The Health Care Crisis in Public Education

A CECHCR White Paper

Based on the First Annual Health Care Summit

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Sheraton Grand Hotel

Sacramento, CA

Acknowledgements

Special thanks to Governor Arnold Schwarzenegger for his letter of support, and to Lt. Governor John Garamendi and Speaker Pro-Tem Darrell Steinberg for their appearances.

CECHCR Members

- Association of California School Administrators (ACSA)
- California Association of School Business Officials (CASBO)
- California County Superintendents Educational Services Association (CCSESA)
- California Federation of Teachers (CFT)
- California School Boards Association (CSBA)
- California School Employees Association (CSEA)
- California Teachers Association (CTA)
- Community College League of California (CCLC)
- School Employers Association of California (SEAC)

Funders

Center for Collaborative Solutions
California Health Care Foundation
The California Endowment
CECHCR Member Organizations

Moderator & Facilitator

Ruben Ingram, Moderator
Cindy Young, Facilitator

Participants

See Page 13 for the Complete List

Recorder/Reporter

Special thanks to Bob Schultz for recording the proceedings and drafting the White Paper.

> *"Today's conference is a fantastic example of the leadership that we need to achieve reform. You have brought together a diverse coalition of groups all working towards the same goal. A broken health care system affects each of us, so we all must be part of the solution. The time for action is now. – Governor Arnold Schwarzenegger*

PURPOSE

The First Annual Health Care Summit was called by the California Education Coalition for Health Care Reform (CECHCR) to facilitate knowledge-building and alignment of leaders in the field, to help connect purchasing and policy agendas and to further the goals of CECHCR. The summit was facilitated by Dr. Ruben Ingram, Management co-chair of CECHCR and Ms. Cindy Young, CECHCR's Labor co-chair.

THE ORGANIZATION

CECHCR is a coalition of the major management and labor education associations and unions in California, representing all 1,166 public school/community college district and county offices of education and the 1.1 million employees who serve the 6.2 million students in the public schools of California. The CECHCR project is an initiative that is part of Center for Collaborative Solutions (CCS), made possible with funding from The California Endowment, The California HealthCare Foundation, and the CECHCR Coalition Members. CECHCR provides research, information, advocacy and training to assist both management and labor in securing and providing the best quality health benefits in the most cost effective manner for the school employees of California.

The CECHCR coalition was formed in 2005. During its first eighteen months as an organization, CECHCR engaged in intensive research and education to deepen its understanding of healthcare costs, quality, equity and coverage issues. CECHCR is now engaged in meeting a series of objectives that will lead to key outcomes, including:

- Increased capacity within school districts to be effective health care purchasers
- Increased engagement in the health care reform debate by leaders of the California public education community

CECHCR has held trainings with school district management and labor representatives across the state, resulting in increased engagement in the health care reform debate by leaders of the California public education community. This Health Summit took that engagement to an even higher level by not only bringing together the management and labor groups, but also bringing in other key stakeholders, including the health care providers, health care advocacy groups, and state political leaders. This First Annual Health Care Summit was a bold step which brought all the key players together to broaden and deepen the dialogue, to better define the issues and barriers to reform, and to seek solutions that will be widely supported by the stakeholders.

THE HEALTH SUMMIT PROCESS

Rather than holding a series of workshops or panel discussions for an audience, CECHCR chose to hold a true summit in which 35 leaders in education and health care were seated in a square with Dr. Ruben Ingram in the middle of the square serving as moderator. The morning session was kicked off by an opening address by Senator Darrell Steinberg, and a luncheon

address by Lt. Governor John Garamendi launched a lively afternoon discussion. The result was a free flowing discussion in which everyone in the diverse group of participants had the chance to present the problems from their unique perspectives in a morning session and then to forward ideas that could lead to solutions to the problems in the afternoon.

LEGISLATION

Several bills were mentioned during the Health Summit. The complete text of the bills can be found at http://www.leginfo.ca.gov.

SB 32 – Steinberg – This bill expands Medi-Cal and Healthy Families Program eligibility to cover all children with family incomes at or below 300% of the federal poverty level. The legislation is supported by a majority of CECHCR members.

SB 840 – Kuehl - This bill would make all California residents eligible for specified health care benefits under the California Healthcare System, which would, on a single-payer basis, negotiate or set fees for health care services provided through the system and pay claims for those services.

AB 256 – De La Torre – This bill, already signed into law, requires the Board of Administration of the Public Employees' Retirement System to conduct a study to examine the feasibility and cost-effectiveness of creating a single statewide health care pool that would cover all public school employees or would include all school employees in the Public Employees' Medical and Hospital Care Act and cover them within the programs offered by CalPERS. This legislation is supported by all labor groups in CECHCR.

AB 2589 – Solorio – This bill would require a health care service plan or health insurer to annually disclose to the governing board of a public agency the name, address and amount paid to any agent, broker or individual to whom the health plan or health insurer paid fees or commissions.

AB 2967 – Lieber – This bill would create the California Health Care Cost and Quality Transparency Committee in the Health and Human Services Agency, with specified powers and duties, including the development of a health care cost and quality transparency plan which would include various strategies to improve medical data collection and reporting practices. This legislation is supported by a majority of CECHCR members.

DATA RELATED TO HEALTH CARE COSTS AND PRACTICES

The California Healthcare Foundation issued a guide to health care costs that was distributed at the Summit. Among their key findings in "Health Care Costs 101" were:

- National health spending increased from $714 billion in 1990 to $1,354 billion in 2000, and is projected to be $2,394 billion in 2008.
- National health spending has risen from 12.3% of the Gross Domestic Product in 1990, to 13.8% in 2000 and is projected to be 19.6% by 2016.
- Health spending per person rose from $3,398 in 1996 to $7,868 in 2008.
- Health Care costs represent 15.3% of the 2007 gross domestic product in the United States, but only 8.1% in the United Kingdom, and 9.9% in Canada.

- Per capita health care costs in the U.S. in 2007 were $6,401 per person, which was over $2,000 more than the cost in the next developed country in the survey.

- Between 1986 and 2006, the percentage of health care costs devoted to prescription drugs doubled from 5% to 10% and the administrative costs rose from 5% to 7%.

- National health spending has risen at about double the rate of inflation with the 2005-06 growth at 6.7% compared to a consumer price index (CPI) of 3.2%.

- According to the Congressional Budget Office, the total cost of U.S. health care came to $2.3 trillion, which is more than was spent on food in 2007.

- Prescription drugs show an 8.5% increase compared to the 3.2% CPI.

- Nearly half a million people file for bankruptcy each year due to high medical costs.

- Consumers spend five times more on all consumer goods now than they did in 1970, but spend twenty times as much on health care.

- Out-of-pocket spending has increased by 60% from $536 per capita in 1990 to $856 in 2006.

- The life expectancy of Americans is shorter than that of citizens of Canada, Japan, and all but one Western European country.

- The average school district contribution per full time equivalent employee has risen from $6,606 in 2002-03 to $8,714 in 2006-07, an increase of 32%.

DATA SHARED BY PARTICIPANTS DURING THE HEALTH SUMMIT

- Blue Cross noted that 80% of medical costs are the result of lifestyle choices.

- 47 million Americans, including over 6 million Californians are without health insurance.

- The California Teachers Association stated that health and welfare costs for California teachers grew from $2.5 billion in 1998-99 to $5 billion in 2006-07. In addition, teachers spent $329 million for the cost of health care not covered by district agreements.

- The California School Employees Association stated that health care costs to California's classified staff members increased by 143% between 2000 and 2006 while their wages increased by 24%.

- The California Physicians Alliance noted that health care is not evenly distributed so there is one physician for each 200 white patients, one for each 3,000 Latinos, and one per 3,500 African-Americans.

- American Medical Association polls of physicians show that 59% now favor a national health care plan compared to 49% ten years ago.

- The Community College League of California noted that the high cost of health insurance means that community colleges shift from full-time benefited instructors to

part-time instructors who don't receive benefits, so that about half of the community college instructors are now part-time.

> *"Educators are saying in an organized way that we want to talk about health care because it has a direct bottom line impact on education. We are about seeing beyond the horizon of crisis and framing a California that will work for everyone." – Senator Darrell Steinberg*

THE PROBLEMS, THE BARRIERS AND POTENTIAL SOLUTIONS

The following Problems and Barriers were identified by the Summit participants, and do not necessarily represent the views of CECHCR or its individual members, nor do they necessarily represent a consensus of the parties taking part in the Summit. The Solution Statements included below also are not a consensus of the participants, nor were they voted on by the group. They are, however, fair representations of the majority views of the participants and many of the CECHCR members.

TRANSPARENCY AND ACCOUNTABILITY

Problems

- Minimal transparency about costs, procedures, success rates
- Minimal accountability for errors, and poor care

Barriers

- Agreements between insurance companies, doctors, the provider community, and hospitals
- The CMA is opposed to rating doctors
- Perceived industry opposition to transparency

Solution Statement **– Employers and employees must have full access to the cost, utilization and success of procedures, doctors, and hospitals so they can make educated decisions about health care.**

Steps to be taken

- Agreements that were made between insurance companies, doctors, hospitals, and the provider community to preclude disclosure of key health care data must be discontinued and no further agreements of this kind should be made.
- Data needs to be available for purchasers and consumers so that they can improve the quality of care they are purchasing.
- Employers need to share the information they receive in an understandable and usable way with their employees so that educated decisions about health care can be made.

PRIMARY CARE VS. SPECIALIST CARE

Problems

- There are too few primary care doctors and too many specialists
- Too few doctors choose to go into primary care positions
- Certain areas and certain populations are underserved

Barriers

- The high cost of medical school and need to repay student loans
- Medical schools are not turning out enough primary care physicians
- Immigration policies discourage foreign-born doctors in U.S.
- Relative higher compensation for specialists over primary care
- Little incentive for doctors to serve underrepresented populations

<u>Solution Statement</u> - Strong primary care services should be the basis for a universal national health care program.

Steps to be taken

- Medical schools must prepare larger numbers of primary care physicians.
- Programs to repay or forgive student loans for students who agree to practice for an agreed upon period of time as primary care physicians, especially in underserved areas or with underserved populations, need to be expanded and more readily available.
- Incentives need to be put in place to encourage practicing physicians to provide primary care and to serve in underserved areas or with underserved populations.
- Immigration policies that discourage foreign-born physicians, especially those trained in the United States, from practicing in the United States must be reviewed and adjusted.

<u>PHARMACEUTICAL COSTS</u>

Problems

- Percentage of health care costs for prescription drugs has doubled in the past twenty years
- Pharmaceutical costs are rising at over twice the rate of inflation
- New prescriptions may be only marginally better than generic
- The top 10 pharmaceutical companies earned $39 billion profit in 2006

Barriers

- Advertisements encourage requests for new pharmaceuticals
- Doctors are highly likely to grant requests for new pharmaceuticals
- Doctors fear law suits if they don't grant requests
- There is little independent research on which drugs (generic or name brand) are most effective

<u>Solution Statement</u> – Medical professionals must be fully informed about the effectiveness of the prescription drugs being prescribed. Consumers and purchasers must be fully informed about the costs of the patented and the generic prescription pharmaceutical options available to them.

Steps to be taken

- Doctors and health care providers must be encouraged to prescribe generic prescriptions unless there is a strong reason why a patented pharmaceutical is necessary.
- Doctors need to be provided with sufficient evidence to refute claims by the drug industry or from advertisements.
- Consumers must be made aware of the full cost of all prescription drugs.
- Consumers must be informed about the costs and benefits of generic and patented pharmaceuticals so they can make educated choices.

- As already occurs with tobacco and alcohol advertising, greater control and increased restrictions and disclaimers must be put in place on advertisements for patented pharmaceuticals.

WELLNESS PROGRAMS AND INCENTIVES

Problems

- We have a fragmented health care system that does not provide an incentive to physicians for prevention
- 47 million Americans and 7 million Californians have no health care
- Those without health care often delay receiving care until it is more costly and less likely to succeed
- Rates of obesity and diabetes are climbing

Barriers

- Absence of or little emphasis on wellness programs
- Lack of awareness about wellness programs that do exist
- Programs are not offered in ways convenient to consumers
- Programs are underutilized by consumers
- The uninsured have no access to care at all

Solution Statement - Wellness programs need to become a universal part of all health care plans and must be made more convenient and accessible with incentives for use so consumers will take advantage of programs that will enhance their health and reduce the need for and cost of their health care.

Steps to be taken

- Health care providers and employers need to increase the employee awareness of the availability and value of existing wellness programs.
- Insurance companies should use incentive payment to physicians so they will better incorporate prevention in treatment plans.
- Existing programs need to be expanded and new programs added that are convenient and accessible for consumers.
- Incentives such as reducing premiums or co-pays for consumers who demonstrate their participation in or completion of a wellness program need to be more readily available.
- Wellness programs need to be incorporated into collective bargaining agreements.
- Wellness and preventive care programs need to be universally available to all consumers.

COLLECTIVE BARGAINING

Problems

- Rapidly rising costs require choices between salaries and benefits
- School district contributions have increased by one third in four years
- Out-of-pocket costs are also rapidly increasing for school employees
- High cost of benefits encourages employers to hire part-time staff, leading to more uninsured Californians
- Bargaining is increasingly contentious due to cost of health insurance
- Because health care is so complex, employers and bargaining units spend inordinate amounts of time at the bargaining table discussing health insurance

Barriers

- Access to quality affordable health care
- Lack of well documented research for employers and bargaining units to make better decisions about health care benefits
- Purchasing fragmentation of school districts reduces the power and leverage school districts have over the health insurance industry

Solution Statement – Employer and Employee bargaining teams should continue to pursue all efforts that will improve access to quality affordable health care for all school employees.

Steps to be taken

- Employee and employer bargaining teams need to take advantage of the training that is currently available from CECHCR across the state.
- Agreements need to be reached between management and employee groups that will set the stage for the enactment of legislation that creates statewide or regional pools with the potential of lowering health care costs, reducing conflicts at the negotiation table and bringing some sense of standardization and consistency to health care costs across the state.
- The employer and union should continue to jointly support legislation that will provide a more transparent health insurance industry.

TRUE COSTS OF MEDICAL SERVICES

Problems

- National spending on health tripled between 1990 and 2008
- Per capita health costs are about 50% higher in U.S. than in other developed countries
- At least 30% of what we spend on health care results from poor quality
- There are significant differences in price variation, volume and intensity of health care services
- There are seven million uninsured Californians. The costs of treating the uninsured are passed on to every insured Californian through cost shifting

Barriers

- There is little public data available on why there is such variation in the cost of health care services from region to region
- Options of health care providers/doctors are limited in many areas
- Administrative costs are high and their percentage is increasing
- Purchasers and consumers are influenced by advertisements
- Lack of consensus on moving forward on broad solutions

Solution Statement – Insurance companies and health care providers must make the cost and quality of services and products accessible to purchasers and consumers. Employers and unions can then use their financial leverage to purchase quality health care for school employees.

Steps to be taken

- Insurance companies and health care providers must make purchasers aware of actual costs and quality of services and utilization of those services.

- Employers and unions must develop programs and communications that will clearly present cost and quality data to employees to help them to make better-informed decisions.
- Employees must take the responsibility to look beyond their co-pay costs and learn the true costs of the services they receive and the choices they can make.
- Insurance companies, health care providers, employers and employees need to make use of the data they have collected to make decisions about which doctors or hospitals will be allowed to provide service within their network.
- Insurance companies, hospitals and doctors who don't comply with the sharing of information or who do not provide information on the cost and quality of care should not be financially rewarded by having schools as a business partner.

COMPREHENSIVE HEALTH CARE REFORM

Problems
- The system is fragmented and expensive
- There are seven million uninsured in California

Barriers
- There is a lack of consensus on how to move forward
- There is political sentiment to reach a solution, but not political will
- Step by step reform is arduous and unfocused and seen as unacceptable to those who want comprehensive reform now
- Disagreement over whether government or private sector can best deliver the needed service
- Some see health care as a commodity distributed according to ability to pay instead of as a universal social service

Solution Statement – Universal health care must be made available to all citizens of California.

Steps to be taken
- The goal of providing universal health care must be agreed upon by health care providers, doctors, employers and employee groups.
- Businesses that do not currently provide health care or who only provide it for some employees must be given incentives to provide such care for all.
- A comprehensive plan to move to universal health care must be developed.
- Significant strategic steps toward a comprehensive reform of health care must be taken.

> *"In order to have a just society where individuals have the opportunity to succeed and a competitive society that will be able to keep pace with other countries around the world, we have to make the necessary fundamental investment in K-12 and higher education funding." – Lt. Governor John Garamendi*

CECHCR'S 2008 PROGRAM

- ❖ Identify key points of presidential candidates' health care reform plans
- ❖ Keep key leaders informed on relevant legislation
- ❖ Work to get uninsured children covered by the California Healthy Families Program
- ❖ Provide three training modules to school district management and labor organizations to become better purchasers of health care

NEXT STEPS IN THE SUMMIT PROCESS

At the end of the session, the group reviewed what they saw as the strengths and opportunities for improvement in the summit.

Diversity of opinion and representation - A key strength was the diversity of opinion and broad range of organizations represented at the summit. The importance of continuing the dialogue with the employers, employee groups, health care providers, and advocacy groups was seen as a key element in the success of this summit and future gatherings. It was suggested that we include representation from hospitals and that we hear from legislators or others opposed to single-payer health care to better understand their concerns.

Format - One of the key elements in the success of the summit was the format of having a facilitator in the center of the room with all participants able to directly interact throughout the event. A workshop or panel discussion would not have drawn out the rich discussion or the broad perspectives presented through the summit format.

Educators and health providers together - It was noted that this was that rare opportunity where educators and health care providers came together to focus on health care issues that are at the heart of collective bargaining agreements and school funding. Having the groups from both sides of the negotiation table working together with the health care community was extremely valuable.

Digging deeper - Even though this was a full day with no time wasted, there was a comment that the group had just scratched the surface of the most contentious and challenging issues ahead. The discussion began on a broad scale and became more specific as the day went on. It was hoped that a next event would build from that point.

Summary - The event was such a rapid fire and rich dialogue that attendees felt a strong need for some kind of summary of the day. This white paper is designed to give that information in a way that will allow the group to move forward rather than have to revisit territory already covered.

> *"CECHCR is here to stay. All of the Coalition member organizations are committed to providing the best possible health care benefits to employees in the most cost effective manner. CECHCR is always ready and willing to work with any and all health care interests to achieve that goal." – Dr. Ruben Ingram*

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