HEALTH CARE CONSUMER

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Consumers Pay More For Less

REPORT BLASTS HMO FINANCES

Local HMOs have signed 'sweetheart' contracts with their parent corporations, resulting in higher costs to consumers despite a drop in the number of services being provided. According to a new report by the Champaign County Health Care Consumers, this is just one of the findings that raise serious questions about the need for recent HMO rate increases.

"Last September, our first report found that utilization in local HMOs had dropped considerably over the past five years," explained CCHCC Executive Director Mike Doyle. "Those findings contradicted claims by local HMOs that overutilization by patients was responsible for sharp rate increases. Since it was obvious that higher premiums and co-payments weren't being used to pay for additional services, we decided to analyze how the extra money was being spent. What we found was a cesspool of conflicts of interest."

On March 7, CCHCC released a study titled "Lower Utilization and Higher Costs: Where Does the Money Go?" The report had four major findings.

Local HMOs failed to hold down costs even though utilization rates decreased dramatically.

* Even though the average number of office visits per PersonalCare member decreased 38.8%, PersonalCare paid physicians 26% more per member, or an increase of 106% per ambulatory encounter, up from $40 in 1984 to $82.46 in 1987.

* CarleCare HMO's administrative expenses skyrocketed from $1 million in 1984 to nearly $6 million in 1988, resulting in a 77% increase per member, from $35.68 in 1984 to $63.16 in 1988.

* From 1984 to 1988, PersonalCare HMO saw inpatient days per 1000 members drop 22%, from 622 to 482 days. Despite this decrease, PersonalCare HMO paid hospitals 7.4% more per member. When incorporating the $100 deductible, actual hospital revenues from PersonalCare members increased 44%, from $452.42 per day in 1984 to $651.25 per day in 1988.

Benefit cuts and rate increases instituted by local HMOs in 1989 generated huge financial windfalls, while substantially lowering the levels of service to HMO members.

* In the first half of 1989, 81% of all office visits by CarleCare members resulted in the patient seeing a doctor. However, after the $10 co-payment was introduced, only 53% of all office

Continued on page 9

Coming Next Issue

- The Politics of National Health Care
- Local AIDS Controversy Gains Public Spotlight

News-Gazette photo by Darrell Hoemann

CCHCC Low Income Task Force members Debbie Doyle (left) and Amber Adams (center) join Medicaid recipient Corina Ramsey (right) in calling for an end to patient dumping at Christie Clinic (story on page 4).

CCHCC Findings Confirmed

AUDIT CRITICIZES IDPA, DELTA DENTAL

In a 166 page report blasting Delta Dental and the Department of Public Aid, the Illinois Auditor General confirmed all of the charges CCHCC has raised during the past two years regarding the way the State of Illinois provides dental care to the poor. The audit confirms that, in the past five years, access to dental care for the poor has significantly decreased, while an ever increasing amount of Illinois tax dollars has been wasted.

The audit was the direct result of CCHCC's efforts over the past two years to halt the abuses occurring under the $23 million annual management contract that Delta Dental, a River Forest based corporation, has with the Illinois Department of Public Aid (IDPA).

Among the audit findings:

* Delta Dental, which receives $23 million from the state in premiums, has been steadily decreasing the amount it pays in claims for care, from $17.7 million in 1985 to $15.4 million in 1988;

* Delta Dental has generated a surplus profit of $17 million from the public aid contract;

* Delta Dental spends over three times the amount of money on administrative costs per claim than the State did when it administered the program in-house, and nearly four times more than other states (see graphs);

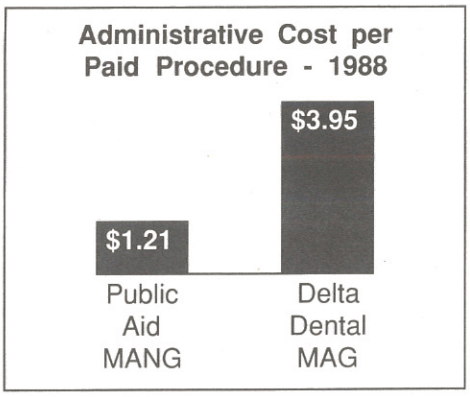
* The IDPA has failed to enforce its contract with Delta or properly monitor the company's finances;

* In violation of federal law, IDPA failed to determine that the contract with Delta was less expensive than running the program itself. Furthermore, IDPA never justified the basis for the amount paid to Delta, nor did IDPA rely on an open bidding process in selecting Delta, both of which are also violations of federal law.

* Medicaid recipients face severe problems of access to dental care. In fact, an analysis of Delta Dental's dentist referral list found that 52% didn't treat Public Aid recipients, and 23% were without either listed or working phone numbers.

The audit also uncovered some highly suspect practices by both Delta and IDPA. For example, Delta charges some $300,000 in travel and entertainment expenses to the Public Aid contract, of which they could only justify 3%. The Department of Public Aid, on the other hand, signed the contract with Delta in 1984 even after the Medical Programs Administrator recommended against it, continued the contract in 1985 despite recommendations by the Bureau of Program Integrity to terminate the contract, and negotiated a renewal of Delta's contract in 1988 before reviews of finances or access were completed.

Delta Dental has generated a surplus profit of $17 million from the public aid contract...



CCHCC first began investigating Delta Dental's management of the Public Aid contract in 1987, after receiving several calls on the Consumer Health Hotline from Public Aid recipients who were unable to find a local dentist who would treat them. Members of CCHCC's Low Income Task Force then met with representatives of the local Dental Society.

According to dentists, Delta was presenting obstacles to providing care, such as denying claims on highly questionable grounds, processing claims slowly, and increasing paperwork, thereby increasing the administrative time and costs for dentists providing care to Public Aid recipients. As one dentist summarized, "The whole Delta Dental process stinks. They constantly reject things without any valid reason. I really can't afford to fool with them."

To get to the root of the problem, CCHCC began an investigation of Delta Dental's management of the dental program, which culminated in the January 1988 release of a report entitled "Dental Care for the Poor in Illinois: The failure of pre-paid health plans under Medicaid." Following the report, members of CCHCC's Low Income Task Force testified before the state legislature, met with representatives of the Illinois Attorney General and the Illinois Auditor General, and worked with Representative Helen Satterthwaite to initiate a resolution in the General Assembly calling for an audit of Delta.

CCHCC's hard work paid off with the completion of the Auditor General report. However, the battle to protect both Illinois Public Aid recipients and Illinois taxpayers is far from over. Adding insult to injury, the IDPA recently expanded its current contract

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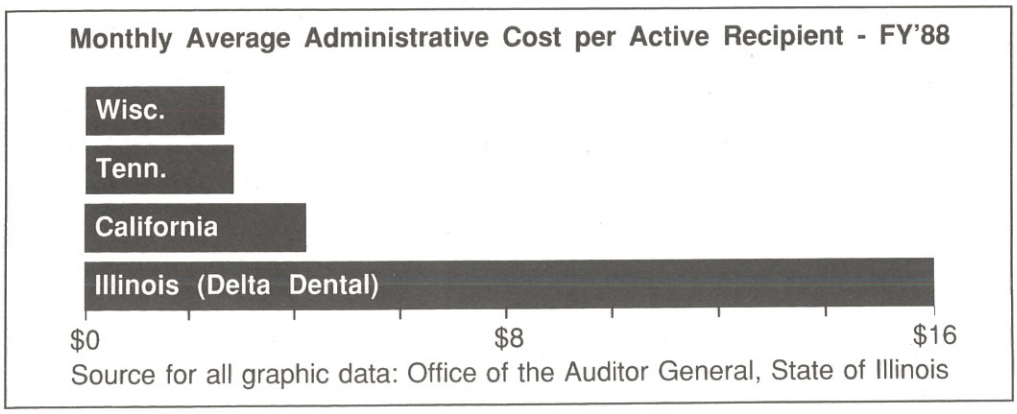

Source for all graphic data: Office of the Auditor General, State of Illinois

U of I Employees Oppose HMO Rate Increases

Dissatisfied with their HMO coverage, University of Illinois employees have begun to fight back. On March 9, over 150 university employees packed an open forum on health benefits to express their dissatisfaction with recent changes and rate increases. Sponsored by the U of I Faculty Benefits Committee, the forum was held in response to the efforts of CCHCC and two campus unions, AFSCME and the Union of Professional Employees (UPE).

Sparked by postcards from dozens of CCHCC members who work at the university, the Committee voted at its February meeting to hold the forum before the negotiations for next year's benefits are finalized. The forum was seen as a vehicle to provide employees input into the development of the package. Speaking in favor of the proposed hearing, Committee Chairperson Fred Giertz stated that "we need the university to take a more hands-on approach."

For those who attended the hearing, local HMOs didn't win over too many supporters. First, grumbling spread through the crowd when Giertz announced that both HMOs had suddenly reversed their decisions to attend, leaving only a representative from the state to hear employee concerns. Second, Mr. Keith Van Geisen, a representative from Central Management Services, which negotiates the HMO contracts, confirmed CCHCC's findings that HMO utilization had dropped in recent years. This contradicts HMO claims that last year's rate increases and physician co-payments were necessitated by increasing utilization. However, Mr. Van Geisen failed to explain why the state negotiated higher rates when utilization was dropping.

The hearing also coincided with the introduction of a Senate resolution by a dozen faculty members calling on the university administration to pressure CMS and the HMOs to implement consumer oriented reforms. "The university has never shied away from lobbying for a bigger budget in Springfield; there is no reason they shouldn't do the same for employee health benefits," claimed AFSCME representative Cynthia Halsizer.

"Ulitmately, the employees' benefits have an impact on the quality of the faculty and staff the university is able to recruit and retain," argued UPE President Ron Peters.

If you are a state employee and want to express your dissatisfaction, you can write to Senator Stan Weaver, who serves on the Economic and Fiscal Commission, which approves HMO contracts.

Delta Dental

from preceding page

with Delta. As of March 1, dental claims for over 360,000 additional Medicaid recipients previously covered by the state will now be covered by Delta Dental.

Determined to protect our tax dollars and assure that the poor are getting the services required by law, CCHCC is planning several activities for ending these abuses. First, we've begun working with legislators to force IDPA and Delta to comply with the law, to correct the abuses, and, if necessary, terminate the contract with Delta Dental.

CCHCC is also looking into legal action as a means of correcting the current situation. CCHCC has contacted Illinois Attorney General Neil Hartigan's office to see if criminal charges against Delta are warranted. CCHCC has also been in contact with several attorneys regarding legal action on behalf of Public Aid recipients.

Since the release of the Auditor General's report, several reporters have picked up on the story and raised serious questions about the involvement of former high ranking Thompson administration officials in assisting Delta.

"Clearly the fix has been in on this contract," explained one Low-Income Task Force member. "But we've come too far to let this issue drop."

CCHCC Briefs

CANVASS BEGINS

CCHCC's community outreach and education campaign is underway for its seventh year. The door-to-door canvass began recruiting CCHCC members on March 5. This year our goal is to reach 10,000 households in 22 communities by the end of August.

The 1990 canvass has already been crucial to CCHCC's work on HMOs. Talking to people on a one-to-one basis has increased both awareness and involvement, in the form of a strong postcard campaign and increased turnout at a U of I hearing on employee health benefits.

From the support the canvass has already seen, it looks to be an exciting and productive campaign. Anyone wishing to participate can call CCHCC staff member Nancy Greenwalt at 352-6533. For those who don't want to canvass, but wish to continue their support for CCHCC, please be sure to renew your membership when our canvassers come knocking.

A BETTER WORLD

Do you really know the companies behind the products you buy every day? For a limited time, CCHCC Friends (contributors of $50 or more) will receive a free copy of a unique guide called **Shopping for a Better World**. This 289 page guide is easy to use and rates the makers of over 1600 brand name products on 11 issues.

Published by the Council on Economic Priorities, **Shopping for a Better World** rates corporations on: support of charities; womens' advancement; advancement of minorities; military contracts; animal tests; disclosure of information; community outreach; nuclear power; South Africa; the environment; and family benefits.

"Although health care is not one of the issues that corporations are rated on," explained CCHCC Fundraising Director Elizabeth Hamlin, "many of our members are deeply concerned about a wide range of issues, and this seemed to be a valuable way of saying thanks to our friends and supporters."

CCHCC Challenges Patient Dumping at Christie Clinic

The impact of having your doctor refuse to treat you can be devastating. It is even more threatening when you are several months pregnant. But that is exactly what happened to Corina Ramsey, Sharon Ashworth, and several other pregnant women who were patients at Christie Clinic in Champaign.

Worse yet, the problem doesn't seem to be isolated to a few pregnant women. In the past nine months, the Health Care Consumers have heard from dozens of patients who were denied care by Christie Clinic.

What did these patients do to deserve such treatment? Actually, they didn't do anything except to qualify for Medicaid. And for most, it was a nightmare.

According to Ms. Ramsey, she saw an ob/gyn physician at Christie while enrolled with PersonalCare HMO. As a member of the HMO, Ms. Ramsey never had any trouble seeing her physician. In fact, in June of 1989 her doctor at Christie verified that she was pregnant, and set up her subsequent prenatal visits. Unfortunately, Ms. Ramsey was never allowed to see that doctor again after family responsibilities required her to leave her job, and forced her to drop the HMO.

Similarly, Ms. Ashworth also selected an ob/gyn physician at Christie as her primary doctor, who she had been seeing since 1987 without incident. However, when she was informed by the physician last July that she was pregnant, Ms. Ashworth had no health insurance.

At first, both women thought they were protected. Recent changes in state and federal regulations broadened Medicaid eligibility guidelines, making it easier for pregnant women without insurance to qualify for Medicaid. However, when both Ms. Ramsey and Ms. Ashworth attempted to get their Christie physician's signature to verify their pregnancies for Public Aid, he refused to see them. In fact, he had the nurse inform both that he wasn't taking any new Medicaid patients, and refused further prenatal care.

"I was scared. I didn't know where I was going to go. All I knew was that just because I needed a medical card, I couldn't go to my doctor at Christie Clinic anymore. Nobody should have to go through this," explained Ms. Ashworth.

After hearing of similar stories, CCHCC wrote Christie Clinic in August of 1989 to ask for a clarification of their Medicaid policy. In a letter dated August 31, 1989, Mr. Robert Thompson, Christie Clinic's Chief Executive Officer, dismissed our concerns, stating "If a patient's financial class changes from a non-Medicaid to a Medicaid status, there is no denial of services."

However, several weeks later, after a half-dozen cases of patient dumping by Christie Clinic were passed on to CCHCC by another physician in town, CCHCC's Low Income Task Force voted to go public with the problem. At a December news conference, CCHCC recommended that Christie Clinic:

1) Conduct a complete investigation into the practice of patient dumping and discipline any physicians found to be in violation of Christie Clinic's policy.

2) Create a specific policy which insures that Public Aid patients will not be treated any differently from other patients.

3) Establish a clear, written policy on patient rights that would clarify the type of treatment that can be expected from Christie Clinic, including:

- a readily accessible grievance procedure for all patients;
- an agreement that Christie Clinic will monitor physicians' compliance with Clinic policies; and
- a mandate for disciplinary actions against those physicians who violate Christie policies.

The Task Force followed up with a request to meet with Christie officials to discuss a resolution of the problem. But on February 5, Mr. Thompson responded that "there will be no meeting ... We do not conduct our business in the public forum."

"We aren't surprised that Christie doesn't want this to be out in the open and publicly debated. Unfortunately, our experience has taught us that these problems just get swept under the rug unless you shed a little public light on them," explained Task Force organizer Mary Kelly. "The irony is that institutions such as Christie somehow feel betrayed when problems like this are made public. They never even consider that they are the ones who betrayed that trust when they refused medical treatment."

With Christie unwilling to talk, CCHCC's Task Force has already begun plans to pursue other avenues to change the Clinic's policy. As Low-Income Task Force member Debbie Doyle explains, "It worries us because people's lives are on the line. With the size of the health care institutions in this community, everyone should be getting the health care they need. We need assurances that health care providers will not discriminate against patients. We intend to pursue this with Christie until we get a satisfactory resolution."

9-1-1 Comes to Champaign County

On February 5, Champaign County took a giant step forward with the establishment of a county wide 9-1-1 system. Currently, we have what is known as 'basic' 9-1-1. This offers the ability to dial just 3 digits to obtain police, fire, or medical assistance. These calls can be made free of charge without a coin from pay phones.

In the Champaign-Urbana area, it is also possible for METCAD operators to ring back calling parties or forcibly place a line on hold to run a trace. Under basic 9-1-1, however, it is still necessary to provide information regarding the nature of your emergency, the location, your name, and phone number. Enhanced 9-1-1, which is expected to begin in about two years, will automatically provide information regarding the number and location of the caller.

Campaign for Self-Suficiency

Last summer CCHCC's Board of Directors announced our Campaign for Self-Sufficiency, a five year plan aimed at broadening financial support for the Health Care Consumers. During the past nine months, CCHCC board members, staff, and numerous volunteers have been hard at work implementing the first phase of that initiative. With more than three months to go in our first year, CCHCC membership contributions have topped $53,000 and are projected to reach $70,000 by the end of our current fiscal year on June 30, 1990. This is a 23% increase over last year, and nearly double the amount contributed by our membership just three years ago.

For the first time, several businesses have added their support by sponsoring our Medicare 100 and Medicare Plus programs, while others have donated gifts and prizes that were awarded to volunteers who helped make our first annual Phone-A-Thon such a huge success.

But the real success of our efforts has been the dozens of volunteers who have committed hundreds of hours of their time to make each event a success. In an effort to recognize these special contributions, we'd like to take this opportunity to say thank you to the following individuals and the thousands of other members who make it possible for CCHCC to continue its fight for a more responsive and humane health care system. Together we **can** make a difference.

The following local businesses graciously donated either prizes for the CCHCC raffle or meals/gifts for the volunteers in CCHCC's first annual Phone-A-Thon last fall. We greatly appreciate their help in making both events tremendous successes, and encourage our membership to patronize them whenever possible. Thanks again.

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Aunt Sonya's
Bermuda Onion
Bresler's
Burger King
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The volunteers listed below were kind enougn to work either as ticket sellers in the CCHCC raffle, or callers in our first annual Phone-A-Thon. Many of the people listed here particpated in both events, and quite frankly, we just couldn't have done it without you. You're the real reason CCHCC continues to grow after 13 years. Somehow, this simple thank-you seems woefully inadequate, but for what it's worth: **THANKS!**

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Survey: Consumers Unhappy with HMO Changes

"It's not clear that the HMO concept is working..."
"I feel as if my family and I are being held as hostages."
"It's so difficult to get a doctor's appointment..."

These are just some of the hundreds of written comments University of Illinois employees expressed in a survey conducted by the Health Care Consumers, the Union of Professional Employees (UPE), and the American Federation of State, County, and Municipal Employees (AFSCME).

Last spring, both local HMOs announced major rate increases and co-payments on physician visits. These changes caused an immediate and significant backlash. To assess the feelings of university employees, CCHCC joined together with UPE and AFSCME to send surveys to over 6000 university employees, asking them to rate their HMOs on issues of cost and quality of care. The results from the 2300 responses were released on March 1.

The general feeling stated by survey respondents was expressed by UPE President Ron Peters when he stated that "the promise of HMOs is not being met ... here in Champaign-Urbana." Overall, only 51.5% of the respondents reported they were satisfied with their HMO experience, meaning that nearly half of the respondents were less than satisfied. University employees were also unhappy with the changes made in the 1989-90 HMO benefit package, with 59.2% expressing dissatisfaction, and a sizeable number of employees (28.7%) saying they were so dissatisfied they might not re-enroll. As one respondent explained, "I think whoever 'negotiated' for the state with the HMOs sold the employees down the river."

The primary cause of dissatisfaction was in the area of premiums, where 64.7% stated they felt their premiums were too high. The co-payments were also targets, as 66% believed they were not justified, and one respondent commented that the "co-payment on office visits is ridiculous." A common theme among the respondents was that the HMOs were "guilty of overcharging [or] double-dipping by raising premiums and requiring co-payments." University employees also feel consumers should have more say in how HMOs are operated, with 64.7% agreeing with this statement. As one respondent stated, "I would opt out of my HMO, if I had a viable alternative. Unfortunately, they seem to have the consumers over a barrel, and know it."

The survey also found differences between members of each local HMO. CarleCare members seem to be more dissatisfied with their cost (70% vs. 57%) and more likely to reconsider their decision to re-enroll (19.4% vs. 31.5%). One CarleCare member responded: "Over the past years I was satisfied with CarleCare, but have come to believe they are taking advantage of a position of trust. I find their claims of rising cost to be unsupported and in many cases unbelievable. It appears they are ... just forcing CarleCare users to pay for corporate growth, not increased medical services." On the other hand, PersonalCare members were more likely to be dissatisfied with availability of primary care physicians (29.8% vs. 13.9%) and lengthy appointment waits (45.9% vs. 38.9%). Reflecting the opinion expressed by many others, one respondent wrote: "I am reaching a point of intolerance for long waits (both in the waiting room and examination room) and short examinations by the doctor!!"

Law Prohibits Physician Kickbacks

Too often, doctors refer their patients for laboratory tests to facilities which they partially or completely own. According to a study released last May by the Office of the Inspector General (OIG) of the Department of Health and Human Services, 25% of testing laboratories are partially or completely owned by doctors who refer patients to the lab. Of doctors who bill Medicare, 12% refer patients to labs in which they have a financial interest. Even more disturbing is the OIG's finding that Medicare patients who went to doctors that owned labs received 45% more laboratory tests than patients who went to doctors who did not own or invest in clinical laboratories.

Legislation contained in the 1989 Budget Reconciliation Bill makes many of these arrangements illegal. The bill prohibits referrals to clinical laboratories by a physician who has a financial relationship with the lab, except under certain circumstances. All physicians who refer patients to labs that they own or invest in will have to report the ownership details to the Secretary of Health and Human Services (HHS).

...patients who went to doctors that owned labs received 45% more laboratory tests...

This is a start toward eliminating one way that doctors profit at public expense. It is highly unlikely that patients referred to laboratories owned by doctors need any more tests than the rest of us. Unfortunately, there seems to be no stopping the medical profession from doing its best to milk our tax dollars. Just weeks after the law was passed, CCHCC received a promotional notice with the salutation "Dear Physician Practice Administrator:" The offer was for a subscription to "Part B News -- Independent means to get your fair share of Medicare Part B dollars," and promised "dozens of tips to boost Part B Medicare reimbursements." A few days later, we received another promotional brochure, for a workshop titled "Medicare Anti-Kickbacks -- A to Z ... New Challenges, New Solutions," which promised to help doctors "get every Medicare dollar you're legally entitled to," and offered "guidance from a former assistant U.S. Attorney who defends providers." It's no wonder we spend more on health care than any other nation.

HMO finances

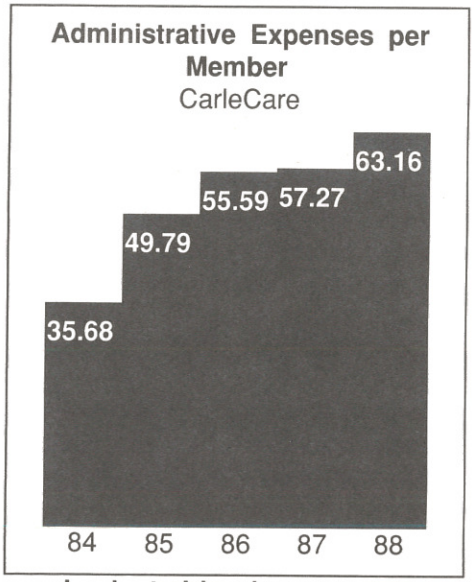
from page 1

visits resulted in the patient seeing a physician.

* Actual physician encounters at CarleCare are projected to decline at least 7.8% from 1988, but physicians are expected to receive $1.3 million more than they did in 1988.

* Similarly, CarleCare HMO members are projected to spend 4,480 fewer days in the hospital in 1989 than in 1988, but hospital revenues for HMO members are expected to climb over $2 million, from $27.1 million in 1988 to $29.1 million in 1989.

Conflict of interest is a major problem on the Boards of Directors of local HMOs, which

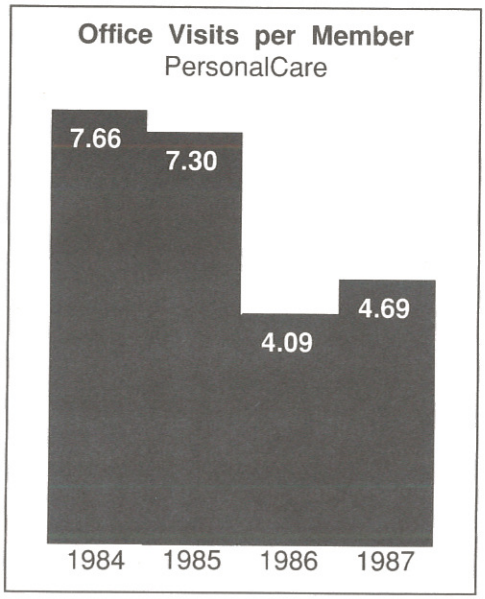


are dominated by the very same doctors and hospitals that have contracted to provide services to HMO members.

* From 1984 through 1989, 45 individuals have served on the Boards of Directors of PersonalCare and CarleCare. Of these, at least 30 have a direct conflict of interest, in that they benefit from contractual arrangements with the HMOs.

HMOs sign lucrative sweetheart contracts with their parent corporations, guaranteeing larger payments to doctors and hospitals who are providing fewer services, higher costs for HMO members, and unnecessary financial losses for the HMOs.

* Incentive mechanisms for the doctors and hospitals which own the

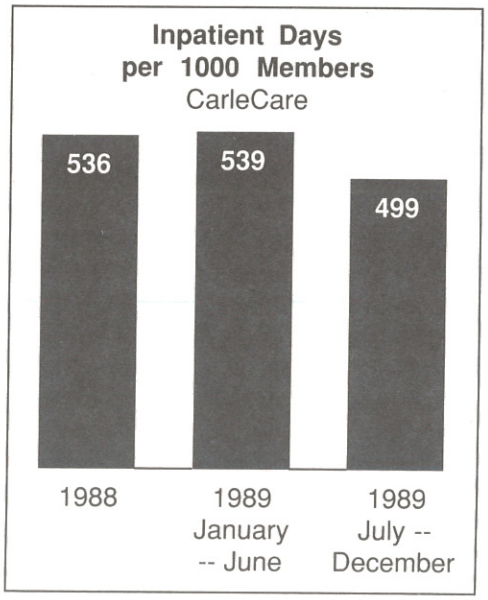


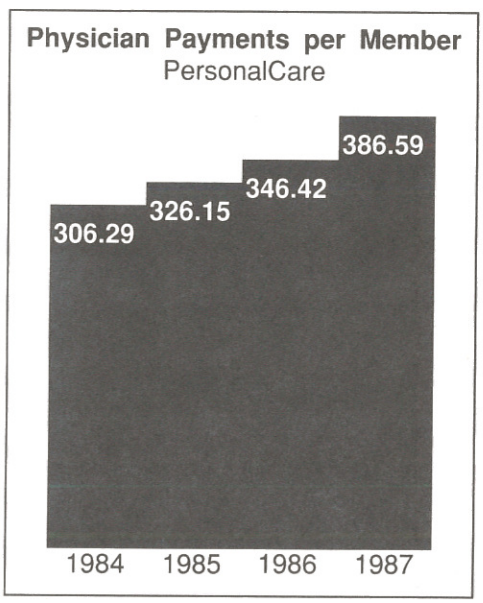
HMO reward the providers with bonuses for providing less service to the members. These bonuses are used to distribute the savings from lower utilization to the doctors and hospitals, rather than to lower rates for the consumers.

* PesonalCare HMO, which claims to have lost $1,859,518 in the period from 1984 to 1988, would have shown a profit of $253,613 without the incentive pool payments.

* CarleCare HMO, which claims a profit of $307,603 in the period from 1984 to 1988, would have shown a profit of $1,703,802 in the same period without the incentive payments. CarleCare has only posted losses since 1986, the same year in which they began making incentive pool payments.

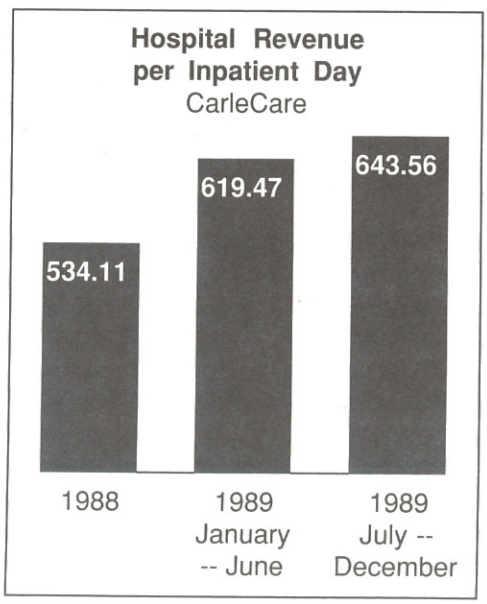
"Theoretically, HMOs are expected to reduce unnecessary utilization, which in turn reduces or, at the





minimum, holds down costs," explained CCHCC board member Susan McGrath. "What we have found is that our local HMOs have only accomplished the first part of the equation. Unfortunately for those of us who foot the bill, they have failed miserably in passing the savings on to the consumers."

According to the report, it is no accident that the HMOs haven't succeeded in holding down costs. "When the health care providers that contract with the HMO dominate the board of directors, there is no longer any effective mechanism for holding down costs. It's no surprise that this type of arrangement produces sweetheart contracts for health care providers and higher medical costs for consumers ... [it] is analogous to the wolf guarding the chicken coop."



Public Action Unveils Universal Health Plan

On February 13, CCHCC joined with the Illinois Public Action Council in launching a statewide campaign for universal health insurance. Public Action, the state's largest public interest organization, is working with its local affiliates such as CCHCC in pushing for legislation modeled after the Canadian health care system.

"Over the last decade, health care costs have risen twice as fast as inflation," said Robert Creamer, Executive Director of Public Action. "Rising health costs have not only restricted access and reduced the quality of care, but have placed an intolerable burden on consumers, business, and government."

"An estimated 1/3 of our health care dollars go to pay for waste and inefficiency in the system. We simply can't afford to survive in the 1990s without universal health insurance."

CCHCC Chairperson Abdul El-Jamal echoed similar concerns at a news conference in Champaign. "According to the Congressional Joint Economic Committee, just the paperwork created by our current system adds a $20 surcharge for each $100 spent on health care. And that doesn't include doctor overcharges, advertising by both the insurance and medical industries, and built-in profits."

Creamer said Public Action is supporting legislation to be introduced by Rep. Anthony Young (17-Chicago), Deputy Majority Leader of the House, that would establish a Canadian-style insurance program in Illinois.

"Canada and other comparable nations with universal health insurance not only spend considerably less on health care, but have been able to control costs. And they get more for it: Those countries have both longer life expectancies, and lower infant and child mortality rates."

The advantages of the Canadian approach were outlined by Public Action in a newly released study, "UNIVERSAL HEALTH CARE/We Can't Afford to Go Without It." Major findings include:

* **Inefficiency and waste total one-third of America's health bill:** Some 23% of U.S. health spending goes for billing and bureaucracy, while 20 to 30% is spent on unnecessary medical procedures. The Canadian health care system, which provides universal coverage and much lower consumer dissatisfaction, costs 28% less per capita than the U.S. system. Compared to similar nations with universal coverage, the U.S. spends 50% more of its Gross Domestic Product for health care.

* **Countries with universal health care systems pay less and receive better quality care:** Health care expenditures in the U.S. during the 1980s increased almost three times

Continued on next page

Illinois Universal Health Care Plan

The Illinois Universal Health Care Program (IUHCP) developed by Illinois Public Action contains the following key components:

Oversight Agency: The creation of a 13 person Governing Board, consisting of five consumers, five health care representatives, the Director of Public Health, the Director of Mental Health and Development Disabilities, and the Director of Insurance. All members would be approved by the Senate. This board shall develop an annual budget and list of service requirements to meet the health needs of the state.

Comprehensive Coverage: Most health care services would be covered: inpatient and outpatient hospital care, physicians and other licensed health professionals, prescription drugs, substance abuse, long term/nursing home care, mental health, and other community services.

Delivery/Reimbursement: Budgets will be set by the IUHCP for each hospital, using historical data and projected changes. Health providers will be reimbursed on a fee for service, salaried, or capitation basis set uniformly by the IUHCP.

Task Forces: The Governing Board shall designate a Cost Control and Efficiency Task Force to improve the timeliness and efficiency of health services, and control costs. Also, a Quality of Care Task Force will be established to monitor quality of care, develop methods to improve the quality, and develop proposals for training, recruitment, and retention of needed health care personnel.

Prohibitions on Insurers: After 1993, no insurer may independently insure, contract, or provide health service included in the IUHCP benefits package.

Financing: The IUHCP would be financed through five sources of revenue: 1) 31% from federal funds (from already existing expenditures for Medicare, Medicaid and the Veterans' Administration); 2) 13% from state funds (again, from existing expenditures); 3) 3% from doubling tobacco & alcohol tax revenues; 4) 35% from an employer payroll tax (equal to current employer payments for health care); and 5) 19% from the state income tax (based on a 3.4% state income tax -- compared to the current 5.1% average out-of-pocket costs paid per family).

Cost Savings: The implementation of IUHCP is expected to reduce medical costs by 10%. According to a recent study by the New England Journal of Medicine, the implementation of such a system nationally would save $66 billion, with 58% of the savings coming from insurance administration; 28% from physician overcharges; 7.4% in insurance profits; and 6.5% in insurance marketing costs.

Out-of-Pocket Savings: Overall, consumers would experience a 19% savings in out-of-pocket costs. Currently, the average family spends $1,135 in out-of-pocket medical expenses, or 5.1% of family income. Under IUHCP, consumers would have no direct medical expenses, but the average family would contribute $917 into the system through higher taxes on income, cigarettes, and alcohol.

Public Action

from preceding page

faster than in Canada and other comparable countries that have universal health care programs. While the U.S. spends substantially more on health care, the U.S. infant mortality rate is 37.5% higher, and life expectancy averages one year less.

*** Soaring health care costs are hurting business:** Over the last two years, health insurance benefit costs for employers have increased an average of 20% annually. Rising benefit costs are reducing average company profits by 25%, according to the National Association of Manufacturers, and now equal 37% of average net profits for manufacturers.

"The single biggest step the General Assembly could take to encourage economic development and job creation in Illinois would be establishing a universal health insurance program," said Creamer. "As Chrysler Chairman Lee Iacocca has pointed out, health costs add $700 to a car made here, but only $223 to the same car made north of the border in Canada."

"Any solution to our current crisis must address access, cost containment, and quality of care. This universal health care program does all three," stressed John Lee Johnson, a Public Action board member.

Creamer said that he is hopeful that introduction of state legislation will also promote the campaign for national universal health care, noting that Canada's federal system began with the adoption of individual provincial plans.

Creamer added that Public Action is joining with other organizations across the country to promote universal health care in Congress. He said that several Illinois Congressmen, including Marty Russo (3-South Holland), George Sangmeister (4-Joliet), Cardiss Collins (7-Chicago), Sidney Yates (9-Chicago), Lane Evans (17-Rock Island), and Richard Durbin (20-Springfield), have already agreed to support such a plan.

HELP THE UNINSURED

Rural and urban community health centers (CHCs) are struggling to meet the health care needs in medically underserved areas. Severe federal budget cuts throughout the 1980s, as well as an increasing number of uninsured, have forced community health centers to near-bankruptcy. Although community health centers, such as Frances Nelson Health Center, are founded on the principle of "serving the needy regardless of source of income," the lack of financial support is threatening their very existance.

Numerous studies have found that community health centers are the most cost effective means for providing basic primary health care. Last year, Frances Nelson provided health care services for over 18,000 patient visits -- with 80% having no health insurance.

This year Illinois taxpayers have a unique opportunity to support the Frances Nelson Health Center here in Champaign County and dozens of other community health centers throughout Illinois. To show your support, just check line 11F (Community Health Center Care Fund) on your 1989 Illinois Income Tax Form, and contribute $10, $5, or whatever you can afford. This is one positive way we all can begin addressing the growing health care crisis.

The Community Health Center Care Fund was sponsored by State Senator Penny Severns and State Representative Donnie Trotter.

Human Services Council Sponsors Health Care Forum

The future of the Frances Nelson Health Center (FNHC) will be the topic of a forum sponsored by the Human Services Council of Champaign County and FNHC on Thursday, April 12, 11:00 AM to 1:00 PM, at the Champaign Campus of the Covenant Medical Center.

Large cuts in federal and state spending for community health services, as well as elimination of programs that have provided physicians for clinics like FNHC, now threaten the future of this agency. The forum will address in practical terms both the problem and prospects for solutions that can be provided by local governments.

When revenue sharing funds were supplied to the City of Champaign by the federal government, the City provided a portion of those funds for area social service agencies. Currently, however, the City provides no funding to FNHC or to any social services despite the need created by the "new federalism". Only local action can bring about local funding, and specific calls for action will be discussed at the forum.

The forum is open to the public. Those attending the forum may buy lunch in the hospital cafeteria or bring a brown bag lunch. For more information about the event, contact the secretary of the Human Services Council, Kenneth Zeigler, at 384-4144.

CCHCC 1990 MEMBERSHIP RENEWAL FORM

(Please clip out and return with your membership dues.)

[ ] Enclosed is my check for $_____.
[ ] Please bill my credit card.

Membership Levels:
$50 - Friends of CCHCC
$36 - Family Membership/Adopt-A-Senior
$25 - Individual Membership
$15 - Senior Citizens/Students/Fixed Income

Check one: _____VISA _____MasterCard Expiration Date:_____/_____
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Universal Health Care—

The Choice is Ours

Annual Conference and Awards Dinner
Saturday, April 7, 1990
Jumer's Castle Lodge, Urbana, Illinois

As we enter the 1990s, fundamental reforms in the U.S. health care system loom on the horizon. The sudden repeal of the Catastrophic Health Care Act of 1988 has increased pressure for a more responsible approach to our health care needs. Politicians are being confronted by consumers who are no longer willing to accept the burden of expensive patchwork reforms that fail to get at the heart of the problem. With few options left, a growing number of politicians, corporations, unions, physicians, and policy specialists are joining consumer activists in calling for a universal health care system.

With so much at stake, consumers across the country are gearing up for the long awaited debate on a universal health care program. In a coordinated effort, citizens' groups around the nation are planning an "April Advance" to begin mobilizing people at the grassroots level. This "Advance" has been scheduled in connection with the upcoming Congressional recess that begins on April 6.

Several events and activities are being planned around the state. Here in central Illinois, the Health Care Consumers have scheduled our Annual Conference and Awards Dinner for Saturday, April 7, around the theme "Universal Health Care -- The Choice Is Ours." This year's conference will feature former HEW Secretary Arthur Flemming, PhD, and will be held at Jumer's Castle Lodge in Urbana.

Conference registration begins at 11:00 AM, with panel discussions running from noon until 3:30 PM. Panelists will address the reasons why recent reforms have failed to solve the crisis, how support for a universal health care program is growing, and what kinds of models we can draw from as we develop our own program here in the United States. The conference will close with a one-on-one debate between medical and consumer representatives on the merits of a universal health care program. There is no charge for attending the conference, and all are encouraged to attend.

Later that evening, CCHCC's Awards Dinner will feature Dr. Flemming, who currently serves as the chair of the National Health Care Campaign, a coalition of over 130 organizations nationwide. Dr. Flemming, who has been an outspoken advocate of national health care since serving as the Secretary of Health, Education, and Welfare during the Eisenhower administration, will receive our Leadership Award. CCHCC will also be honoring Dr.

Dr. Arthur Flemming, PhD

Camilla Parham with our Provider of the Year Award. A former CCHCC board member, Dr. Parham is the Medical Director at the Frances Nelson Health Center. Along with our other awards, CCHCC will also announce the first winner of our newly created Golden Bedpan Award.

Champaign County
Health Care Consumers
44 East Main, Suite 208
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