inflated the value of its assets by $800 million. "This case ranks up there with the likes of Enron and WorldCom," according to the SEC, which has charged the firm and its founder/CEO, Richard Scrushy, with accounting fraud. Nine of the firm's top executives have already pleaded guilty to criminal charges of securities fraud.

Scrushy, whose name sits atop the University of Alabama's new "Richard M. Scrushy Building, School of Health Related Professions" profited more than $225 million from stock sales between 1999 and 2001, when HealthSouth reported profits of $1.22 billion – 100 times what the SEC says was the correct amount ($12 million). Another $180 million in fraudulent profits were reported in the beginning of 2002. Scrushy also received tens of millions in salary and bonuses during this period.

Scrushy and the firm are accused of heavily inflating profits almost back to the chain's public launch in 1986. When the firm's results were short of Wall Street predictions, Scrushy allegedly directed executives to fix the discrepancy by recording false earnings. In company lingo, employees were filling the gap or "hole" with "dirt" – that is, false entries. The people who falsified the books were known as "family members" and referred to their gatherings as "family meetings".

Ernst and Young, the company's auditors, said they were misled by senior executives who created false entries (e.g. of how much of patients' bills would be paid by insurance), false invoices (e.g. overstating the purchase price of an asset), and in some cases, entirely fake ledgers.

HealthSouth operates 209 surgery centers, 1,427 outpatient and 118 inpatient rehabilitation centers, 136 diagnostic centers, and four medical centers. The FBI raided the company's headquarters in Birmingham on March 19. The company is also being investigated for Medicare fraud (Washington Post, 3/20/03, New York Times, "Hospital Chain Accused of Huge Accounting Fraud," New York Times, 3/20/03, New York Times, "Options Payday: Raking it in Even as Stocks Sag," 12/29/02, Wall Street Journal, 1/7/03 and 4/3/03, New York Times, 3/4/03).

HCA Settles Fraud Charges for $1.7 Billion and Sheds Name "Columbia"

HCA, the nation's largest for-profit hospital chain, settled its Medicare fraud charges with the government for a total of $1.7 billion in criminal and civil penalties, by far the largest amount ever secured by federal prosecutors. HCA has also agreed to plead guilty to 14 felonies. These

settlements end a seven-year investigation by the U.S. Justice Department of Columbia-HCA for intentionally overcharging Medicare by inflating the seriousness of diagnoses; keeping a second set of (inflated) Medicare cost reports; conspiring with the wound-care firm Curative Health Services (which operates out of HCA hospitals) to bill Medicare for management fees and marketing expenses not eligible for reimbursement; submitting claims for home care not eligible for reimbursement; "bundling" unnecessary laboratory tests not eligible for reimbursement; and kickbacks for physician referrals (New York Times, 12/18/02, 12/20/02).

HCA is buying a large non-profit health system based in Kansas City, Missouri, for $1.13 billion (Wall Street Journal, 11/12/02).

Newly appointed Senate Majority Leader Bill Frist (R-TN) financed his election to the Senate with profits from Columbia-HCA stock. For more details on Frist's connection to corporate health care, see page 38.

HCA announced that it will give "discounts" to low-income uninsured persons on their hospital bills, but the discounts won't be as deep as the ones insurance companies and Medicare receive. It also said that it will no longer garnish the wages of patients "with a proven inability to pay for care," and would no longer file liens on the primary residences of patients if their homes are valued at less than $300,000 (The Tennessean, 3/18/03).

• No competition: Between 1995 and 2000 there were more than 350 mergers involving health insurers or HMOs, according to the AMA. The ten largest firms now cover more than half of all privately insured people in the U.S. (Reuters.com "US Steps up Scrutiny of Health Insurers" 9/9/02).

• Cigna will pay up to $200 million in back claims to over 600,000 physicians to settle a class-action lawsuit brought against the firm in Illinois federal court. Cigna used a software program called "Claimcheck" that reduced or eliminated payments for legitimate services. A separate class-action lawsuit is underway in Miami federal court against Cigna and seven other HMO's for allegedly rejecting claims for necessary treatments as part of a racketeering conspiracy.

Cigna will also pay $24.5 million to settle allegations of Medicare fraud at a hospital it owns (Lovelace Hospital) in New Mexico. The settlement is the largest that the Justice Department has ever reached against a single hospital (Miami Herald, 12/14/02, Philadelphia Inquirer, 12/5/02).

Tenet: "The Poster Child for Corporate Greed"

• For-profit hospital chain Tenet, formerly National Medical Enterprises (NME), is the subject of four separate federal investigations. The Justice Department is suing the Santa Barbara-based firm for up to $500 million in damages for filing false Medicare claims between 1992 and 1998, and investigating inflated "outlier" payments the firm collected from Medicare. The FBI is investigating charges of unnecessary heart surgery at one or more Tenet hospitals. Finally, the SEC is looking into the sudden drop in the company's stock price and charges of insider trading.

Tenet's CEO Jeffrey Barbakow cashed in $111 million in stock in January 2002, shortly after calling the company's business "sensational" and increasing its profit forecast. Rocked by scandal, the company's stock plummeted 70% by the end of 2002. Nevertheless, Barbakow will also receive a doubled pension (a total of $1.89 million a year) if he stays with Tenet until 2004).

This is Tenet's second round of fraud investigations: in the early-1990s, Tenet's predecessor NME, then the nation's largest operator of psychiatric hospitals, was convicted of paying kickbacks and bribes for referrals, and holding patients against their will until their insurance ran out. The firm

pleaded guilty to seven federal charges and paid fines and settlements of nearly $1 billion (Contra Costa times, 1/19/03).

In the current case, Tenet allegedly assigned false diagnostic codes to claims to inflate Medicare payments for conditions such as pneumonia and septicemia. Tenet is also accused of collecting $115 million on 19,300 Medicare claims through "upcoding," and may be liable for triple damages and civil penalties. In addition, by rapidly raising their retail prices, Tenet received unusually large "outlier" payments from Medicare and "stop-loss" payments from HMOs and other insurers. Tenet nearly doubled their prices in California in three years, increases of about ten times the rate of inflation. Tenet's outliers made up nearly 24% of its revenue from Medicare, more than eight times the national average. Tenet's outlier payments from Medicare were estimated at $763 million in 2002 (on total revenues of $14.7 billion), while "stop-loss" payments from HMOs for exceedingly costly care were about $2.2 billion.

Private insurers are also investigating their Tenet claims for overpayments. Blue Cross of California, for example, found that it paid Tenet hospitals an average of $15,213 per patient, 43% more than other California hospitals, and that "stop-loss" charges accounted for more than 50% of the total amount Blue Cross paid certain Tenet hospitals (Sacramento Bee, 11/27/02, Los Angeles Times, 1/10/03, San Francisco Chronicle, 2/7/03).

Tenet CEO Jeffrey Barbakow admits the firm had an "aggressive pricing strategy." By increasing Medicare's outlier payments, Tenet was able to triple its profits for the third quarter of 2002 to $315 million, up from $89 million in the third quarter of 2001 (Los Angeles Times, 1/14/03).

In January, Tenet announced that it would "voluntarily" reduce the amount of money it charges Medicare for outlier payments in 2003, reducing its Medicare outlier revenues from $65 million per month to $8 million (Wall Street Journal 1/7/03).

Tenet also inflated bills by allegedly overcharging for medications. According to an analysis of medication charges at 5000 hospitals, Tenet's markup on drugs was twice the national average. (California Nurses Association, New York Times, 11/24/02).

Tenet's price gouging especially hurt people without insurance, who were denied the discounts offered to insurers. Tenet collected an estimated $376 million more in 2001 from inpatient self-payers than it would have if the uninsured had paid Tenet's average prices. (www.TenetMonitor.com, Service Employees International Union, 12/6/02, San Francisco Chronicle, 1/29/03).

Despite charging more, Tenet's hospitals skimp on care. A study of 10 Los Angeles hospitals purchased by Tenet found that the number of direct patient care hours was reduced by an average of more than 15% after Tenet took over. In California as a whole, Tenet spends 26% to 30% less on labor costs, and uses 34% to 65% more temporary nursing staff than other California hospitals. Studies show worse patient outcomes, such as an increase in post-operative infections and mortality, when hospitals skimp on nursing care ("Tenet Hospitals: Corporate Conduct Puts Patients at Risk," SEIU, www.TenetMonitor.com, 12/12/02).

The Justice Department has demanded information on 19 of Tenet's 114 hospitals, including 15 in California. Last year, Tenet agreed to pay $17 million for incorrect laboratory billing in a similar Justice Department probe. In February of this year, Tenet paid $4.15 million to settle allegations that five Florida hospitals overbilled Medicare in the mid-1990's. These fines are on top a $9.75 million settlement for Medicare fraud at a hospital in Culver City California, and another $29 million for improper billing for home health services associated with Florida's Palmetto General Hospital (LA Times, 6/19/02).

(New York Times, "Options Payday: Raking it in Even as Stocks Sag, 12/29/02,

"Tenet CEO to Receive Double Pension" Los Angeles Times, 8/27/02).

• Wellpoint has agreed to pay $9.25 million to settle charges that its Blue Cross subsidiary in California defrauded Medicare. The company falsified audit information so that the government would believe that it audited more Medicare claims and cost reports in than it actually did (Los Angeles Times, 7/30/03).

• Mortality rates are 8% higher at for-profit dialysis centers, compared to their not-for-profit counterparts. Researchers analyzed eight previous studies conducted between 1973 and 1997 covering 1,342 facilities. For-profit dialysis centers serve 75% of the 208,000 Americans on dialysis, resulting in an estimated 2,500 premature deaths annually. Private for-profit facilities have to generate profits to satisfy shareholders and pay taxes—typically these two expenditures are in the range of 10%-15% of expenses. Not-for-profit facilities can spent this money on patient care (Journal of the American Medical Association, Devereaux et. al., 11/19/02, Press Release, McMaster University, 11/19/02).

• A Federal appeals court in New York ruled February 11, 2003 that a health insurance plan could be sued in a state court for malpractice. The ruling has sweeping implications for HMO's, which have used the 1974 ERISA (Employee Retirement Income Security Act) law to avoid such suits in the past. The United States Court of Appeals for the Second Circuit ruled that the health plan could not invoke ERISA to stop Bonnie Cicio from suing Vytra HMO for medical malpractice in the death of her husband. Mr. Cicio died of myeloma in 1988. The plan denied coverage for the double-strength bone marrow transplant his physician recommended, and only approved a single-strength transplant after a delay that went past the "window of opportunity" for effective treatment. According to the New York Times, "a growing number of rulings recognize a patient's right to sue in state court if an HMO refuses to pay for a specific treatment ordered by a physician" (New York Times, 2/20/03).

• Aetna is profitable again. The company's secret to success: cherry picking healthy patients. According to the New York Times, Aetna has cut the number of people it insures to 14.4 million from 22 million people in 1998, and it expects to make further cutbacks. Becoming smaller has so far proven to be more profitable. Aetna is happy to see some customers go because they were heavy users of medical services and had been costing Aetna money. The trick is not to drive away the profitable customers. "If you don't raise your prices with surgical precision," said a company spokesperson, "you can chase away your healthy customers and be left with the sicker people." "We're not interested in being the largest. We're just interested in being the best, and most profitable," said CEO Dr. John W. Rowe (New York Times, 8/2/02, "Aetna's Strategy Results in Tenfold Jump in Quarterly Profits").

Former Aetna CEO William Donaldson is Bush's choice for head of the SEC. Donaldson made $7 million in salary and $11.6 million in stock options during his 11 months as Aetna CEO in 2001 (Citizen Works e-mail newsletter, 2/3/03).

• For-profit insurance giant Anthem, which owns Blue Cross and Blue Shield plans in eight states, bought Virginia's Blues plan, Trigon Healthcare Inc., with 2.2 million subscribers, for $3.3 billion. Anthem now has 10.5 million enrollees.

Anthem's bid to buy the Kansas Blues plan was stopped by the Kansas Insurance Commissioner, Kathleen Sibelius, who concluded that it would be "hazardous and prejudicial to the insurance-buying public." Premiums in the individual and small group market would have to increase an estimated

$248 million over five years to meet Anthem's profit goals from the Kansas plan. The Kansas Supreme Court will decide the case.

• Blue Cross and Blue Shield plans in Alaska, Maryland, New York and North Carolina are trying to convert to for-profit status. In Maryland, a judge halted the Blues' conversion with a scathing attack on the plan's Board of Trustees, who stood to profit nearly $119 million from the conversion (Community Health Assets Project Update 7/23/02, Washington Post, 3/6/03).

• The nation's largest managed mental health plan, Magellan Health Services, filed for Chapter 11 bankruptcy. The firm has contracts with Aetna, Blue Cross, and other health insurers to manage mental health benefits for 67.4 million people nationwide. It purchased three of its four largest competitors in the 1990's (Washington Post, 3/12/03).

• A company that processed claims for Medicare, General American Life Insurance Company, will pay $76 million to settle charges that it failed to properly process claims and submitted false information to the government. Two former employees told Medicare that the firm hid, altered, and falsified documents, particularly those related to its error rate. The company systematically deleted claims scheduled for review that would have adversely affected its error rate (Modern Healthcare, July 1, 2002)

Medicare HMO's

• Since 1998, Medicare HMOs have dropped 2.4 million people, including 934,000 patients in 2001 and 536,000 patients in 2002. This year, Medicare HMOs will drop an estimated 200,000 people, and cut benefits for most of the remaining five million patients (13% of all Medicare beneficiaries). When the "Medicare + Choice" program was launched in 1997, the Congressional Budget Office predicted that more than one-third of beneficiaries would be in HMOs by 2005. Despite their record of selectively enrolling healthy people and cutting benefits for the sick, the plans complain that they can't make money, and are lobbying heavily for additional subsidies for the program (Contra Costa Times, 9/10/02).

• Medicare HMOs reduced their benefits and raised their premiums to seniors 40% between 2001 and 2002. In addition, the proportion of HMOs that charge a co-pay for hospital care increased from 33% of plans to 78% of plans in 2002.

The cost-sharing burdens fall most heavily on the sickest beneficiaries. Costs for beneficiaries in "good" health – the overwhelming majority of enrollees - increased 20%, to $1,430, while out-of-pocket costs for seniors in "poor" health increased 34%, to $4,783 – over three times what an enrollee in good health spent (Achman and Gold, Mathematica, The Commonwealth Fund, Publication #580 and Issue Brief #575, 11/02).

• Prescription drug coverage for seniors in Medicare HMOs is disappearing. In 1999, 13 of 41 states with Medicare HMOs had at least one plan with no dollar cap on the drug benefit. In 2002, only five states (out of 36) had at least one plan that wasn't capped, but in one of those states – Hawaii – the plan only covers 15% of medication costs (Families USA, May 2002).

• A novel form of cherry-picking: A new HMO in Florida that doesn't provide any drug coverage is signing up healthy seniors in droves. The HMO plan "CareFree" offers skimpy coverage but one huge bonus – it pays seniors' Medicare Part B premiums ($58.70) out of the money it receives from Medicare each month. Thus, enrollees get an additional $700 a year in Social Security,

while the firm pockets Medicare payments of over $600 a month on its (mostly) healthy beneficiaries (Florida Sun Sentinel, 11/12/02).

• Bait and switch: Kaiser notified 25,000 enrollees in its Washington, DC – Baltimore Medicare HMO plan "Senior Advantage" that the plan is being eliminated. They were given the option of being automatically enrolled in the firm's new plan, "Medicare Plus," which features higher premiums and reduced benefits, but "allows" seniors to keep their physicians. In 1999, there were nine Medicare HMOs in D.C. Currently there is only one (Washington Post, 9/10/02).

• Medicare beneficiaries report greater satisfaction and access to care than do enrollees in employer-sponsored private health plans, according to a survey of about 3,500 people aged 19 and over by the Commonwealth Fund. Medicare beneficiaries were 2.7 times as likely as privately insured persons to rate their insurance as "excellent" and one-third as likely to say they couldn't get health care because of the cost. Medicare beneficiaries, particularly those without supplementary drug coverage, do face higher out-of-pocket costs. Overall, 29% of elderly Medicare recipients paid more than 5% of their income in out-of-pocket costs, compared to 10% of the privately insured (Karen Davis, Health Affairs web exclusive press release, 10/8/02).

Pharmaceuticals, Inc.

• Pfizer is buying a competitor, Pharmacia, for $60 billion. The European Union approved the merger provided that the two companies divest a few medications (Wall Street Journal, 2/28/03).

• Eight of nine of the largest drug companies spent more than twice as much on marketing, advertising, and administration as they did on R&D in 2001. On average, firms spent 27% of revenues on marketing and overhead, 11% on R&D, and took 18% as profits.

Top executives at the nine firms studied averaged annual income (excluding stock options) of $21 million in 2001. The most highly-paid executive was C.A. Heimbold, Jr., former CEO of Bristol-Myers Squibb, who received pay of nearly $75 million. Executives had an average of $48 million additional compensation in stock options (Profiting from Pain, Families USA, July 2002).

• GlaxoSmithKline's profits rose 28% in 2002, to $6.34 billion, while revenues rose 3.5%, to $34.3 billion, for a profit rate of 18.5%, about five times the Fortune 500 average for all firms (Wall Street Journal, 2/13/03).

Glaxo is going after Canadian pharmacies that sell medications to Americans. The giant drug company stopped shipments to pharmacies selling medications to Americans in January. Merck, Wyeth, and Lilly have all threatened similar action. There are over 80 mail-order pharmacies in Canada that serve an estimated one million U.S. customers; Americans spent about $1 billion on prescriptions from Canada last year, in person or via the internet or mail. Drugs purchased in Canada cost up to 80% less because of government price controls in Canada and the strong American dollar (Los Angeles Times, 2/27/03, Boston Globe, 1/21/03).

• Drug companies "routinely" make payments to insurance plans to increase the use of their products, to expand their market share, to be added to formularies, or to reward doctors and pharmacists for switching patients from one brand of drug to another, according to comments submitted by manufacturers, HMOs, and doctors in response to an HHS proposal to restrict practices that "look like illegal kickbacks." Banning such practices would "criminalize a wide range of commercial

conduct," according to Merck. The American Association of Health Plans (the HMO trade association) commented that the standards would "cast doubt on the propriety of many well-established practices undertaken by health plans to develop and administer their drug benefits" (New York Times, 12/26/02).

Medco Health Solutions, a pharmacy benefit manager (PBM) and subsidiary of Merck, for example, received more than $3.5 billion in rebates from drug companies between 1997 and 1999 alone. The rebates were an incentives to promote expensive medications (particularly those made by Merck) "at the expense of similar medications that often cost less," according to documents filed in a class action lawsuit by several employer health plans. Last year, Merck agreed to pay $42.5 million to settle the lawsuit. One of the documents filed in the case was a 1999 Medco internal memo showing that Medco customers used a higher percentage of Merck products than the national sales patterns in six medical categories (New York Times, 3/13/03).

According to Prime Therapeutics, a Minnesota-based PBM for Blue Cross, the business model for PBM's "is largely focused on extracting revenue from pharmaceutical companies, only some of which is passed on" to employers and health plans as savings. A GAO report came to the same conclusion (New York Times, 3/18/03).

Express Scripts announced in March that it will stop accepting money from drug companies to promote their products to doctors and patients. However, it will still accept rebates from manufacturers for increasing drug sales and market share. (New York Times, 3/17/03).

• Drug companies are not complying with a 1990 law requiring them to disclose to Medicaid the best prices they give any customer. According to one whistle-blower lawsuit, Merck sold Pepcid for 10 cents per tablet to some hospitals at the same time it charged Medicaid $1.65 per tablet. Abbot Laboratories reported to Medi-Cal that it sold a one-gram dose of Vancomycin for a minimum of $55.59. However, the actual cost to one small pharmacy, Ven-A-Care, was $6.29, according to a complaint field by the California Attorney General. The practice of charging hospitals, pharmacies, and doctor's offices very low prices while not reporting them to Medicaid appears to be "widespread," according to industry lawyers. Bayer and GlaxoSmithKline recently settled charges for almost $350 million (Wall Street Journal, 2/24/03, AP, 4/17/03).

• Pfizer will pay $49 million to settle charges that the firm defrauded Medicaid and 40 states by overcharging for Lipitor. Warner-Lambert, which has since been purchased by Pfizer, gave an HMO $250,000 in "educational grants" to get the drug on the insurer's formulary. The government sued, saying the payments were actually a "disguised rebate" and that Medicaid should have been informed of that discounted price (Wall Street Journal, 10/29/02).

• A study by the General Accounting Office concluded that some drug companies "repeatedly disseminate misleading advertisements" for prescription drugs, and that a new Bush administration rule giving the firms up to 11 weeks (up from two weeks) before the FDA can cite them for ad violations has undermined the FDA's effectiveness. One-third of ad campaigns are less than two months, so they can run their course before the FDA can censure them. Since 1997, the FDA has issued 88 regulatory letters to drug companies for misleading ads, including 14 to GlaxoSmithKline, 6 to Schering and 5 to Merck. Some firms have received multiple letters over time for new advertisements promoting the same drug (New York Times, 12/4/02).

• He who pays the piper: A recent study

by the National Heart, Lung and Blood Institute found that diuretics are better than costly calcium-channel blockers for the treatment of hypertension. Some previous research had favored calcium-channel blockers, but 96% of the studies favorable to the newer treatment were performed by scientists receiving money from the drugs' manufacturers. Overall, industry-sponsored research is 3.6 times more likely to produce results favorable to the firm that sponsored it, according to a meta-analysis of 37 peer-reviewed studies published between 1980 and 2000. One-quarter of biomedical researchers have a commercial conflict-of-interest, but even higher proportions of institutions do. Two-thirds of universities are financially involved in commercial ventures and/or start-up companies whose research they are also expected to monitor. Regulatory changes since 1980 allow scientists and schools more freedom to profit from work previously considered in the public domain. Public spending on medical research has doubled in the last five years, but corporate funding has risen even faster, to 62% of total spending (Los Angeles Times, 1/24/03).

• Pfizer will pay $6 million to settle an investigation by 19 states into how the company promoted its antibiotic Zithromax to treat ear infections in kids. The states accused Pfizer of misrepresenting the drug's effectiveness, and of not disclosing the risks of antibiotic overuse. (New York Times, 1/7/03).

• A survey of 108 research centers conducting clinical trials funded by pharmaceutical firms found that few (less than 2%) adhered to guidelines issued by the International Committee of Medical Journal Editors in September, 2001. The guidelines call for independent committees to oversee study design, monitor safety, ensure that data is shared between different medical sites participating in the trial, and that trial results are published and that independent researchers have control of that process. Lead author Dr. Kevin Schulman from Duke University said that the research institutions "feel almost powerless in these contracts" (NEJM, Wall Street Journal, 10/24/02).

• TAP Pharmaceutical Products, the maker of Lupron, agreed to a record $875 million fine in 2001 to settle charges that it inflated the drug's price to Medicare and gave kickbacks to physicians. Since then, federal prosecutors have indicted 14 people, including TAP employees and doctors who allegedly billed Medicare for drugs they received as free samples. In addition to bribes and kickbacks, one of the firm's sales tactics was to pitch the drug at support groups for prostate cancer patients (Boston Globe, 11/13/02).

• Generic drug company Andrx Corp will pay $60 million to settle claims that it conspired with Aventis Pharmaceuticals to keep a generic version of Cardizem CD off the market. Andrx still faces lawsuits by the attorneys general in 14 states over the scheme. In 1998, Andrx agreed to keep a generic form of the drug off the market until mid-1999 in exchange for $90 million from Aventis (Miami Herald, 7/9/02).

• Americans' purchase of medications over the Internet from Canada is causing a shortage of pharmacists in Manitoba. More than half of Canada's 80 Internet pharmacies are based in Manitoba, employing 150 of the province's 1,100 pharmacists. Pay at the Internet firms is high. Winnipeg's Grace General Hospital nearly closed in 2002 when four of its seven pharmacists left for Internet jobs. Manitoba recently spent $3.2 million to pay for $20,000 rentention bonuses for Winnipeg hospital pharmacists (Wall Street Journal, 3/31/03).

Policy and Politics

• The U.S. Supreme Court will decide if Maine can use the state's Medicaid program to require drug companies to give discounts to 325,000 residents lacking drug coverage. The legislation creating "Maine Rx" passed in early 2000, but the drug industry has held up the law in court. Hawaii just passed a similar program, and 27 states have filed legal arguments in support of Maine (Boston Globe, 1/21/03).

• Maine is one of nine states and the District of Columbia that are organizing a non-profit group to buy medications for both state employees and Medicaid patients. The other states are Connecticut, Hawaii, Massachusetts, New Hampshire, New York, Pennsylvania, Rhode Island and Vermont (AP, 1/15/03).

• "Proposal Would Bring Health Insurance to All" read the headline in USA Today. But Sen. John **Breaux's** (D-LA) plan requires individuals to buy private insurance. We are reminded of Voltaire's sardonic quip that: "the law, in its majestic equality, forbids the rich as well as the poor to sleep under bridges, to beg in the streets, and to steal bread." Further stigmatizing and even criminalizing the plight of the uninsured is scarcely a solution. Breaux likens his plan to regulations that car-owners hold auto insurance – but auto insurance is 10-fold less costly than health insurance and driving, unlike illness, is a voluntary activity.

Breaux would also privatize Medicaid and Medicare, turning the government health programs into voucher programs. Voucher programs are also called "defined contribution plans." The government pays a capped amount towards premiums and beneficiaries must cover the rest; there is no guarantee of benefits. Those unable to pay extra receive the skimpiest plans, creating a multi-tiered system; and a higher percentage of the health care dollar goes to overhead and profits.

Breaux also seeks to establish state-based risk pools where the uninsured could purchase coverage at affordable "group rates." State-based risk pools attract the highest risks, and have markedly higher-than-average premiums and long waiting lists. Breaux also fails to promote measures to streamline overhead and control costs. Instead of "bring[ing] health insurance to all," Breaux would subsidize the waste and profits of investor-owned insurers/HMOs while leaving millions uninsured and weakening Medicare (USA Today, 1/23/03, Los Angeles Times, 1/30/03).

Bush's proposal for **Medicare** reform is a second attempt at privatizing the program after the failure of Medicare HMOs. He cites the "Federal Employees Health Benefits Program" (FEHBP) as a model of cost-effective reform that "gives seniors the same choices members of Congress have." The FEHBP offers Federal workers a menu of private plans with varying benefits and premiums from which workers chose.

There are two problems with his logic. First, the FEHBP has failed to control costs. The Director of the Office of Management and Budget testified that costs in the FEHBP are rising faster than in traditional Medicare, and specifically warned against Medicare using the program as a "model." Second, FEHBP insurance plans with comprehensive coverage require hefty additional monthly premiums that few seniors can afford. On average, the nine million people in the FEHBP pay one-fourth of their plans' premiums out-of-pocket. Private plans on FEHBP's menu operate with much higher overhead than the Medicare program. The overall effect would be to shift costs from the Medicare program to seniors in the form of higher out-of-pocket costs, and from direct provision of care into insurance overhead.

What about Bush's proposed extra $400 billion for Medicare (over the next 10 years) to fund improvements and a prescription drug benefit? Call us cynics, but Bush's huge tax cuts and war budgets would seem to leave little room for real Medicare

expansions. But even taking Bush's proposals at face value, most of the new spending would end up subsidizing the drug and insurance companies. In order to qualify for most of the new benefits seniors would have to sign up for a private plan. Seniors who stayed in traditional Medicare would be eligible for a "drug discount card" estimated to save 10 to 25% on the (grossly inflated) retail price of drugs. Very low-income seniors would be eligible for first dollar coverage – but only up to $600. "Catastrophic drug coverage" would kick in for seniors spending over $6,000 a year. PNHP President Dr. Don McCanne argues that the administration opposes improving benefits in traditional Medicare because they want to use any new benefits to lure beneficiaries into private plans (Quote of the Day, 3/4/03).

Bush's **Medicaid** proposal would increase federal Medicaid spending $3.25 billion dollars in 2004, but would cut the program later on. It would cap the federal Medicaid contribution, regardless of factors such as increased enrollment or service costs; fund the program through block grants; end the requirement that states match federal Medicaid funding; and end eligible patients' entitlement to receive coverage for certain benefits (such as mental illness) in "sufficient amount, duration, and scope" to treat their conditions. States would be allowed to cut benefits, alter eligibility criteria, and increase cost-sharing. (Bazelton Center for Mental Health Law, Alert, 2/20/03).

Bush is proposing just $169 million in additional funding for community health centers – his most often-cited solution to caring for the uninsured. The nation's 3,500 community health centers – combined – receive just $1.6 billion in federal funding per year to care for over 10 million Americans (HHS Press Office, 2/11/03).

Presidential Candidates' Reform Proposals

Democratic rivals for President in 2004 are floating a variety of health proposals.

Former Vice-President Al **Gore** endorsed single payer national health insurance in December, shortly before withdrawing from the presidential race. The most promising potential candidate as we go to press is Dennis **Kucinich** (D-OH), an original co-sponsor of (HR 676) "The National Health Insurance Act." If he does run, he says he will make national health insurance one of his top campaign issues. He will announce his decision in June (Washington Post, 2/18/03).

The other candidates are pushing failed incremental reforms, often at the same time as they proclaim that they are for "universal coverage." Unfortunately, this rhetoric is confusing to the public, and even much of the media is hoodwinked. A typical headline reads "Democrats Focus on Health Care for All" (Los Angeles Times, 2/24/03). Former governor Howard **Dean** from Vermont, for example, is often praised for his support for "national health insurance" and/or "universal coverage," when his proposals would leave as many as 30 million people uninsured.

Dean's proposal has three parts: Expand Medicaid to cover uninsured children, add a drug benefit to Medicare, and give tax credits to the 32 million uninsured adults between ages 22 and 65. Tax credits are costly but have almost no impact on the number of uninsured, because they cover only a fraction of the cost of insurance (i.e. a $1,000 tax credit covers only one-quarter of a $4,000 individual policy). Most low-income, uninsured people could not afford insurance, even with a tax credit. Many people who now have insurance would be eligible for the $1000 credit or become eligible if employers responded to the program by cutting back health benefits. Hence tax credits cost billions of dollars yet provide very little new coverage. Dean's proposal would also perpetuate the waste and fragmentation in the current system, keep poor children in a poor health program (Medicaid), fail to control costs,

and keep insurance tied to employment.

Rep Richard **Gephardt** (D-MO) is also touting his support for health insurance "for all working Americans" through a tax credit approach. The core of Gephardt's plan is to eliminate the tax-deductibility of employer-sponsored health insurance premiums and instead offer employers tax credits. Employers preferring not to provide insurance would pass the credits on to employees. He also seeks to "limit the cost increases employers can pass on to workers" but, in the absence of any plan to control skyrocketing health costs, such a policy would simply result in eroding benefits. Aside from failing to cover the uninsured (see above for why tax credits don't work) eliminating the tax advantages of employer-sponsored coverage is most likely to increase the number of uninsured. Hence Gephardt policy is even weaker than Dean's.

Sen. John **Kerry** (MA), Sen. John **Edwards** (NC), Sen. Joseph **Leiberman** (CT), former Sen. Carol **Mosely-Braun** (IL) and Rev. Al **Sharpton** have yet to articulate their health policy platforms. We'll keep you posted.

Single-Payer in the States

• A flurry of new bills for single payer have been introduced at the state level. In California, Sen. Sheila Kuehl (D-Santa Monica) has introduced SB 921 to cover that state's 7.3 million uninsured residents. The chief lobbyist for the California Association of Health Plans candidly told the Los Angeles Business Journal that his group was "definitely opposed to a single payer system, since that would cut out the insurance industry." About one-third of the physicians in the California Medical Association are for single-payer, according to the chief executive, Jack Lewin (Los Angeles Business Journal, 2/24/03). [Also in California, voters in Los Angeles overwhelmingly approved Measure B, a property tax increase to keep Los Angeles County's emergency rooms and trauma centers open (Sacramento Bee, 2/13/03).]

Hawaii legislators introduced a single payer bill at the end of January, noting that their experiment with an employer mandate had failed to control costs and provide universal coverage. For more information, see House Bill #1617 at www.capitol.hawaii.gov/ (Quote of the Day, 1/30/03).

In Minnesota, Rep. Mike Jaros (DFL-Duluth) introduced a single payer bill in February. Jaros served on the Minnesota Healthcare Cost Study Commission in the early 1990's and based his proposal on the Commission's findings (Duluth Budgeteer News, 2/7/03).

In New Mexico, legislators introduced HB 955, a bill authorizing $250,000 for a fiscal study of single payer health care reform, after legislation (HB 498) to implement a single payer plan was tabled in committee. Activists are hoping the fiscal study will help with their educational efforts and move the proposal farther next year.

In Delaware, a single payer bill was introduced in the House in March (HB 62). The bill is endorsed by Rep. Dennis Williams and Sen. Margaret Rose Henry, two prominent African-American legislators.

In Massachusetts, Sen. Steven Tolman (D-Brighton) is the lead sponsor of single payer legislation introduced in December. Senate President Robert Travaglini and about 50 other lawmakers have signed on to the plan, (Masscare2@aol.com, Boston Herald, 12/05/02).

In Wisconsin, Rep. Mark Miller introduced a single payer bill in March (AB 229). www.legislstate.wi.us

In Maine, the state's universal health care task force is continuing to work on the design and financing of a single-payer plan to present to the legislature. A study by Mathematica found that single-payer would cover everyone and save money. For details, see page 8, this issue.

International News

In Canada, the 2003-2004 budget increases federal spending for health care over the next five years by $30.5 billion. The final report of the Romanow Commission was critical to refuting the myth that private for-profit health care is efficient and in gaining additional funding and coverage for home care and prescription drugs (see pages 42-46 for Romanow's summary). The full report is on-line at www.healthcarecommission.ca.

The Malaysian Medical Association (MMA) is promoting national health insurance for their country. MMA President Dr. N. Athimulam said the Association "feels any insurance scheme should be owned and run by the Government, and operated as a non-profit entity." Taiwan has had a single-payer system since 1995, and Malaysia may well be inspired by that system, according to Princeton economist Uwe Reinhardt. Thailand adopted national health insurance in 2001. (New Straits Times, 12/22/02, Quote of the Day, 12/23/02).

Resources

An audio recording of a discussion/debate about the uninsured and options for reform with participants Dr. Don McCanne (PNHP President), Uwe Reinhardt (Princeton economist) and Robert Moffit (Heritage Foundation) is available at www.aarp.org/radio/ptrtopics.html .

The Centers for Disease Control has a new survey that may be of interest to researchers in PNHP. The "Joint Canada-United States Health Survey" (JCUHS) is a one-time phone survey in both countries that uses the same questionnaire and methodology. The survey obtains information about health status; chronic impairments; and health services. See the JCUHS category on the National Health Interview Survey (NHIS) home page. www.cdc.gov/nchs/nhis.htm.

An American Health Care Dilemma is a painstakingly researched, two-volume book on race and racism in American Medicine by Drs. W. Michael Byrd and Linda A. Clayton. "Treating patients differently on the basis of race and class is a 383-year-old tradition in American medicine," Dr. Byrd told the Boston Globe. The first volume was nominated for a Pulitzer prize.