Website readers: If you are interested enough in the concepts expressed here to want to explore in your community, area, or state, feel free to borrow as needed. If your local newspaper editors are not interested, surely the major employers will be. Try it. I have no pecuniary interest in any outcome. RC

To: VP-Finance:

Want a workable solution that can lower your costs for quality health care for family and employees?

Many 'helpful' souls are now suggesting that you might try the insurance exchanges if you are not yet satisfied with your current coverage or prospects.. The exchanges deal in commercial policies--and that's tweedle-dum/tweedle-dee. That's also the generic recommendation for mass needs. But publications, like politicians, are reluctant to offend major advertisers or campaign contributors.

There's a much better way: a new paradigm, described below. Business organizations of all sizes can control their health care coverage under the new law while working totally . . .alone or together with other companies and unions! Yes, size counts: 3-5,000 plans is optimum.

The following press release is based on fact and successful pilots (described below), not blue sky.
Questions? Contact me.

Cordially,
Richard Cavalier

www.meetingsCavalier.com
Info: Cavalier; tel 310/671-7262

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FOR IMMEDIATE RELEASE.

PRESS RELEASE (approx 1,731 words); INFO: Richard Cavalier, tel 310/671-7262

Head: LOCAL ESCROW ACCOUNTS FOR HEALTH CARE
OFFER A VERY "PUBLIC" PUBLIC-OPTION

Tag: Traditional insurance is part of the national problem, not the solution!

Insurance companies contribute only escrows to the health care equation. Escrows can be created anywhere Statistically, any groups of 3,000+ can establish self-sufficient systems and set standards for the coverage that's chosen.

Basic escrow needs: If your company is cooperating with other companies and unions and/or the general community, be aware that legitimate billings from medical facilities will start arriving before all of the monthly premiums for the year are received from employee participation and/or non-employee individuals (if any). If companies immediately deposit in escrow as much of their first year's premiums as possible--including all--any potential variations from the local average should take care of themselves in short order. For safety: ask your Congressional Senators and Representative for a federal guarantee of solvency for your Wellness Co-op during its initial years (ala car companies) for valid and vetted actuarial plans. Absolute independence for health care needs and plans in the future is worth working for!

If that idea intrigues you, then consider yourself to be a starting point, not an end-reader. It's legal according to the new law. So you can help to implement a valid local program: Any group should be interested in controlling truly 'public' public options. Local-escrow groups can improve care-quality and determine local care standards, while saving money now paid into insurers' treasuries and control! Details, below. Key to improved quality is containment of medical injury/damage, which continues at rates of over 4% of all hospital admissions, with under 1% caused by negligence, according to a California study of 20,000 cases by Dr Don Harper Mills. Published decades ago. Instances of negligence are potentially compensated:

Never challenged. Never implemented.

Patient damage is often hidden if it's not evident to damaged patients, who might live with pain and cost for a lifetime. That hiding creates a 'long tail' (7 years) of belated claims that insurance companies complain about but could solve with prompt and full disclosure (proved at L.A. County, decades ago).

Frivolous lawsuits are a large part of all lawsuits-brought. Known cases of PCEs--Potentially Compensable Events--are settled out of court, with gag orders, and never become part of the law-suit statistical universe! Frivolous law suits are a tiny part of the damage-done universe. Their professional groups (including care-givers, lawyers, and insurers) should abolish that regrettable practice of frivolous law suits seeking easy settlement money.

Moreover, medical malpractice insurance policies are obscenely profitable for the insurers. That's why they refuse to release statistics. Consider the statistics. Give the huge number of physicians in this nation and the relative-few (but highly-publicized, huge court awards as punishment from juries), physicians are stampeded into paying premiums that are driving them out of practice. By the numbers, physicians are more likely to be damaged by lightning than by law suit. They can establish their own coverage; same concept.

Containment of medical malpractice (not premiums price or access matters alone) is key to reforming the nation's system, and for improving quality while reducing costs. Proved! Yes, access for the nowuninsurable patients is important, but a side issue in the matter of the cost of quality. Only 100% statistical universes will be valid in your area for these purposes.

For credence: www.meetingsCavalier.com.' 'Business Writing' is not related. See 'Targeted Writing'; then 'Essays' and 'Health Care.' My published articles, as reprinted on the three base-buttons, include McGraw-Hill's "Modern Hospital" and Chicago "Tribune." This is proved theory in pilot-projectsrevisited, not blue-sky.

'Other HC' button contains both an early version of this release (for forwarding as you choose) and a previously-published (2005) version of the same discussion. Why are slogans more powerful than facts in this society? Why does the healthcare industry prefer emotional arguments to the facts?

Lower costs of local Wellness Co-ops can provide coverage for the uninsurable and chronically-ill neighbors among us without raising premiums costs significantly, if. Well-neighbors know who, if any, the fakers and scammers might be. . .well-neighbors will otherwise be paying for those fakers!

Reasons for potential savings:

a) Quality control: Reduction of hidden injuries from likely malpractice, as discussed above. Eliminate hidden damages and legal gag orders (Mills: "Patient charts indicate malpractice.") and you've eliminated much unproductive cost. Cure: National registry for proved (court or peer review) malpractice; mandatory jail terms for medical professionals and facility executives when proved guilty of hiding malpractice injuries to patients.

b) Overhead: About 20% of all insurer premiums-income is devoted to profit. Advertising and attorney costs are deductible. Actual non-health-care monies deducted are considerably more than the 20% profit.
-- Because hospitals must argue individual policies and patients' bills with the insurers, perhaps 20% of all hospital administrative costs are also devoted to insurance issues. That's money not devoted to health care, either.
--This double cost-source is never acknowledged when the overall cost of '20%-for-insurers' is quoted. Consequently, potential savings on administration costs alone could comprise up to 40% of all premiums-paid!
-- The local escrows will begin with that cost-savings potential advantage and stated exclusions. Only truly difficult cases will go to court. Capping legal awards benefits only the cheaters!

c) In addition: Individually-paid related costs for long-term treatment of unreported PCEs; plus elimination of law suits relating to late discovery of culpable causes. That malpractice info and Mills' report are unfavorable to insurance companies. Add the already-recognized savings if more people get
preventive care, not emergency care.

Then-contacts and stats are valid contrarian ideas. This writer participated and observed as the ideas were proved (before publications) in practice at Michael Reese Hospital, Chicago, and in the County of Los Angeles Health Care System, then the nation's largest. Reported in McGraw-Hill's "Modern Hospital," Jan 07 (Patient Advocacy /Crisis Intervention); and Chicago "Tribune's 'Sunday' magazine, Dec 7, '86 (Medical Malpractice). Nothing has changed. View

materials on this writer's website: www.meetingsCavalier.com. Click 'Targeted Writing'; then 'Essays'; then "Modern Hospital" and Chicago "Tribune" base-buttons; plus 'Other HC,' for the '95 Los Angeles-local publication.

Significant:

In print, Reese Hospital/Chicago acknowledged ("Tribune") that it was turning back from Holderby's methods to insurance industry statistical methods in its operations because of a need for "statistics." Reese has now been closed for a couple of years, but the newspaper record remains. Findings and events of both programs/articles were consistent with findings from Health-PAC, NYC.
"The American Health Empire: Power, Profits and Politics"; New York, Random House, 1970; B. & J. Ehrenreich, preparers): First line of the Preface to 1971 Penguin edition: "If this book can be said to have a single thesis, it is that the American health system is not in business for people's health."

Extrapolating from the Reese/County originators' data bases:
With all premiums held locally or regionally, any 3-5,000 enrolled persons/families will have about the same experience statistically as do the Federal reports, currently based on skewed insurer stats. If different, the local stats will be more accurate and more favorable but not representative of our national make-up (age, race, condition, etc. Compare to similar cohorts. Health care: better and cheaper. Proved in practice! Contrary to some "advice" from well-meaning broadcasters, larger member- numbers for "spreading the risk" are not better because size expands the claims possibility along with added premiums-payers.
Optimum: 3-5,000.

Key to implementing locally:

--For local actuaries: Take cost histories for all health care obtained by every program's participant/family during the past 3-5 years, regardless of who paid (or not paid). Average it. Divide by the number of persons/families (separately) studied for program coverage. Multiply by the total number of persons/families covered (at least 3,000): that's a minimum cost-per and program coverage, for dollar payout. Add management/office costs.

--Add a percentage of final cost figures to accumulate for future reserves. That's the optimum local premium for coverage under that individual escrow, no matter how or by whom paid: surely less than now. And the plan will reflect local needs/wants.

--Set quality standards and wants with the hospitals of your operating area. Suggest jail terms for executives and medical personnel who actually hide damage to patients when the damage is known but not obvious. Remember: patient charts!
Any/all interested parties can contribute to the escrow kitty: employers, unions, fraternal organizations, chambers of commerce, cities and states, and employees. Per-time co-pays reduce emergency room calls for hang-nails. Exclude voluntary cosmetic surgeries, if desired; okay if anything is openly excluded, up-front.

This program can begin with a dependable fiduciary bank or credit union and the local escrow deposit of all participants' premiums. All legitimate claims for all covered services can then be paid--locally. No insurance companies—no lawyers—no rejections. Just local control!

Tell your three Congressional Members and the Fed that instead of requiring your company, friends, and itself to pay insane insurance premiums up-front, Fed should just guarantee the solvency of your local Wellness Co-op plan against unforeseeable local disasters in the start-up years. Ask for longer guarantees, if/when your operating plan takes in now-uninsurable neighbors. There's no need for ludicrous levels of Federally approved premiums pay-outs for traditional insurance that offers no dependable health care benefits! -END

Guest editorial:

More Health Insurance Is Not the Answer!

by Richard Cavalier

Senator Hillary Clinton has been promoting healthcare reform since she first entered the fray as First Lady. Now she has a new bill on the docket. But to the extent that she relies on insurance to solve the nation's healthcare problem, she's almost surely in error.

Not only is insurance *not* the answer to the healthcare industry's ills, it is demonstrably a part of the problem.

Consider that not every house will ride an earthquake or burn down; nor every car be in an accident; nor every visitor break a leg on your property. You might wisely choose to share such risks via insurance.

Yet, every person will need medical care to some degree during his/her lifetime. The question here is degree, not likelihood.

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On the other hand, the insurance industry will not even consider degree while it is allowed to argue the policyholder in times of real crisis, whether for personal or property circumstances.

Flatly, not all insurance can be depended upon in a clinch; and clinches are precisely what we're supposedly trying to mitigate through expensive insurance policies.

Although the insurance industry does not like to see it that way, any monies paid for health insurance are only partially paid into the nation's medical system.

Insurance companies pay rates to doctors, hospitals, and clinics that they, themselves, tend to establish. Then they pay banks of lawyers to fight some claims, carry large staffs who argue need and/or merely process paper. Then they distribute profits to their shareholders. Profit for paper-shuffling! Simply stated, medicine is part of the health care system, but healthcare is something else.

Very little of your premium dollar flows into the medical system itself. Like it or not, the terms *insurance* and *healthcare* and *medicine* are not synonymous.

Moreover, Federal and State governments already pay for probably most costs of much care for veterans plus emergency medical care for the indigent, illegal imigrants, and/or otherwise uninsured or under-insured. Any gaps in payment must be covered by the facilities hemselves--that's why fund raiser events are ubiquitous.

Under these circumstances, it *seems* that health insurance is dispensable. No one can argue that insurance is indispensable!

Moreover, doctors are now paying huge premiums for malpractice insurance even though the insurance industry can be shown to be contributing to the crisis from which it profits. Your costs for medical visits pay for that malpractice insurance--or else doctors might leave private practice, as some do.

Malpractice suits allege patient injury, which *does* occur with alarming frequency. Because egregiously-culpable cases are often quietly settled, frivolous suits become a larger percentage of the court case load than they are of the universe of possibly-culpable-events (CPEs). Clever statistics lie.

The insurance industry will argue my judgment. But the facts and stats at LA County Hospital System in the 1980s

supported that conclusion. There's little reason to think that the incidence of CPEs is lower today.

Consider, also, that the insurance industry became a powerful lobby because it can accumulate enormous profits that fund political contributions, not because it pays out too much of your premiums for health!

Profit in return for value is not a sin. But profit taken for little value returned (because of buyer fears) is the worst kind of bald profiteering or opportunism. Alleviating the fear that the insurance industry itself helps to create is not a true consumer service.

Enter the concept of single-payer (gov't) insurance. Various governments probably pay the lion's share of all essential healthcare costs already. Consider routine dental care and/or preventive doctor visits to be a wellness fee without our sickness system.

Such visits buy peace of mind--just as insurance should, but in that instance, the money goes to the service provider, not to the policy premium. Salient difference!

It's estimated that only about 5% of all emergency care is paid for by insured persons. Those few actually seem to be helping to carry the entire national system (because of high premiums)--but no one says *thank you* to them for paying their inflated premiums. There's no actual benefit to the medical *system* from high premiums, no matter how many policies are in force.

The current brouhaha over the importation of American-made drugs via Canada is only one indication of the serious skewing of our system. If the Administration favors the drug companies in this instance, how likely is it that you will ever receive better heathcare at lower costs from an Administration-sponsored single-payer plan?

Two things that you can do to help yourself under these circumstances:

First is to badger your legislators and give an early retirement to those who remain unresponsive to the clear and massive need for reform in our healthcare system.

Second is to encourage major groups (such as unions and employee credit unions) to self-insure for a brief period during which to switch over to premiums based on the actual medical experience of member families, as averaged over the past few years.

The unions/credit unions can become small single-payers until the legislators wake up to national reality. All that's needed is a closed universe of about 3,000+ participants. At that level, group experience will be within a few percentage points of national stats and experience--and so will be safely bracketed.

The insurance industry uses the same national figures to justify insurance rates, but the industry does not necessarily contribute its fair share to the actual expenses that are implied by the statistics.

Now consider that if governments are already paying the lion's share of the cost of *actual* medical care for the nation, then the governments should simply eliminate the unnecessary middleman--and pay it all.

"Horrors," says the insurance industry. "That's communism." Not really. Universal healthcare has been operating in Canada and Europe for decades. And although the monied portion of those populations might complain about not getting special or even exceptional public service via appointment, neither do the poor and other needy complain that it's essentially free to them. Those who chose to pay for private service can do so.

As one who has traveled in more than 40 countries, this writer has seen the actuality of stories that become distorted in the retelling in our press.

But with a long history as an observer in the healthcare industry, I strongly endorse a single-payer system and all immediate steps to study andimplement a national single-payer plan.

Relax? Only your physical, emotional, and economic health are at stake. . . .

Richard Cavalier

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Private Single-Payer Co-ops Solve Insurance/Healthcare Dilemma

The problem with this Administration's proposed 'solutions' is that they do not deal with the root problem--which is damage to patients.

According to Dr Don Harper Mills' study of nearly three decades ago, an iatrogenic injury occurs to about 4.65% of all hospital patients, and about .79% of those are 'potentially compensable events.'

But many hospitals and doctors routinely hide the fact of injury from their patients, while hoping to pass the 7-year expiration date for claims. Enter law suits.

Enter contingency lawyers who champion those who don't have the money to bring and maintain a suit: public service. Cheaters? Aren't they nearly everywhere? Baby/bathwater, remember?

Let's review these key points:

a) The root problem is patient injury, of both iatrogenic and malpractice causes, not legal claims *per se*.

b) Compensation is due for any/all malpractice and could be due for some instances of iatrogenic injury; jury cases are inescapable. Because some hospitals and doctors routinely hide the fact of injury from their patients, punitive damages are often justified. Contingency cases are often the only option left to the poorer of the damaged patients; so trial lawyers can be performing a respectable public service.

c) Professionals often resent any oversight intended to reduce the incidence of injury caused by preventable accident and carelessness. Therefore, the capping of awards has the effect of encouraging and rewarding unnecessary injury. The hiding of the fact of injury has the further effect of aggravating the original injury over time, before discovery. With many/most clearly-compensable events already settled out of court, frivolous cases seem to be a falsely-larger part of the *law-suit universe* than of the *injuries-done universe.* Of course the insurers know and ignore that.

d) Insurance is a numbers game in which the insurer bets that the policyholder will remain well; and the policyholder bets that he will become ill. The entire actuarial universe was the original statistical base; but if insurers refuse previous claimants or drop first-time claimants, the actuarial universe is then skewed toward the healthy--read 'most profitable.' So the fact of an insurance policy no longer guarantees the expected payment of costs. Policy-holders pay the costs for all uninsured groups if not paid by taxes for indigents, illegals, and other uninsureds.

e) Although Americans have a knee-jerk reaction to the thought of government involvement, a single-payer of

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all legitimate costs is the logical answer to the problem of skewed insurance statistics and argued claims.

Yet any private group of 3,000 participants will create a universe that's within a few percentage points of national averages. Participants can be employees, unions, religious congregations, and fraternal organizations, etc. By forming cooperatives for medical *care* based on actual incidence (averaged for the past 3 [?] years, regardless of who paid), those groups will eliminate the middle-man insurance company, which deals only in paper-shuffling and bleeds away (in legal expenses and profits) the money that is much better paid directly to doctors and hospitals for actual health care. Think *care*, not merely insurance!

We might never move politicians to vote against the best interests of the insurance industry, and so it's senseless to look for a solution from Washington. But individual groups can take action for themselves. If any competent group creates a model for action by those groups, we can move the healthcare field.

What can you contribute to a solution?

Richard Cavalier

Editor's note:

Mr Cavalier wrote one of the nation's first articles regarding patient advocacy in McGraw-Hill's *Modern Hospital* magazine (Jan '70) and also the nation's first challenge to the then-current excuses for the malpractice crisis (a major article in the Chicago *Tribune's Sunday* magazine, Dec 7, '86).

In recent years, he personally conducted more than one thousand long (20-35-min) structured telephone interviews in chronically-ill patients at Rand Corporation for specific hospitals as Rand's clients.

The author was previously a consultant to PRM, at that time, the American insurance arm for Lloyd's of London, which then provided excess-coverage insurance to the County of Los Angeles Health Care System, the nation's largest. He was President of The Crisis Ministry, in Chicago, which attempted to advance the 1960s ideas and findings of Rev. Robert A.P. Holderby, the probable instigator of patient advocacy action (not conversation!) in the nation's hospitals.

It's clear that this person with an educated view does not subscribe to the current public-relations versions of the national healthcare crisis. What should that mean to you?

Editor's note to this reprint:

In the two reprinted and third original article in this issue, the words 'health care' are written as both two words and one word. In the language, they are two; in the healthcare industry, they are usually combined in one word. The emphasis of the moment is reflected. We felt that it's more import to render these articles exactly as first printed than to be concerned about irrelevant details. MS

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Letter to the Editor:

There's too much conflicting information out there regarding health care and possible solutions. But the articles that MS has printed already don't jibe with what I see and hear from other sources. Hillary believes that insurance is the answer, but your writer thinks that insurance is part of the problem. Could you explain, please?

Name Withheld

Editor responds:

Glad to oblige. Here's still another article by the same writer--who has a long history of involvement in healthcare matters. MS will now reprint those two earlier articles so that everyone has the same understanding.

ML

From "Mind Set" publication, South Los Angeles

Single-Payer Health Care Co-op Offers a *Real* Solution

If you've heard anything at all about the single-payer plan to deliver universal health care to the nation, you've probably been told to be afraid of it. Too bad.

That's the sort of information that the many insurance companies themselves would like you to believe. After all, they can continue to make money from mere paper-shuffling only if the old format survives.

Insurance is a numbers game:

You're betting that you will become ill or die, and the insurance company is betting that you will be okay. The odds are set by comparison with the national (or company) statistical universe. Any *sure* universe will do for odds-making for that universe.

However, if 3,000 or more members form your local co-op's universe, then your stats will be comparable to those of the Fed, within a couple of percentage points.

The Fed uses the statistics provided by the insurance industry, which might or might not be accurate. The rates that you pay should reflect costs plus a profit that's obtained by their serving as middle-men between you and your health care provider.

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But you don't really need a middle-man. In fact, some HMO's have shown that some middle-men can have conflicts of interest.

If the stats of the actuarial table for the nation are accurate, then we have a picture of the actual incidence of illness, whether a cough or a death or any point between.

However, the Fed still permits insurance companies to cancel the policies of persons who make claims against their policies. That skews future claims in favor of those same offending insurance companies. . .it's the equivalent of shimming the roulette wheel in favor of the gambling casino: it's a racket, no longer a game. Where's your security?

But there's a catch:

The insurance companies do not deliver (and are *not* essential to) the delivery of health care itself. Doctors can manage it.

Therefore, the many insurance companies can be replaced easily by anyone who has a valid universe at hand. That's the type of information that neither the Fed nor the insurance companies wants you to know. Hillary is, I hope, just misinformed.

"But you don't want the Govt involved in your health care, do you?" the shysters ask. Of course, Americans have been conditioned to say "No." But explain to me why Govt is the *preferred* guarantor of Social Security right now. This is a case of the actual public experience vs Administration's scare tactics. Ditto for insurance industry scare tactics.

One of the advantages of any numbers game is that if you have a closed universe of about 3,000-minimum random samples of any type of question, that same 3,000 will give responses that are approximately the same as the answers would be obtained if the entire nation were questioned. That's what political sampling is all about, too. Be careful: it can be skewed by carelessness or hidden personal motives.

Therefore, if your employer, union, church, fraternal organization (or any other reputable group of manageable--or 3,000+ size) were to form a health care co-op, your group would have the confirming stats of

Single Payer continued on page 8

— Single Payer continued

able than the insurance companies when it comes time to pay? Put all co-op payments in escrow every month, and the money will be there when the claims and bills arrive.

The advantage of the *multiple* single-payer plan is that it takes the wind out of the argument against Govt participation. Your local leaders should be more accountable. Yet co-oping can deliver payment for all health care that will be needed by your group--and it's controlled by your group. And flexible, too; just gather new stats when needed by changes caused by admission of any newly-included persons. Just factor-in their personal previous medical histories.

Malingerers? In any system. But whose life is safe from all neighbors' knowledge?

That leaves the VA, the poor, and otherwise non-insured. . .but the Fed and local govts are already paying for them via free service, welfare, Medicare, and fund raiser charity when the poor, including illegal immigrants, don't pay for the health care that they demand. (You are already paying for those insured who claim.)

When considered all together, these ideas form a highly workable answer to the huge and growing national problem with health insurance, because insurance is more a part of the problem than of the solution.

You cannot evaluate this information if delivered in a vacuum. Therefore, I invite you to re-read the two articles previously published in MS. They are reprinted in this edition exactly as they appeared, except for correction of typographical errors. For more depth of the argumental bases, read this writer's two articles as previously-published in nationally-respected publications, as identified in one reprint.

The next step: talk with your employer and union and religious groups and see what you can do for yourself, because the Govt and the insurance companies are surely not going to do it for you!

Could political contributions from the insurance industry have anything to do with the reluctance of our Congress to act responsibly?

Richard Cavalier

Editor's note: For further information on the underlying topic, see Cavalier's published articles: 'Ombudsman is middle man, etc' (McGraw- Hill's *Modern Hospital* magazine, Jan '70) and 'Strong Medicine' (Chicago *Tribune Sunday* magazine, Dec 7, '86). Useful background for decades--ignored.

We think that you should know what the health-care industry doesn't want you to know. MS

Single Payer continued from page 4

the Fed at your disposal while you build your own data base, or actuarial table for your group.

How to begin? Suggestion: Survey each and every member of that group (of 3,000 ?) and note the incidence of every illness of any consequence over the past 3 or 5 years. Record those numbers carefully.

Then ask for the total amount of billings from all health care providers (doctors and dentists, clinics, hospitals, emergency rooms, etc--*regardless of who paid!* Note all the elective surgeries separately, so the group can decide whether or how to cover them.

Now do some basic arithmetic: the total billed costs divided by the total number of years surveyed (3 or 5, etc.) will deliver an accurate assessment of the average annual costs of all the illnesses of everyone included in that universe. Then divide by the number of participants in the co-op.

Now compare that distributed-cost number (plus a buffer for emergencies, unusually-heavy early claims, etc.) to the expected or quoted premium cost if buying commercial insurance with its paper-shuffling and legal arguments (and high profits that you'll be charged if you buy traditional insurance elsewhere).

Compare that local actuarial table to the national stats, if you choose. . .or just distribute the projected-actual cost for next year among the (3,000?) co-op members.

Your universe will be essentially just as valid as anyone else's, including the Govt's.

Will your own group be more dependable than the insurance companies when it comes time to pay? Put all co-op payments in escrow every month, and the money will be there when the claims and bills arrive.

— **Single** Payer continued

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