EMPLOYER ADVOCATE

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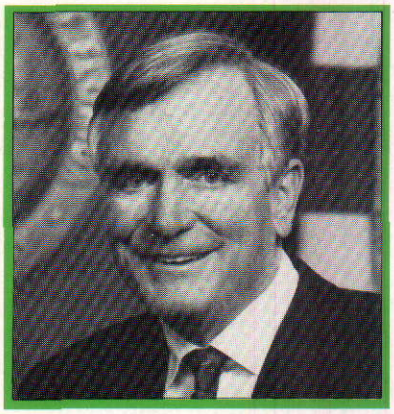
Why Reform Health Care? It's Simple, Folks



by Florida Gov. Lawton Chiles

America spent 9.1 percent of its gross domestic product (GDP) on health care in 1980. By the year 2000 health care costs are projected to eat up 16.4 percent of our GDP. Why reform our health care system? As Ross Perot would say, "It's simple, folks."

In her new book, *"Reviving the American Dream,"* Alice Rivlin estimates that the United States would save $4 trillion between now and 2000 if we could simply hold increases in health care costs to the same percentage of GDP as that of our competitors like Germany and Japan.

In Florida alone, we estimate savings of $131 billion over a 10-year period if we just keep the state's health spending as a percentage of gross state product (GSP) constant. Left unchecked, the state's health care bills will triple from $31.4 billion in 1990 to more than $90 billion at the turn of the century.

What kind of return does the United States get on this $4 trillion "health care tax"? Not much when measured against Germany and Japan where access to health care is guaranteed for all citizens. By contrast, 37 million Americans are without health insurance today, including 2.5 million Floridians.

Imagine how we could put that $4 trillion tax to better use: Eliminating the national debt? Rebuilding our infrastructure? Improving our schools? Protecting the environment? Take your pick. It's that simple, folks.

The health care tax has been particularly cruel to businesses and their employees. In 1984 the average health care cost per employee was $1,645. Seven years later, in 1991, that figure had more than doubled to $3,605. In many ways, companies that provide health benefits are at a competitive disadvantage with those that don't. Skyrocketing costs are taking a bigger bite out of the bottom line and causing profits to erode.

I once subscribed to the school of thought that access to health care for our citizens could not be provided without

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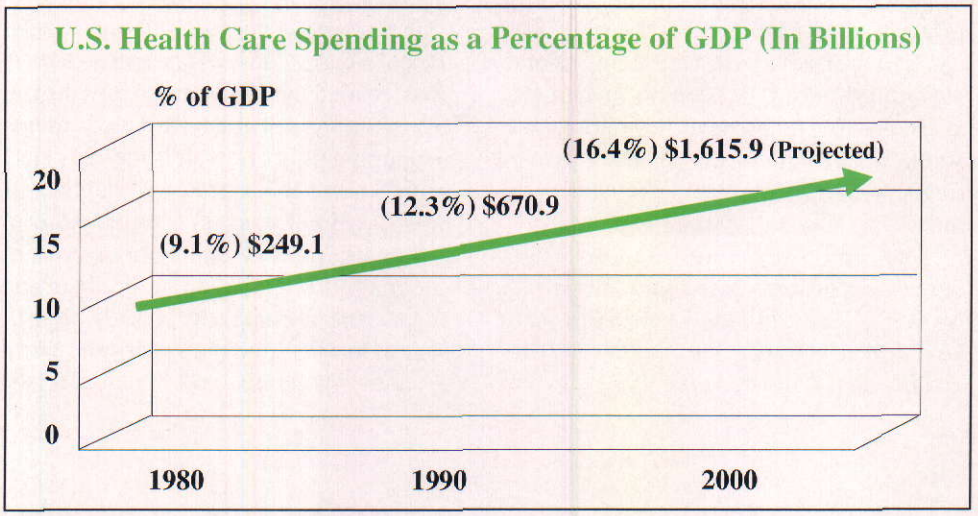
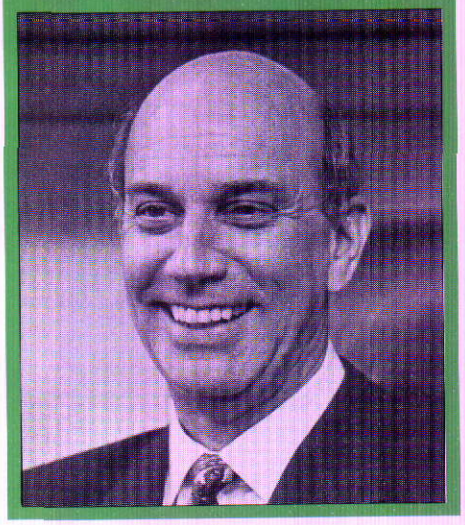


President's Message



This Time: Health Care Reform

by Jon L. Shebel, President and Chief Executive Officer, Associated Industries of Florida

In 1947, Secretary of State George Marshall traveled to Moscow to discuss terms for the future of occupied Germany. Frustrated with the lack of progress, he paid a call on Joseph Stalin. Showing little interest in the negotiations, Stalin sketched wolves' heads with a red pencil as he told Marshall, "We may agree the next time, or if not then, maybe the time after."

On a large scale, the health care crisis we face today may not weigh as heavily as the international conflicts spawned in post-war Germany, but it is a serious situation that strikes at the well-being of our state and nation. Past attempts to mediate an end to the crisis have run up against smokescreens and stalling maneuvers. Every year business said "maybe next time."

This time "next time" is now. The bargaining process has begun, propelled by Gov. Chiles and the Legislature who have forced the matter to the table. The Health Care Reform Act of 1992 sets the framework to guarantee coverage for all Floridians, while putting the reins to the runaway costs of health care. The law sets a deadline of Dec. 31, 1994, to get all Floridians covered by some type of health insurance. The question remaining is not will we do it, but how will we do it.

The debate centers on cost and access. Some claim the first step to controlling costs is to extend coverage to everyone who does not have it. There is a small glimmer of legitimacy to that argument. Currently 2.5 million Floridians, 18 percent of the state's population, have no health insurance. Uninsured citizens are forced to seek treatment at emergency centers or neglect their health problems until their conditions become serious. Either way, the treatment they do receive is unnecessarily expensive. With some form of health insurance, these people will be able to reduce the cost of their care while improving its quality. Nevertheless, this represents just a part of the expenditure equation.

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The crux of the solution has to be the issue of cost. Medical expenses are growing at a rapid clip, more than double the rate of inflation that applies to other items on the balance sheet. The increased cost and subsequent unavailability of health insurance is directly linked to the spiralling cost of medical care. Unless that spiral evens out, Florida will not be able to bear the expense of guaranteed access to health care.

Undoubtedly, the state will toy with the idea of a Canadian-style universal access plan, funded by some kind of payroll tax, but that option will be little more than a bargaining ploy. Hawaii is the only state in the nation with a universal plan; its model will not work in Florida. Hawaii is a small, isolated state, both in terms of geography and population. Tourism and sugar cane farming are its only significant industries, and the sugar cane farmers are virtually untaxed. Visitors to the island paradise foot all the bills, including medical.

If there is a prototype in America that Florida can follow, look to Oregon (see related article, page 6). That state assembled a consortium of consumers and providers, along with business, labor and insurance company representatives to analyze its health care system and then clarify public policy. The Oregon plan includes a structure for rationing of care. Those very words, "rationing of care," always set off a firestorm of conflict, but any effort to control the costs of health care must include a reasonable approach to allocation of limited resources.

With this edition of *Employer Advocate*, we hope to define and explain some of the facets of this complicated problem. There is not one easy solution. The medical profession must agree to accept reasonable economic restrictions. Government must allow insurance carriers the leeway to develop affordable health insurance policies. Insurance companies must cooperate with business in the pricing of these policies. Business then has the responsibility to seek out the insurance options it can afford so that we can bring more and more Floridians under the tent of health care coverage. And each of us, in our role of consumer, must decide to pursue preventive measures to keep ourselves healthy.

Beginning in January, insurance companies will be able to offer economical health insurance packages to employer groups with three to 25 employees. I urge qualified employers to contact their insurance representatives about the availability of these packages. By doing so, we can demonstrate the willingness of the business community to cooperate in the health care reform movement.

That movement will succeed if all the parties make a commitment to the kind of candid and meaningful compromise that forges lasting solutions.

Expand Hospice: Caring, Cost-Effective Alternative

by the Honorable Bob Graham, United States Senate

Don Ackerman can't speak. He's weak, bed-ridden, and dying of Lou Gehrig's disease.

Don uses his right hand, a keyboard and a computer screen to communicate with the world. During a recent visit as part of my workday with the staff from Hospice, Inc., I asked Don, a patient, how hospice had affected his life.

"Staying at home," he answered via computer.

Don Ackerman, 38, can stay at home in Deerfield Beach. At home, with his wife and their young child.

Using only three words in our vast language, Don Ackerman offers a poignant summary of why hospice is a good option for those with terminal illnesses. Virtually all terminal patients want to stay at home, and three out of four hospice patients achieve that goal.

Old Idea Made New Again

Hospice is an old idea that is gaining acceptance in modern times. Its goal is to make the last months of a person's life as comfortable and meaningful as possible. Hospice care does not use artificial life-support systems or surgery when there is no reasonable hope of remission.

Hospice uses a team approach to care for the terminally ill and their families, from addressing clinical symptoms to offering spiritual counseling and emotional support. Hospice offers dignity for the dying and avoids costly, often traumatic, acute-care hospitalization.

As a hospice volunteer for a day, I joined team members—physician, nurse, chaplain, social worker and home health aide—in caring for terminally ill patients like Don Ackerman. The Rev. Ron Mudd, chaplain of Methodist Hospice in Jacksonville, summarized hospice: "When medical science can add no more days to life, then it is the mission of hospice to add more life to every day."

Expand Concept to Veterans, Others

Hospice makes sense and should be a part of an emerging health-care reform, available as a basic benefit through federal health-care programs such as CHAMPUS for military families and health care for veterans.

> *"When medical science can add no more days to life, then it is the mission of hospice to add more life to every day."*

Former Veterans Administration Secretary Ed Derwinski understands the wisdom of hospice, and has begun moving the giant agency in the right direction. But the VA, America's largest health care provider, must do more to expand hospice for terminally ill veterans.

By its own reckoning, the VA says only six to eight percent of its patients are able to live out their final weeks in their own homes. Conversely, 92 to 94 percent of VA patients die in institutions—the most costly location for care.

Acute-care hospital costs associated with terminal patients are alarming. Typically, one third of the last 60 days of a dying person's life are spent in an acute-care hospital bed. Nearly half of all costs of care in the last year of a terminal patient's life are consumed in the final 60 days, according to federal health care officials.

In addition to the considerations of humanity and cost-effectiveness, there are two other reasons hospice should be available to veterans:

- Hospitals may not be convenient. Many veterans live far away from VA hospitals. Allowing the VA to contract with community-based hospices to provide services would allow terminally ill veterans to remain at home in familiar environments.

- Hospital beds are scarce. If veterans have the option of at-home hospice care, that will help other veterans with medical needs by opening hospital beds.

During my workday, I saw how hospice care for veterans could work. I met hospice patient Elias Kassar, an 88-year-old veteran who lives in Coconut Creek. Kassar has lung cancer, but he's able to cook for himself, at home. In fact, he loves to cook. Cooking is part of his dignity and independence, which would be stifled in a hospital.

Florida—a Leader

Florida has been a pioneer in the modern hospice movement. In 1979, Florida became the first state to set standards for hospice and recognize hospice as an option for the terminally ill. The Florida law served as a model for licensure laws in nearly 30 states and for national legislation. In-patient and at-home hospice care has been covered by Medicare since 1982.

The lessons we've learned in Florida—to respect dignity and control costs—should be expanded nationally. The combination of quality care and the ability to hold down costs for the terminally ill by avoiding acute-care hospital stays could become a paradigm for health care delivery for patients and families facing other serious illnesses.

Chiles, from page 1.

first containing costs. I'm now convinced that we will never control costs until we first guarantee access. Until our health care system is anchored in the discipline of full access, we can never expect government, business, health care providers, insurance companies and consumers to come to the table to restructure the system.

The health care market is the only market in the world where the provider determines what and how much the consumer buys, and someone else pays the bill. Without full access to health care, costs will continue to be shifted to others, and people with no insurance will continue to use the emergency room when they could have been treated earlier at a lower cost.

I believe every Floridian should have a "health care home" where regular check-ups and primary and preventive care are guaranteed. Regular visits to a family doctor will make expensive emergency room services the last resort for medical treatment instead of the first stop. It's that simple, folks.

In March 1992 Florida enacted a landmark health care reform package premised on full access as the key to solving the state's health care crisis. First among all states, we established a Dec. 31, 1994, deadline for the key players in Florida's health care system to come together to redesign the system so that all Floridians have access to affordable health care.

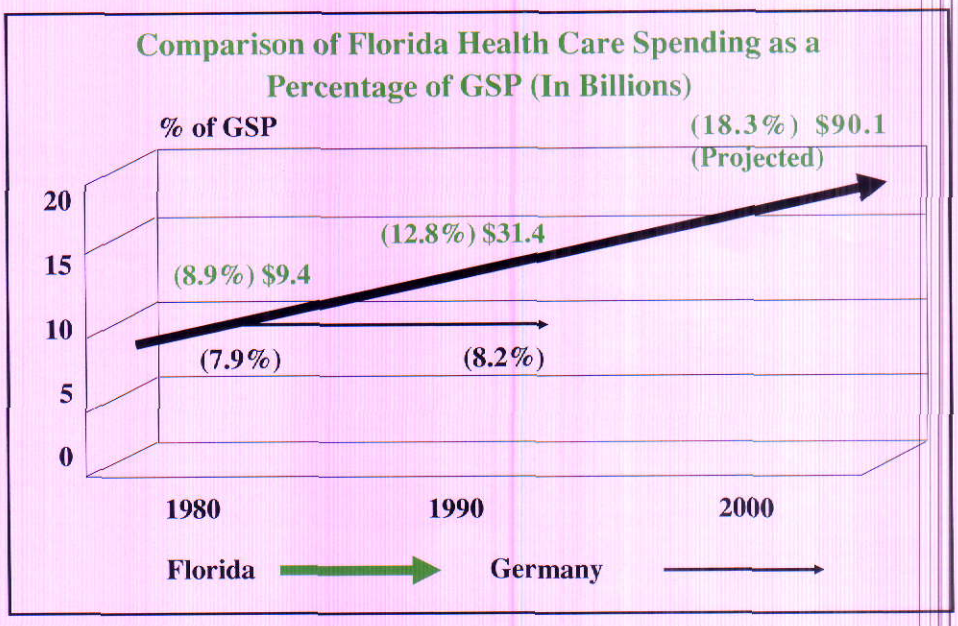
The Agency for Health Care Administration (AHCA) was created to reinvent the system and coordinate the state's health care financing, purchasing, planning and regulation. Working at the community level, this new agency will develop the Florida Health Plan which will serve as our road map to achieving the 1994 goal. It will provide local businesses, doctors, hospitals and insurance companies new insurance products and new reforms to help them meet this challenge.

On Nov. 9, I convened Florida's first-ever health care summit in Orlando to collaborate with businesses, health care leaders, insurance companies, consumers and others on the design of the Florida Health Plan. This historic two-day summit was an outstanding success that produced an excellent exchange of ideas on how best to reform the health care system. Participants reached broad agreement on key reform strategies for achieving the goal of full access by the end of 1994.

We are now drafting our interim plan based on the summit agreements and as the details of this plan take shape we will continue to rely upon the expertise of summit participants. By the end of the year, our recommendations will be sent to the Legislature and we will take the plan around the state for communities to review.

The road to the Orlando health care summit began in August 1991 at the annual meeting of the nation's governors in Seattle. Together with Gov. Bill Clinton, I worked to forge a consensus among the governors that full access to health care could not wait until the year 2000. With the recent election, I am hopeful that Washington will become a part of the health care solution, by untying our hands and giving us the flexibility we need to implement state-based health care reforms.

I am confident we can win this battle. With a strong federal partnership, emphasis on access and public-private partnerships, and a community-based approach to the problem, we can find the cure for our ailing health care system. Floridians can't afford to wait any longer. It's that simple, folks.



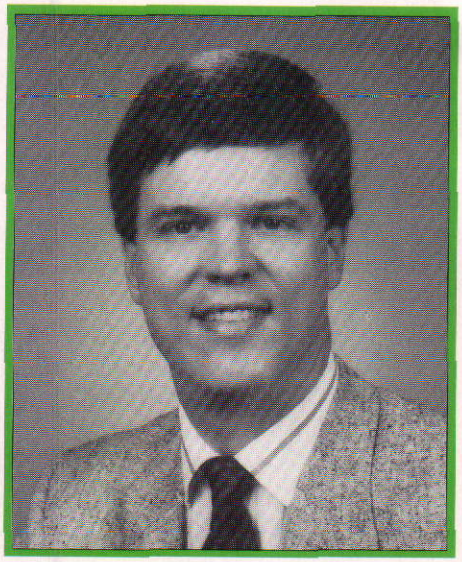
Graphs on pages 1 and 4 courtesy of the Agency for Health Care Administration (AHCA).

Health Care Reform Act of 1992

- Agency for Health Care Administration
- Florida Health Plan (interim plan 12/92, final plan 12/93)
- Universal coverage by Dec. 31, 1994
- Voluntary private health insurance and cost containment program with annual targets
- Basic benefit standard for all health plans
- Small business private health insurance reforms
- Florida Health Services Corps
- Healthy Communities, Healthy People
- State contractor insurance mandate (July 1, 1994)

Family Physicians—

Health Care Gatekeepers



by Walter Larimore, M.D., Kissimmee

"The health of the people is really the foundation upon which all their happiness and all their powers as a state depend." Benjamin Disraeli

In the 1960s, less than three percent of U.S. medical students indicated an interest in becoming general practitioners.

What Americans needed, it was determined, was a new kind of physician—one who was better trained yet still committed to family centered, whole-person care. As a result, family practice became this nation's twentieth major medical specialty in 1969.

Unlike the general practitioners of the past, today's family physicians complete a three-year residency program and are trained in the specialty known as family practice. The only specialists trained to treat 85 percent of all ailments, family physicians provide comprehensive, continuing health care for all people, regardless of age or gender.

As our nation's leaders strive to develop more economical ways of delivering quality health care in an environment of complex and costly health options, the broadly trained physician becomes increasingly important.

The family physician is best prepared to fill that role. In fact, major public opinion surveys show that people prefer having one physician treat the entire family.

The family physician is trained to treat most ailments, oversee the patient's comprehensive and continuing care, and use consultants only when necessary. This allows family physicians to practice just about anywhere—including rural and inner city areas.

The family physician is America's number one physician of choice. Consider these facts:

- In one year, 75 percent of American households reported they had seen a family physician for their health care.
- Two hundred million office visits are made to family physicians—that's 120 million more visits than any other single medical specialty.
- Approximately 30 percent of all contacts between patients and physicians are with family physicians. The next highest percentage for any specialty is pediatrics at 12.6 percent.
- 50 percent of all office visits for children between the ages of one and 18 are to family physicians.

Canada, Great Britain, New Zealand and Australia depend upon general/family physicians for virtually all their primary health care; and in each country approximately one-half of all physicians are generalists (compared to 13 percent in the United States). These nations provide universal health access to their citizens, achieve excellent health care outcomes and spend dramatically less on health care than the United States.

With the state-wide shortage of family physicians already facing us, the need for additional family physicians is critical. Florida's medical students should be encouraged to select family practice and should be assured that the community hospitals with family practice residency programs are adequately funded.

Combine their comprehensive training with their ability to provide cost-effective continuous health management and you can see why family physicians are positioned to deliver the ultimate in medically supervised, judicious and affordable health care.

We are all concerned that the cost of health care in Florida is growing too fast. To correct this, some are proposing a new reimbursement system that would pay for basic health care services that make the greatest improvements in quality of life for the majority. But doing this will require choices. The Florida Academy of Family Physicians believes that family physicians should play a major role in developing state policy since they face these medical decisions continually and know the full scope of patient disease and disability.

The Florida Academy of Family Physicians, representing 3,000 members in 67 counties of Florida, is committed to strengthening the quality and fairness of our health care system. FAFP is working with the Legislature, Gov. Chiles, the Agency for Health Care Administration, the Florida Medical Association and Florida's business leaders to develop solutions and programs of positive action that will serve the best interest of Florida citizens: to protect the strength of our current system and correct the weaknesses—now and in the future.

Dr. Walter Larimore is a Board-certified family physician in a two-family-physician group practice in Kissimmee, and president-elect of the FAFP.

The Oregon Health Plan

A Bold Move At A Critical Time

Despite the added attention focused on our nation's health care crisis by an election year, nothing of substance has been done to address the crisis on the national level. The lack of direction from the federal government on an issue that affects every citizen in the United States has led to a variety of efforts at the state level. Some health care system reforms have been bolder than others. Some have outright failed. Some have not been given the opportunity to succeed or fail.

The state of Oregon recently concluded a well-conceived process to analyze its health care system and make dramatic and radical changes in what services will be covered and the way health care coverage will be provided to Oregonians.

Oregon readily admits its plan does not represent a definitive solution; nor could it in light of the fact that it is only one state in a nation of 50 where there is a free flow of individuals across state boundaries. Any state adopting a universal access health care plan obviously risks the rapid influx of ill people from other jurisdictions seeking help.

Clearly, a comprehensive approach to health care at the national level is the only answer. In the meantime, however, Oregon's efforts represent a bold step to address a critical situation.

One of the unique features of the Oregon plan is how it was assembled. The plan represents a broad-based, bipartisan agreement among health care providers, health care consumers, business, labor and insurance companies.

The plan clarifies the state health policy, creates a rational and accountable resource allocation process, and establishes a clear framework in which comprehensive reform can take place.

Any state adopting a universal access health care plan obviously risks the rapid influx of ill people from other jurisdictions seeking help.

Rationale Behind the Plan

Underlying Oregon's plan are two premises: the reality of fiscal limits and the need for accountability. As to the first premise, legislators everywhere understand there is a limit to the amount of taxation people will tolerate.

Legislators also realize there is a finite budget from which to govern all of the activities of state government. The Oregon health plan takes into consideration that as health care costs increase, states must either raise taxes or cut other programs, many of which have a direct bearing on health.

The second premise, the need for accountability, accepts the first premise of a finite health care budget, and goes further. An explicit decision to allocate money for one set of services means an implicit decision has also been made not to spend money on other services. This, in essence, constitutes the rationing of health care, and legislative bodies do it every budget cycle. However, it is rationing done implicitly, and for which there is no accountability.

Currently, there is far too much emphasis placed upon the highly publicized child who needs an organ transplant, requiring a major shift of resources to one individual to the detriment of thousands of American children who die each year before their first birthdays.

The Oregon plan restores accountability by requiring policy-makers to make health care resource allocation decisions explicitly weighing the overall social costs and benefits involved and assuming clear accountability for the decisions and their consequences.

The Oregon health plan is more comprehensive than a mere rationing scheme. It attempts to develop not simply a health care policy, but a health policy; an integrated approach in which allocations for health care are balanced with allocations in related areas which also affect health.

A plan such as Oregon's requires that many explicit choices be made along the

way, helping to assure greater accountability throughout the health care delivery process.

Allocating Scarce Resources

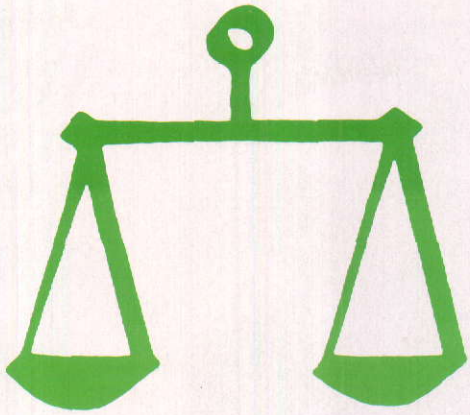
The Oregon plan encompasses the broader concept of health and the need for resource allocation, while acting on the principle that universal access be provided to all Oregonians. Other underlying principles in the Oregon plan include:

- the obligation of society to provide sufficient resources to finance a basic level of care for those who cannot afford to pay for it themselves;
- the establishment of a process to determine what constitutes a basic level of care;
- the criteria used in the process must be publicly debated, must reflect a consensus of social values, and must consider the common good of society as a whole;
- the health care delivery system must offer incentives to use services and procedures that are effective and appropriate rather than those that are of marginal or unproven benefit;
- the distribution system must avoid creating incentives for over-treatment; and
- the funding must be explicit and the system must be economically sustainable.

The Oregon health plan extends Medicaid coverage to all Oregonians with an income below the federal poverty level. Despite the Medicaid expansion, many people would still be uninsured, most of them workers or the dependents of workers. The plan requires employers to provide health insurance coverage to all permanent employees (those working 17.5 hours per week) and to their dependents by July 1995.

Those employers who voluntarily offer coverage prior to July 1995, would receive a series of tax credits and would be exempt from current state insurance mandates.

The plan also created the Oregon Medical Insurance Pool to provide health insurance to Oregonians unable to obtain



coverage because of medical conditions. This pool is supported financially by assessments on Oregon's health insurance carriers and the premiums paid by enrollees.

The plan also contains significant reforms in the small group insurance market, similar to those adopted by the Florida Legislature in 1992. These reforms include: guaranteed issue of coverage, guaranteed reissue of coverage, prohibition of exclusions based on pre-existing medical conditions, weight bans, and limitation of underwriting to geography and family size and composition only.

Coverage For All

What does the Oregon health plan actually do? It virtually guarantees everyone in the state access to the health care system. The debate thereby shifts from who is covered to what is covered, and this creates a framework for beginning to evaluate the effectiveness and appropriateness of the actual services being purchased with our health care dollars.

The benefit package was produced by the Health Services Commission, an 11-member body appointed by the governor and confirmed by the Senate after public hearings. The commission comprises five primary care physicians, a public health nurse, a social worker and four consumers.

It was charged with developing a comprehensive list of health services ranked in priority from most to least important, based on clinical effectiveness and social value.

The commission used a methodology which prioritized medical condition/treatment pairs. The commission ranked the pairs to reflect the health improvement likely to result from each procedure for a given condition. For example, a bone marrow transplant for a 95-year-old terminally ill patient would be ranked much lower than a similar procedure for someone younger and more likely to improve following the transplant. Implicit social rationing is gone and accountability is assured.

The plan stresses primary and preventive care and the benefit package serves as the minimum standard, not the maximum level, of benefits available to Oregonians.

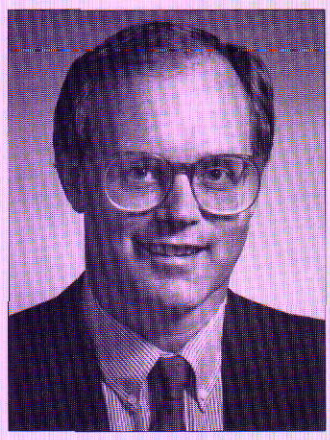
From a cost containment standpoint, the plan emphasizes managed care and the need to control the costs associated with excessive duplication and use of medical facilities, technologies and services. It provides a system whereby the effectiveness of medical services and procedures may be examined. More importantly, it modifies physician practice patterns, which in the past have led to extreme increases in overall health care costs. Finally, the act attempts to establish a statutory distinction between medical malpractice (which should always be litigated) and the distribution of services based on the consideration of effectiveness. Undoubtedly, this area of the plan is one of the most controversial and will be subject to the attentions of the trial lawyers in that state.

Lessons To Learn

The Oregon plan represents a bold attempt to address a most complex problem. The plan was developed in a logical and thoughtful way, taking into account the realities of life and economic limitations. It throws off the cloak of implicit rationing and assumes responsibility and accountability for explicit rationing decisions. It challenges us to re-evaluate what we expect from the health care system and compels us to face the tough decisions associated with the inevitability of death.

Although the rationing aspect of this law has basically been placed on hold by the federal government pending further review, there are many features of the plan Florida should carefully consider.

Now's The Time To Reform Workers' Comp



By William Hager, President, National Council on Compensation Insurance

Workers' compensation, originally enacted nearly a century ago to benefit both employee and employer, is today itself critically ill.

In fact, without the aid of system reform, rate increases, improved safety and reduced litigation, state workers' compensation could become a costly fatality. At the heart of the crisis is financial impropriety, much of which is reflected in soaring health care costs.

Even though workers' compensation insurance is second only to wages as a major expense for employers, the cost of providing that coverage is rising considerably faster than the premiums insurers are permitted to charge.

Workers' compensation medical costs have risen 14 percent a year for the past decade, almost twice the eight percent rate of medical cost inflation in general. However, as Gov. Lawton Chiles recently said, "Florida business cannot take much more. True reform is needed now."

Over the past five years, workers' compensation insurers have lost more than $1.6 billion in Florida. In 1991, insurers paid out $1.17 for every dollar earned. It doesn't take a Cape Canaveral rocket scientist to figure out that this is bad business.

Several national factors are driving costs up. Medical costs nationwide, for example, accounted for 40 percent of all compensation claim dollars in 1990, compared to 30 percent in 1980. The average medical claim cost on lost-time cases was $6,611 in 1990, compared to $1,748 in 1980. And inflation of workers' compensation health care costs has soared at a 50 percent higher rate than other health care costs.

The cost shifting has been documented all across the nation. For example, a Minnesota study found that average workers' compensation claims were twice as high as identical claims that went through a non-compensation system.

A recent California study shows that when physicians have the option to refer injured employees to medical facilities they own, the percentage of cases referred—as well as the ultimate charges—becomes astronomical.

Doctor referrals for MRI scans are three times as prevalent as other referrals. In just one year this abuse cost the California system one-third of $1 billion. And medical abuse in other forms adds to the cost of workers' compensation, as revealed earlier this year by CBS' "60 Minutes." One employee, a claimant with a cut finger that required but three stitches, was out of work for three weeks and generated a $37,000 medical bill.

If the health of workers' compensation is to be resuscitated, states like Florida will have to take the lead. True reform is needed now.

Juggling Workers' Compensation

The names used in this article have been changed to protect all parties involved.

In October 1989, Troy Stanton was making $500 a week installing alarm systems. At 35, he lived with his wife and two sons in a nice little house in Fort Lauderdale. Then one day at work he fell off a ladder.

No one was with Stanton at the time of his accident. When he got back to the company's West Palm Beach office, Stanton told his boss, Mike Weaver, about the fall. Stanton asked for permission to go to his family doctor in Fort Lauderdale.

Stanton claims Weaver insisted that he go to a walk-in clinic in Boca Raton, 35 miles from the Stanton home. Weaver says he suggested that Stanton should see a doctor, but Stanton said he wasn't badly hurt and did not need medical help. Neither thought to report the accident to the company's workers' compensation carrier, the AIF Property and Casualty Trust (PCT).

Whichever version is true, Stanton's or Weaver's, Stanton visited his family physician, who treated him for a minor hip injury. Stanton paid the medical bill out of his own pocket. He later complained about soreness in his neck and left shoulder. The pain continued so Weaver assigned Stanton to light duties.

Over the next several months, however, things began to sour on the job. Stanton refused to work on weekends and would only accept certain kinds of tasks, whether they were in his range of ability or not.

In February of 1991, Stanton went back to his doctor and asked for a disability slip. The next day he took the slip to Weaver who decided enough was enough, and fired him on the spot for poor job performance. Stanton, however, had a slip that excused him from light work or any kind of work at all. He was officially disabled. Instead of joining the ranks of the unemployed, Stanton became a workers' compensation statistic.

The PCT's first notice of the case came when Stanton filed a claim for benefits a few days later. Weaver disputed Stanton's story about his request for medical treatment. He doubted that the fall from the ladder actually occurred and he had good reason to believe that Stanton asked the doctor for a disability slip after hearing rumors that he was about to be fired. There was no way to confirm Weaver's suspicions, however,

and with the doctor's statement of disability, Stanton was entitled to workers' comp benefits.

The PCT immediately made an appointment for an evaluation by Dr. Cox, an orthopedic physician. After performing numerous tests, including an MRI and EMG, Cox concluded that Stanton suffered from a cervical herniated disc and a possible tear of the rotator cuff. Both injuries cause discomfort, even distress, and effectively restrict movement of the entire upper body. A rotator cuff is easily treated, but the treatment for a cervical herniated disc is drastic and painful.

The results of Stanton's tests, however, did not provide conclusive diagnostic proof. Cox's conclusion rested on Stanton's description of the sensations and pain he was experiencing. The tests merely gave evidence to support the possibility that, based on Stanton's subjective complaints, he suffered from a cervical herniated disc. The existence of a rotator cuff injury was even less obvious.

Cox prescribed a regimen of physical therapy. After two months, with no apparent relief or change in Stanton's condition, Cox recommended surgery for the rotator cuff tear. In accordance with standard procedure, the PCT obtained a second opinion from another orthopedic physician, Dr. DeGravia. When DeGravia concurred with Cox's recommendation, Stanton refused to undergo surgery, claiming that he was afraid of anesthesia.

During the time between the first and second evaluations, Stanton took the step that always signals trouble: he hired a lawyer. When Stanton's first lawyer did not dispute Cox and DeGravia's findings or the PCT's handling of the claim, Stanton sought another attorney who would pursue a more aggressive approach to his case. The second attorney made the classic opening move: he requested a change in physician.

Stanton's third orthopedic examination took place in June 1991. This physician proposed extensive physical therapy before considering any surgical procedure. Since this diagnosis did not fit the Stanton game plan, he never went back to the physician's office and refused to follow up on any of her recommendations.

Stanton and his lawyer employed a popular workers' comp strategy. They actively sought a medical prognosis to verify that Stanton had suffered a severe injury, that because of the injury he was unable to return to his pre-injury wage level, and that surgery was the only option to improve his condition.

With these stipulations, Stanton could use his anxieties about anesthesia, or his newfound fear of contracting AIDS, to refuse treatment. He got his wish. The original attending physician, Cox, announced that without surgery Stanton had reached maximum medical improvement. Based on the tests she ran and Stanton's unsubstantiated descriptions of his pain, she awarded him a 20 percent impairment rating.

As Stanton was doctor-hopping, he was also collecting temporary total, temporary partial, or wage-loss benefits. He did return to work for a short time—on a part-time basis at a light duty job with another employer. While there, Stanton apparently took another fall from a ladder. Once again, there were no witnesses to the accident.

Under the law, an employee who reaches maximum medical improvement with a loss of earning capacity is entitled to wage-loss benefits—as long as he makes an earnest effort to find a job. In the workers' comp system, a good faith job search enjoys a rather generous interpretation. The wage-loss candidate who walks through the Yellow Pages making random phone calls is conducting a good faith job search. So is the individual who walks from store to store in the mall. The applicant's suitability for the work or the actual existence of a job opening are not primary considerations.

With this in mind, the PCT staff hired a rehabilitation counselor to help Stanton find a job. He refused to cooperate with the counselor and neglected to follow up on the job leads she sent him.

In the meantime, Stanton's attorney filed another request for a change of doctor. There was some disagreement over the selection of that doctor. Finally, with the help of the rehabilitation counselor, the PCT located a physiatrist who proved acceptable to Stanton and his attorney.

Physiatry is emerging as the new scientific trend in workers' comp treatment. The physiatrist is a medical doctor who blends extensive physical and occupational therapy with pain management, psychotherapy, and behavior modification to help the patient learn "to cope with the physical and emotional trauma of pain." Like chiropractors, physiatrists seek more to ease the patient's condition than to cure it. And, again like chiropractors, the necessity for and success of the physiatrist's treatment is almost impossible to measure.

From Stanton's physiatrist, Dr. McConnell, came another recommendation for an extensive regimen of physical therapy. For approximately two months, Stanton attended therapy on a sporadic basis. In February of 1992 he quit altogether and sought no other treatment. Then, in June of 1992 he returned to McConnell to resume therapy.

Between February and June, observations of Stanton revealed that he led a vigorous life. Ignoring his debilitating condition, he coached a little league baseball team and frequently played

Please see Jugglers, back page.

An Economic Imperative

Health Care Reform

Every member of Associated Industries could tell a story about the health care crisis facing the United States and Florida: telling employees you can no longer provide certain types of coverage, paying the outrageous cost of catastrophic illness, the heartbreak of canceling employees' health insurance.

However, the crisis has an even darker side for business. The economics of this crisis, both the proportion of the problem and the impact of some proposed solutions, threaten to destroy the foundation of our business future. It's not that the human side of the health care crisis is not a compelling reason to change the system; rather, business must fully understand the economics of the crisis so it will recognize this crisis is knocking on its economic door.

The National Picture

A nation's gross domestic product (GDP) is a measurement of its economic input and output. A look at GDP tells where the money is going. Various expenses comprise the GDP, including infrastructure, education and defense. These items notwithstanding, the single biggest expenditure in our nation's GDP is health care.

In 1989, health care costs consumed almost 12 percent of the U.S. GDP. We spend a greater proportion of our GDP on health care than any other nation. In 1989, Japan spent only seven percent of its GDP on health care. That five percent differential means that Japan has more capital to spend to make its companies more competitive.

Four years from now, at the end of President-elect Bill Clinton's term, the Government Accounting Office estimates health care will consume nearly 20 percent of our GDP. That figure is staggering. It means that health care takes money away from research and development, infrastructure and jobs. A nation that spends that kind of money on health care alone can not compete on the global market with nations spending half that amount.

It gets worse. If not brought under control, by the year 2000 the United States will be spending more than $1.5 trillion (in 1992 dollars) on health care. Writer Robert Rankin puts that figure into perspective this way: "One million seconds have ticked by in the past 12 days. One billion seconds took more than 31 years to elapse. And one trillion seconds ago it was the year 29,697 B.C. in the Stone Age."

The federal government pays health care costs in many ways, chief among them Medicare and Medicaid. In 1965, about the time these programs were created, the average stay in a hospital cost $567 (in 1992 dollars). The average cost today: $6,000.

On average, Medicare costs, after inflation, have risen 10 percent a year since 1967. Medicaid costs have risen almost 16 percent a year. In fact, if the health care inflation rate was applied to the cost of gasoline, it would cost $22 per gallon.

Despite all the talk during the presidential campaign of reducing the federal deficit and balancing the federal budget, there is no way to reduce the deficit or balance the budget without controlling health care costs. The three are inextricably linked. By the year 2000 the federal budget for health care will equal the combined defense, education and recreation budgets.

Health care will cost more than any other single government program, including Social Security. There will be no money to pay for defense, no money to pay for education, no money for foreign aid, and nothing for environmental protection or deficit reduction. It will all be funneled into health care.

Health Crisis Affects Business

Business pays the bulk of the health care bill, about 60 percent, while government pays about 40 percent of health care costs. As health costs go up, profits shrink. According to *Fortune* magazine, Anheuser Busch has to sell 11,627 six-packs of beer and Playmates has to sell

Health Care Expenditures as a Percent of GDP in U.S. and Germany--1989

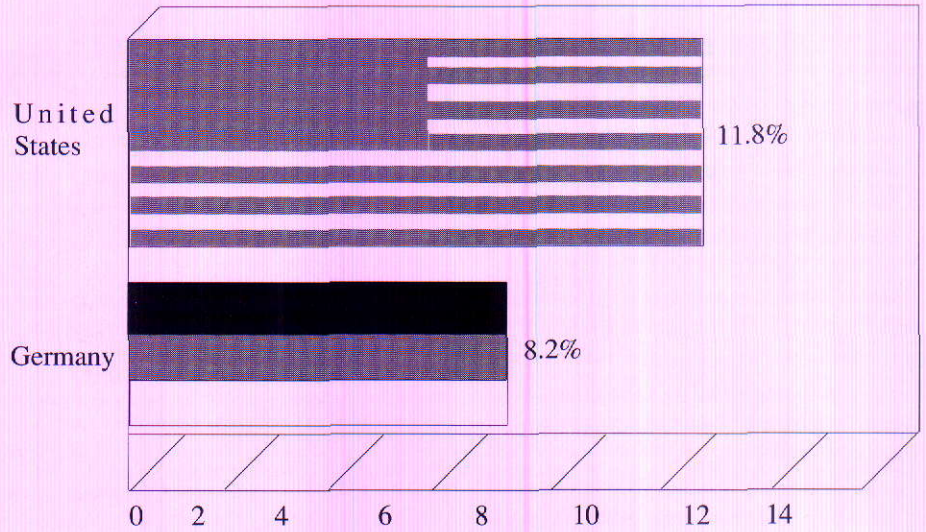


Chart courtesy of The American Context for Health System Reform, Holsham, et. al.

36,000 Ninja Turtles to pay for a single appendectomy.

Employees suffer, too. If a company wants to offer a compensation package, including health benefits, worth $8 an hour, it has to reduce real wages to less than $5 an hour. It's no wonder that one-fourth of the days lost to strike result from disputes over health benefits. And consider this: By the year 2000 these numbers will triple.

The negative impact of the health care crisis is not only a problem for the future. Health care is a culprit in the current recession. Small business is the backbone of our economy and in past recessions small business has been able to generate enough jobs to extricate the nation from recession. However, *The New York Times* reports one of the reasons small business is not generating jobs in this recession is the rise in health care costs. Small companies are afraid to add to the payroll because managers and owners are afraid of the additional health care costs.

Florida—Our Problem

To make matters worse, Americans don't take very good care of themselves. As a nation, we drink too much, smoke too much and don't exercise enough. Our population is growing older and we insist on being kept alive at almost any cost. The federal government has not been able to come to terms with health care, so states are forced to search for solutions.

In Florida, total health care spending is about $36 billion yearly. By the year 2000 that figure will jump to $90 billion. In addition, we have at least 2.2 million uninsured Floridians, most of them either employed by small business or the family member of someone employed by small business.

In concurrance with the *Times* report, small business owners cite cost as the major reason for not providing health insurance to their employees. And costs increase for a variety of reasons including overutilization of the system, defensive medicine—studies indicate that 30 percent of medical care is wasted or unnecessary—and the overabundance of technology.

There are too many hospitals, too many medical specialists and too few family doctors. There is no cost competition in health care (just competition for services) due in large part to the tendency of business to cover employees with fee-for-service or carte blanche health insurance. And insurance companies pay almost any price for any product. Our system also uses too many insurance forms which cost the system hundreds of millions in administrative costs.

Medical costs also increase when health care providers increase prices for paying patients to recoup some of the money they lose caring for indigent patients. Business pays $8 billion a year for this cost shifting.

AIF—Our Solution

AIF has been working for a number of years to bring down health care costs. In 1991 we supported creation of a health care commission to regulate all aspects of the health care system. Most current regulation is focused on hospitals despite the fact that a large portion of increasing costs are outside hospitals.

In 1990 and again in 1991 we supported a bill to eliminate state health insurance mandates in order to bring down insurance premiums. We fought for judicial reforms to ease the malpractice problem and opposed a number of measures that would increase health care costs.

Every year business seems to run into a brick wall in the Legislature because the medical lobby is simply too powerful. However, in 1992, under the leadership and direction of Gov. Lawton Chiles, business finally scored some wins in health care:

- The legislature passed a law banning the abusive practice of physician self-referral, whereby doctors refer patients to health care facilities in which they own an interest. A state study found that self-referral encourages extra testing at a high cost. The 1992 legislation will save the system $500 million yearly.

- Mandated health insurance benefits were reduced with passage of the Small Employer Health Access Act.

- All health care regulation and planning was consolidated into a single government agency that has increased power over health care providers.

Still much remains to be done.

The recent elections spotlight health care reform as an issue for the 1993 Legislature. AIF intends to center its resources and attention around the cost issue. We anticipate reform in the delivery of health care, ranging from the proposal for free and unlimited access to health care for all citizens, which AIF opposes because this so-called free care will be purchased through business taxes without attention to cost containment, to proposals to make providers more accountable for their costs and outcomes.

While it is unclear at this time exactly which reforms AIF will support, it is clear that the Legislature will be presented with a number of proposals.

AIF gives most of the credit for getting the health care cost debate underway to the governor. We will follow his lead on health care cost containment and access into the next century.

Childrens' Groups Survey Florida Businesses

A random sample of 10,000 Florida corporations were given surveys in November regarding their child care policies and programs to determine the current level of employer-sponsored child care in Florida.

Progressive corporate executives are beginning to examine personnel policies and programs that address the need for child care and bring flexibility to the work place.

Currently, nearly 60 percent of mothers with children under age six work, and more than half of the mothers with children under one year of age are in the paid labor force. The increasing number of single-parent and dual career families in the work place has thrust work and family issues to the top of the corporate agenda. Child care is no longer an option for today's working family--it is a necessity.

The survey was prepared by the Employer/Child Care Connection, Inc., and sponsored by the state of Florida and coordinated by the Florida Children's Forum to understand the role of the employer in the child care delivery system in Florida. Survey findings will be printed in a final report due out in January and will be showcased at employer breakfasts across the state.

For more information about the survey or results, please call Susan Muenchow at the Florida Childrens' Forum in Tallahassee at 1-800-423-6786.

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catch with his sons. He sought treatment on a couple of occasions for accidents he claimed aggravated his injuries: once when he hurt his shoulder while pulling his dog on a leash and once when he put his hand through a plate glass window at home.

McConnell conducted another EMG on Stanton. The EMG showed that Stanton did not suffer from any of the nerve damage usually associated with a cervical herniated disc.

In light of these incidents, the PCT asked McConnell to re-evaluate the need for treatment of the original injury. McConnell insists that the first fall from the ladder is the source of Stanton's pain. He also believes that Stanton's athletic activities do not give evidence that Stanton's condition has improved. Rather, they prove that the patient has a desire to lead a productive life and wants to sustain a full, meaningful relationship with his sons, regardless of the pain the effort causes him.

McConnell currently wants to admit Stanton to the hospital so that he can undergo an intensive inpatient program filled with the physiatrist's full menu of services. The cost for this treatment is estimated to exceed $20,000. The PCT has denied approval of the treatment and Stanton has indicated no willingness to undergo it. In spite of these facts, the PCT office receives weekly phone calls from an examiner with the state of Florida demanding approval of the treatment program.

From the time this case opened through the middle of September 1992, the PCT paid medical benefits totalling about $7,500. Another $5,000 has been spent in legal fees and for the services of the rehabilitation counselor. Between February 1990 and September 1992, Troy Stanton collected more than $46,000 in benefit payments. Although he is currently not pursuing any treatment, he and his lawyer continue to make settlement demands, ranging from $70,000 to $120,000.

From the time this case opened through the middle of September 1992, the PCT paid medical benefits totalling about $7,500.

Stanton's case will probably remain open until his lawyer discovers grounds to file a complaint. An employee's attorney does not bill his client for time. The lawyer's only opportunity to recover a fee is through the settlement made to the employee.

Is Troy Stanton getting rich off of the workers' compensation system? No, but he, his attorney, and his doctors are making an unhealthy profit at its expense. This story does not represent an isolated incident of abuse. Instead, it is a small window into the dark room where doctors, lawyers, and employees quietly exploit the system's vulnerability to fraud.

There are reforms that could address the problems. Limiting the number of physician referrals would cut down on the costly practice of shopping for a doctor who will give the employee the diagnosis he wants. Regulating attorney fees would reduce the motivation to hold up the employee's return to work in the name of high priced settlements. Giving teeth to the good faith job search provision would protect employers from injured workers who are reluctant to return to work.

The answers exist. What is still missing is the determination of the Legislature to enact them. Until that time comes, the jugglers of workers' compensation will happily keep all of their balls floating through the air.

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