Don't Get Sick, Part III:

The Most Unkindest Cut of All*

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Alan Warhaftig
Fairfax Magnet Center for Visual Arts
alanwarhaftig@gmail.com

My previous analyses, "Don't Get Sick: The Benefits LAUSD Employees Have Lost" and "Don't Get Sick, Part II: The Devil's in the Details" argue that the cuts in LAUSD benefits were inequitable – discriminating against older employees, employees in poor health, and employees who live or work on the Westside and are established with doctors at Cedars-Sinai and UCLA Medical Centers.[1]

If the health benefit cuts for active employees were draconian, the cuts for retirees are nothing less than vicious.

I. Medicine is More Than Algorithms[2]

A gentleman asks, "You've got something wrong with you. What's the difference if a pill is prescribed by one doctor rather than another?" People have different expectations about medical care, and the gentleman has obviously not had occasion, in his own health or that of a loved one, to discover that healthcare is not a commodity. While Doctor A may be competent and well-intentioned and good enough 80% of the time, it's Doctor B that can handle the 20% of cases that require more than competence and good intentions. It's like teachers: They're all credentialed, but some are better than others.

In *How Doctors Think*, Dr. Jerome Groopman discusses the limitations of the "preset algorithms and practice guidelines" that have become the basis of training in medical schools in recent years:

> Clinical algorithms can be useful for run-of-the-mill diagnosis and treatment – distinguishing strep throat from viral pharyngitis, for example. But they quickly fall apart when a doctor needs to think outside their boxes, when symptoms are vague, or multiple and confusing, or when test results are inexact. In such cases – the kinds of cases where we most need a discerning doctor – algorithms discourage physicians from thinking independently and creatively. Instead of expanding a doctor's thinking, they can constrain it.[3]

Dr. Groopman says that this approach has spread beyond medical school to physician groups and hospitals:

> Similarly, a movement is afoot to base all treatment decisions strictly on statistically proven data. This so-called evidence-based medicine is rapidly becoming the canon in many hospitals…Of course, every doctor should consider research studies in choosing a therapy. But today's rigid reliance on evidence-based medicine risks having the

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* This document may be downloaded at
http://www.lausd.net/Fairfax_Magnet_HS/Don'tGetSickUnkindestCut.pdf

> doctor choose care passively, solely by the numbers. Statistics cannot substitute for the human being before you; statistics embody averages, not individuals. Numbers can only complement a physician's personal experience with a drug or a procedure, as well as his knowledge of whether a "best" therapy from a clinical trial fits a patient's particular needs and values.[4]

This will resonate with educators who chafe at the limitations of programmed, standards-based instruction. The doctor-patient relationship, like that of teacher and student, is human as well as technical.

II. How I Know What I Know

I learned about medical care through the experience of my father, a teacher who retired from LAUSD in 1975; he and my mother received retiree health benefits until his passing nearly 25 years later.

I grew up in Kaiser, and my parents were with Kaiser until my father had a heart attack in 1987, at age 72. The short version of the story is that Kaiser dragged its feet in assessing the damage to my father's heart. About a month after the heart attack, he developed congestive heart failure and was hospitalized at Kaiser Sunset for five days before a cardiologist arrived to examine him. Before the cardiologist became involved, my father was in the care of well-intentioned residents who knew little about heart disease and had prescribed inappropriate medications.

When diagnostic tests were finally performed, it was discovered that my father's life was hanging by a thread – with only one coronary artery open at all (and that one had two 60% occlusions).

Kaiser's surgeons told my father they planned to operate, but an hour later he was informed that the decision had been made to treat him with medication – that surgery was too dangerous.

As this amounted to a death sentence, I sought a second opinion. In those days, patients were not required to sign away their Medicare benefits, so there was no financial obstacle to seeking a second opinion outside Kaiser. A friend referred us to a cardiologist at Cedars about whom everyone spoke glowingly.

When we went to see this cardiologist, I did not expect that his opinion would be different from Kaiser's – "Facts were the facts," I thought at the time. Thankfully, the Cedars cardiologist was not blinded by Kaiser's evidence and accountant-based approach to medicine. Using Kaiser's test results, he concluded that Kaiser was wrong in its assessment of the damage the heart attack had caused. He advised surgery by the top cardiac surgeon at UCLA and quickly made the arrangements. Meanwhile, I was able to change my parents' LAUSD Health Benefits election to what today is Blue Cross Preferred.

In early January, 1988, my father had quadruple bypass surgery at UCLA Medical Center, and while it was touch and go for a few days, and there were hospitalizations and surgeries in the following 18 months for other issues (Kaiser had also missed an abdominal aortic aneurysm), my mother wouldn't become a widow for another 12 years, and my father had a perfectly acceptable quality of life.

Along the way, I heard many similar stories about Kaiser and its practice of delaying access to specialists and diagnostic tests. When he left Kaiser, I witnessed the practice of medicine at its best.[5] The following year, I changed my own LAUSD insurance to what is now Blue Cross HMO Plus.

III. Medicare Basics[6]

Medicare is the primary insurance for people age 65 and older.

Medicare Part A covers hospitalization, skilled nursing and some home health services, including hospice care. Medicare enrollees who have paid into the system through the years pay no premium. Medicare pays 100% of hospitalization costs except for an annual deductible, which will be $1,100 in 2010.

Medicare Part B pays for doctor fees, emergency room services, laboratory and other tests (EKG, imaging, etc.) and other outpatient services and medical equipment. Medicare enrollees pay a monthly premium of $96.40 – 110.50 for Medicare Part B coverage. Medicare pays for 100% of lab tests and 80% of its approved fees for most everything else after an annual deductible, which will be $155 in 2010.

Medicare Part C (Medicare Advantage) is offered through private insurance companies and, in LAUSD's plans, function as an HMO. They often provide coverage for hearing aids and other services that Medicare does not cover. *Participants in these plans must surrender the right to use their Medicare benefits outside of the plan.*

Medicare Part D is prescription drug coverage. Companies offer a wide assortment of plans with different formularies, deductibles and co-pays. For example, AARP offers a policy with no deductible (and no coverage for the so-called "doughnut hole") for $37.60 per month. On this plan, a 90-day supply of generics by mail costs $4.

Medicare Supplement Insurance (Medigap) is available to cover what Medicare does not cover, including the Part A and Part B annual deductibles, the 20% that Medicare B does not cover, and additional days in skilled nursing. These policies are standardized and identified by letter (A-L). AARP offers the comprehensive C, F and J policies for $235 – 295 per month, depending on age.

IV. How Changes in LAUSD Benefits Affect Medicare Retirees

A good Medicare Supplement (Medigap) policy (C, F and J) covers what Medicare does not cover: the annual deductibles, the 20% on Part B doctor fees and other services, and additional days in a skilled nursing facility.

Until now, LAUSD's Medicare retirees could enroll in Anthem Blue Cross Preferred and have what amounted to a great Medicare supplement plan with excellent prescription drug coverage ($5 for generics and $7.50 for brands for a 30 day supply at the pharmacy; $10 for a 90 day supply of almost anything by mail).

The Anthem Blue Cross EPO, which will replace Anthem Blue Cross Preferred on January 1, 2010, **does not function as a Medicare Supplement. Instead, it functions as an "additional insurance."** The EPO has a $300 annual deductible and a $7,500 annual maximum co-pay (not including medications).

The EPO covers some of the Medicare Part A (hospitalization) deductible; how much is covered depends on whether the EPO's annual $300 deductible has been met:

Chart 1

Coverage of Medicare A Deductible	Policy Pays	Patient Pays	Benefit Loss
Ant Medicare Supplement (Medigap) Type C, F or J Policy (AARP: $240-300/month)	$1,100	0	–
Old LAUSD Anthem Blue Cross Preferred	$1,100	0	–
New LAUSD Anthem Blue Cross EPO	$640-800	$220-460	20% - 41.8%

Similarly, the EPO covers some of the Medicare Part B (doctor fee and other services) deductible; again, how much is covered depends on whether the EPO's annual $300 deductible has been met:

Chart 2

Coverage of Medicare B Deductible	Policy Pays	Patient Pays	Benefit Loss
Ant Medicare Supplement (Medigap) Type C, F or J Policy (AARP: $240-300/month)	$155	0	–
Old LAUSD Anthem Blue Cross Preferred	$155	0	–
New LAUSD Anthem Blue Cross EPO	$0 - 124	$31 - 155	20% - 100%

In and of themselves, these are steep cuts, but ironically, this is about the only benefit this "insurance" is likely to provide.

Medicare has a fee schedule. No matter what a doctor bills, if that doctor has signed a contract with Medicare ("accepts assignment") the doctor may only collect Medicare's fee, of which Medicare pays 80%, and not a penny more. A simple example:

Chart 3

Doctor Charges	Medicare Allows	Medicare Pays	Patient Owes
$140	$100	$80	$20

In this example, if the patient had a Medicare Supplement (or LAUSD's current Anthem Blue Cross Preferred), the $20 remainder would be paid by insurance. The doctor would have to settle for the $80 from Medicare plus the $20 from insurance, writing off the $40 difference between what the doctor billed and what Medicare allowed.

As mentioned above, the new Anthem Blue Cross EPO does not function as a Medicare Supplement. Instead, the Anthem EPO has its own fee schedule. An Anthem representative told me that in some instances Anthem allows more than Medicare and in others the same or less. The fee schedule is not publicly available. Here's how Anthem would calculate its payment based on the example in **Chart 3**:

Chart 4

Medicare Allows	If Anthem Allows:	Anthem Benefit (80% of Allowable)	Anthem Less Medicare	Anthem Pays	Patient Balance Due
$100	$105	$84	84 – 80	$4	$16
$100	$100	$80	80 – 80	$0	$20
$100	$95	$76	76 – 80	$0	$20

Since Anthem refuses to disclose its fee schedule, there is no reason to believe that Anthem allows substantially more than Medicare for the vast majority of services and procedures. **The unavoidable conclusion is that the Anthem EPO pays essentially none of the balance left after Medicare has paid 80% of its allowable fee.**

V. Mom

Apologies if the examples stated above are abstract and look like they belong in an algebra textbook. My 93 year-old mother provides a slightly more concrete example. When my father died in February, 2000, my mother was suddenly without health insurance. Through COBRA and then AB528, she paid to continue her LAUSD coverage. For several years, she switched to a commercial Medicare Supplement policy and added Medicare D (prescription drugs) when that coverage became available. For 2009, she returned to LAUSD's Anthem Blue Cross Preferred through AB528.

My mother is frail, but her health is not bad given her advanced age. In June, 2009, she suddenly developed shingles on her head and around her right eye. I arranged her to see a dermatologist who had been very kind to my father. He made the diagnosis, prescribed appropriate medications, and insisted that she see an ophthalmologist. He asked that she return to be checked the following week.

Chart 5 below is derived from the Medicare Explanation of Benefits (10/19/09) my mother recently received. It included the three doctor visits related to the shingles plus her regular appointments with her urologist (twice a year) and her

primary care physician (the Cedars cardiologist who took such wonderful care of my father), whom she sees every three months.

Chart 5

Mom's 10/19/09 Medicare Explanation of Benefits	HCPCS/ CPT Code	Amt. Charged	Medicare Approved	Medicare Paid	20% Balance
Dermatologist (Cedars)					
Diagnose/treat shingles					
Office Visit New (6/3/09)	99202	$95.00	$71.16	$56.93	14.23
Subtotal		$95.00	$71.16	$56.93	14.23
Ophthalmologist (Cedars)					
Shingles around eye					
Office Consult (6/4/09)	99245	$499.00	$249.25	$199.40	$49.85
Subtotal		$499.00	$249.25	$199.40	$49.85
Dermatologist (Cedars)					
Recheck shingles					
Office Visit Estab (6/9/09)	99212	$55.00	$42.07	$33.66	$8.41
Subtotal		$55.00	$42.07	$33.66	$8.41
Urologist (St. John's)					
Regular 6 month appt.					
Office Visit Estab (7/23/09)	99214-25	$145.00	$102.92	$82.34	$20.58
Urinalysis		$40.00	$4.63	$4.63	0
Ultrasound	51798	$150.00	$25.29	$20.23	$5.06
Routine Venipuncture		$25.00	$3.00	$3.00	0
Subtotal		$360.00	$135.84	$110.20	$25.64
Cardiologist (Cedars)					
Primary Care 3 month appt.					
Office Visit Estab. (9/03/09)	99213	$75.00	$68.55	$54.84	$13.71
EKG	93000	$70.00	$24.04	$19.23	$4.81
Subtotal		$145.00	$92.59	$74.07	$18.52
Grand Total		$1,154.00	$590.91	$474.56	**$116.65**
Average per Visit (5 visits)		$230.80	$118.18	$94.91	**$23.33**

I asked Anthem for its fee schedules for these HCPCS/CPT codes, but they refused, even though I had a legitimate consumer interest as I was trying to determine whether to pay ($361.83 per month) for my mother to remain insured through LAUSD.

It is instructive to see the difference between what doctors bill and what Medicare's fee schedule allows. For the services detailed above, Medicare allowed 51.2% of the doctors' billings. After Medicare paid its 80% of allowed charges, the balance that remained was only 10.1% of what the doctors billed.

After Medicare paid its 80% of allowed charges, the balance for the patient (and insurance) to pay ranged from $8.41 to $49.85. The average of the five doctor visits was $23.33.

Since Anthem refused to disclose its fees for these services, it would be imprudent for a consumer to assume that the Anthem fee schedule allows any more than Medicare. **If this is true, the implication is frightening: In order for this "insurance" to pay anything at all for a service covered by Medicare B, my mother would have to have 334 doctor appointments (with an average remaining balance of $23.33) in order to reach the $7,800 threshold (EPO's $300 deductible plus the $7,500 co-pay limit). That's 1.3 doctor visits every weekday of the year, including legal holidays.**

What would the LAUSD Anthem EPO cover if my mother required hospitalization and surgeries? **Not much, if anything at all.** (I look forward to being corrected if Anthem will disclose its EPO fee schedule.) Medicare covers 100% of hospital charges after the aforementioned (see **Chart 1** above) annual Medicare Part A deductible. Physician fees are billed separately under Medicare Part B.

Imagine (Forgive me, Mom) that in 2010 my mother required a quadruple coronary bypass, separate surgeries to remove her gall bladder and appendix, a colonoscopy, and replacement of both of her hip and knee joints – an implausibly large number of procedures in one year. Medicare's fee schedule isn't easily accessible, but the details are informative:

Chart 6

Procedure	HCPCS/CPT Code	2009 Medicare Allowable Fee (LA)	Medicare Pays	20% Balance
Quadruple Coronary Bypass	33513	$2,597.64	$2,078.11	$519.53
Standard Cholecystectomy	47600	$1,019.06	$815.25	$203.81
Appendectomy	44950	$620.29	$496.23	$124.06
Colonoscopy	45378	$422.93	$338.34	$84.59
Total Hip Replacement (L)	27130	$1,408.94	$1,127.15	$281.79
Total Hip Replacement (R)	27130	$1,408.94	$1,127.15	$281.79
Total Knee Replacement (L)	27447	$1,573.45	$1,258.76	$314.69
Total Knee Replacement (R)	27447	$1,573.45	$1,258.76	$314.69
		$10,624.70	$8,499.76	$2,124.94

These are the fees for the surgeon. Anesthesiologists, assistant surgeons, radiologists and pathologists would bill separately.

Again, in the absence of disclosure of fee allowances by Anthem, it would be imprudent to assume that it would pay any of the 20% balance left after Medicare paid 80% of its allowable fee.

That being the case, even if my mother had all of these procedures in one year, she would still need to visit doctors 243 times (@ $23.33 per Chart 5) in order to reach the $7,800 threshold (EPO's $300 deductible plus the $7,500 co-pay limit). That's .94 doctor visits every weekday of the year, including legal holidays.

VI. The EPO and Prescription Drugs

The costs of prescription drugs in all of LAUSD's plans for Medicare retirees are significantly reduced by reimbursement from Medicare D. That being the case, the disparity in co-pays between the Anthem EPO and the three Medicare Advantage HMO options (Kaiser, Secure Horizons and Health Net) is shocking:

Chart 7

	Secure Horizons and Health Net	**Kaiser**	**Anthem BC EPO**	**AARP Med D Preferred**
Retail Rx Co-Pays (30-31 day supply)				
Generic	$5	$5	$10	$7
Preferred Brand	$7.50	$10	$30	$42
Non-Preferred Brand (if permitted)	$7.50	$10	$50	$76
Mail Order Rx Co-Pays (90-100 day supply)				
Generic	$10	$10	$20	$4
Preferred Brand	$10	$10	$60	$111
Non-Preferred Brand (if permitted)	$10	$10	$100	$213

The co-pays for the Anthem EPO are two to ten times as high as those in the Medicare Advantage plans LAUSD offers Medicare retirees.

As it turns out, reimbursement from Medicare D is not considered by LAUSD when it calculates the cost of health benefits. This is both crazy and dishonest. The money reimbursed from Medicare D, some $12 million per year, goes into LAUSD's General Fund.

VII. In Case You Did Not Get the Message

The message to Medicare retirees is not subtle: The EPO doesn't pay for anything, and if you want to be able to afford your prescriptions, you need to move to one of the Medicare Advantage plans.

It's a curious ultimatum. Medicare retirees (except those who do not have Medicare Part A) are among the cheapest members of the group to insure since Medicare, *which they pay for*, is their primary insurance. There is also no bargaining with providers since Medicare sets the fees and makes the rules.

A chart included in a February 10, 2010 presentation on changes in health benefits reveals the cost of health benefits in 2008 for active employees and the two groups of retirees (under 65 and over 65). Note that these are not per insured, but per employee:

Chart 8

	November, 2008	2008 Cost Per Employee
Active Employees	**72,648**	**$9,041.51**
Retirees Pre-65	**6,733**	**$13,580**
Retirees 65 and Over	**27,274**	**$6,440.04**

If half of the retirees 65 and over insure a spouse who is also 65 or older (see Section VIII below for how this number was derived), then the cost per insured under the plans in effect at the time was only $4,293.36 per year, or $357.78 per month. This covered retirees anywhere in the United States, paid everything Medicare did not cover and provided excellent drug coverage. (**Question: What does LAUSD pay per insured for the Anthem EPO, which offers essentially no coverage for Medicare Part B charges?** For COBRA and AB528 participants, the monthly charge for 2010 will be $361.83.)

It appears that many elderly retirees, left without meaningful insurance coverage and unable to afford necessary medications, will lose the doctors that have been caring for them if they switch to one of the Medicare Advantage plans.

My mother's primary care physician is a cardiologist who is available as a specialist in Cedars-Sinai Health Associates. If she were to switch to Health Net, she would have to see a different primary care physician. (**Breaking News: It turns out that this isn't even possible – Cedars is not available through Health Net Seniority Plus** – see Section VIII below.)

My mother's urologist remains on staff at Cedars and had an office at Century City Hospital when my mother first saw her. She has since moved to the medical building at St, John's Hospital in Santa Monica. She is not affiliated with Cedars-Sinai Health Associates, so Mom would not be able to continue seeing her if she joined Health Net (*if Health Net even covered Cedars for Medicare patients*).

Loss of a trusted physician is frightening to any patient and especially frightening to the elderly, who take comfort in their relationships not just with their doctors, but also with the nurses and office staffs. Discontinuity in care can be dangerous, even life threatening.

What percentage of Medicare retirees (and their Medicare spouses) currently on Anthem Blue Cross Preferred would be forced to change doctors if they switched to Health Net? It's impossible to say precisely, but it's not unreasonable to assume that Medicare patients are widely distributed among the active medical staff of hospitals.

Cedars-Sinai Medical Center has two major medical groups (HMOs): Cedars-Sinai Health Associates and Cedars Sinai Medical Group. Health Associates has many more physicians, and many doctors are available through both groups. **Chart 8** shows, by specialty, the subset of the Cedars Medical Staff associated with the two medical groups:

Chart 9

Medical Specialty	M.D.s on Staff of Cedars-Sinai Medical Center	M.D.s in Cedars-Sinai Health Associates and Cedars-Sinai Medical Group	HMO docs as percent of Cedars Medical Community	Notes
General Internal Medicine	260	87	33.5%	64 accept new patients; 23 accept only prior patients
Cardiology	126	32	25%	
Neurology	40	22	55%	
Gastroenterology	65	9	13.8%	
Hematology	48	6	12.5%	Includes Oncology
Nephrology	52	15	28.8%	
Urology	43	8	18.6%	
Gynecology	122	24	19.7%	Includes Oncology
Total	756	203	26.9%	

Sources: http.csmc.edu/mddb/ and http://www.healthnet.com

It appears that a substantial percentage of Medicare patients (at least half) would need to change primary care physicians and even higher percentages would need to change specialists, depending on the specialty.

VIII. How Many Medicare Patients Are Affected?

On March 1, 2007, David Holmquist, then LAUSD's Chief Risk Officer (more recently he was Chief Operating Officer and now he is General Counsel) made a detailed presentation on health benefits to the Board's Audit, Business and Technology Committee, of which I was an "outside member." This is the most comprehensive data on LAUSD health benefits ever released to the public, and it has apparently never been updated. The pdf may be directly downloaded at the following URL:

http://notebook.lausd.net/pls/ptl/url/ITEM/2A357AEFDEBF708EE0430A000210708E

To determine the number of people likely affected, let's begin with the census of retirees and dependents insured by LAUSD:

Chart 10

2006-7 Insureds	Number Insured
Retirees	33,600
Retirees' Dependents	21,087

It's logical to assume that the vast majority of retirees' dependents are spouses – a total of perhaps 50,000 retirees and spouses. That's about 1.5 insureds per retiree.

A subsequent presentation to the full Board of Education (4/24/07) provided a breakdown of enrollment in the two Blue Cross Plans:

Chart 11

2006-7 Blue Cross Enrollments	# Retirees	% of Retirees
Blue Cross HMO	110	0.32%
Blue Cross HMO Plus/Preferred	20,000	59.5%

If 20,000 retirees (at 1.5 insureds each, including the retiree) had Anthem Blue Cross HMO Plus or Anthem Blue Cross Preferred, that's 30,000 people insured in these plans.

A Powerpoint presentation on health benefits, dated February 10, 2009, provides an age breakdown of retirees using November, 2008 data:

Chart 12

November, 2008 Retiree Data	Number	Percentage
Total Retirees	34,007	–
Retirees Pre-65	6,733	19.8%
Retirees 65 and Over	27,274	80.2%

If the Medicare retirees on Anthem Blue Cross Preferred follow this age distribution (80/20) and half of them insure a spouse (also 65 or older), then approximately 24,000 people will be directly affected by the decision of whether to go with an Anthem EPO that provides essentially no benefits.

People will be affected to varying degrees, but the majority of Medicare patients are under care for significant health issues and would suffer discontinuities in their medical care if they lose their primary care physician or specialist. These are real human beings, and they will be forced into a fearful scramble.

Chart 13

% of 24,000 Suffering Discontinuity in Care Due to switching from Blue Cross Preferred to a Medicare Advantage HMO	Number of Medicare Retirees and Medicare Dependents Affected by loss of primary care physician or specialist
50%	12,000
66.6%	16,000
75%	18,000

My best guess is that at least 15,000 Medicare retirees and dependent spouses will be caught in this terrible bind, and I expect that the result will be dozens of tragedies.

IX. Cedars is Not Included?!!!!

The exclusion of Cedars-Sinai and UCLA Medical Centers from the Anthem Blue Cross Select HMO for active employees and retirees under 65 was an outrageous example of geographic discrimination (See "Don't Get Sick 2: The Devil's in the Details"), but at least those medical groups were available, with substantially higher co-pays, through the Health Net HMO.

Correspondence from LAUSD specifically stated that the Health Net HMO allowed access to Cedars and UCLA Medical Groups, and neither the letter (to COBRA and AB528 participants – who pay for coverage) nor the *2010 Annual Benefits and Enrollment Guide*, indicates that the Health Net Seniority Plus did not also allow access to Cedars**. It turns out that Health Net Seniority Plus does not allow access to Cedars for Medicare patients.**

How would anyone know that?

The only way for a Medicare retiree to use Cedars would be through the Anthem Blue Cross EPO which, as has been demonstrated above, is no coverage at all.

Medicare retirees who use Cedars don't even have the option of a Medicare Advantage plan unless they're willing to change doctors and travel several miles across town – not very easy for many elderly people.

X. I Can Only Live Where?

With Anthem Blue Cross Preferred, Medicare retirees were covered anywhere they lived. This was valuable to people who, for any number of reasons, left California after retiring from LAUSD.

The Anthem EPO is valid anywhere in the United States, but that's cold comfort since it offers almost no coverage.

Other than the Anthem EPO, the plans available to Medicare retirees by state are:

Chart 14

States	Plans Available
California	Kaiser, Health Net, Secure Horizons
Arizona	Health Net
Nevada	Health Net
Parts of Oregon	Kaiser
Parts of Washington	Kaiser
Parts of Hawaii	Kaiser
The Other 44 States	You're out of luck – no alternatives to the EPO

XI. Mom Will Be Fine – LAUSD Medicare Retirees Won't Be

My mother does not receive LAUSD health benefits. She purchases them, and they are in no way worth purchasing in 2010. Instead of paying LAUSD $361.83 for the Anthem EPO, she will purchase a Medicare Supplement (F) policy through AARP for $285.31 per month and a Medicare D Plan, also through AARP, for $37.60 per month. The total will be $322.91 ($62.40 less), *and the Medicare Supplement will cover everything that Medicare does not.* The drug coverage, since my mother is mostly on generics, will likely be a wash. She will

come out way ahead by dropping LAUSD's coverage and be able to continue with the doctors who know her and have been taking wonderful care of her health.

Unfortunately, purchasing a Medicare Supplement policy for $2,800 – 3,400 per year per insured is not financially viable for the vast majority of LAUSD's Medicare retirees.

XII. How Did This Happen?

I shudder when I think how these changes would have affected my father were he still alive. Apart from concern about continuity in his complex medical care and the financial implications, he would have felt betrayed – dispirited after serving children and LAUSD well during the prime years of his life.

The Health Benefits Committee includes representatives from LAUSD's bargaining units, and they bear the responsibility for the chaos and pain that will surely follow. Did the union representatives understand what they were agreeing to? There is evidence that some did not. This does not excuse them and the unions' leadership: The representatives to the Health Benefits Committee should have known, or the union presidents should have appointed representatives better able to delve into the details.

As a member of UTLA, I am outraged that Julie Washington and Ed Kaz, the UTLA representatives in the room, permitted this to happen. What were they thinking? Did they understand the suffering the Health Benefits Committee's actions would cause? As co-chair of the Health Benefits Committee, how could Julie Washington be so negligent?

The Health Benefits Committee apparently established a Plan Design Subcommittee, which reorganized the plans for 2010. No retirees were included; neither was George Tischler, LAUSD's Interim Chief Risk Officer. The Plan Design Subcommittee included several union representatives (including Julie Washington and Ed Kaz from UTLA) plus two outsiders, professional negotiator Thomas M. Beatty (used to work for SEIU – not clear who he works for now or how he became co-chair of the Health Benefits Committee) and paid consultant Thomas M. Morrison, Jr., a senior vice president at The Segal Company, a benefits and human resources consulting firm.

If the union representatives did not understand the implications of the plan designs, Tom Morrison – the paid expert – surely did. What possessed him to allow the Plan Design Subommittee to arrive at a result that none of the union representatives in the room, had they understood what they were doing, could possibly have wanted?

When the Plan Design Subcommittee submitted its recommendations to the full Health Benefits Committee, discussion was apparently discouraged and the proposal was quickly put to a vote. Ironically, the sole vote against the proposal was cast by George Tischler, the Interim Chief Risk Officer. Mr. Tischler stood

up for decency and common sense and should be commended for attempting to protect LAUSD's employees from their unions.

XIII. The Law

The changes to retiree health benefits may not be legal, exposing LAUSD and its unions to potential lawsuits.

Retirees do not have a vote on the Health Benefits Committee and cannot vote in union elections. They are essentially powerless, which is why the law offers special protections for their vested health benefits, which are considered deferred compensation, not a gift. The changes in LAUSD's retiree health benefits appear to violate California law.

Oakland attorney Robert J. Bezemek specializes in this area of law and is currently representing the Fresno Unified Retirees Association (FURA) in an important case against the Fresno Unified School District. Fresno Unified is represented by attorney Gregory J. Dannis who, coincidentally, has also worked for LAUSD. He is said to have crafted the February 10, 2009 agreement between LAUSD and the Health Benefits Committee that LAUSD's unions celebrated as assuring continuity of health benefits for three years (with annual increases of 3.5%). Far from assuring continuity of benefits, this agreement may have been a Trojan horse that guaranteed steep cuts in benefits since the cost of insurance premiums has been rising at annual rates far higher than 3.5%.

Attorney Bezemek published "A Short Primer on Retirees' Vested Health Benefits" in the December, 2003 (Issue 163) *California Public Employee Relations Journal*. This article is not readily available, but nearly four years later, he published "Retiree Health Benefits: Still Protected…Still Misunderstood" in the October, 2007 *California Public Employee Relations Journal* (Issue 186). This article may be downloaded at:

http://www.pebc.ca.gov/images/files/CPER Retiree Health Benefits Article.pdf

I will not attempt to summarize the legal issues involved, but courts have thus far protected retirees with vested health benefits from "substantial reductions" in those benefits. I have no doubt that the changes in benefits in LAUSD's plans would qualify as substantial reductions. Beyond the cynical mockery of the Anthem EPO, how about retirees who live in the 44 states where none of LAUSD's Medicare Advantage plans are available?

Powerful interests seek to strip health benefits from retirees of school districts and other public entities (police, fire, etc.). What is at stake is nothing less than our financial security. Through our years of service, LAUSD promised that our compensation included health benefits in retirement, and we have built our plans for old age on that foundation. If the promise is broken, many of us may end up impoverished.

The question must be asked: Did outside forces influence the process?

XIV. January and Beyond

There will be chaos in January as Medicare retirees discover that they must either shell out substantial sums for medical treatment and prescription drugs or beg to switch to one of the Medicare Advantage plans, which will mean losing the doctors who have been caring for them and possibly having to travel significantly longer distances for medical care.

There is no reason why LAUSD should not provide its Medicare retirees coverage less comprehensive than the Medicare Supplement (Medigap) policies (F or J) that are commercially available for under $300 a month – like the AARP coverage my mother will have. These policies cover everything that Medicare does not and may cost the same or less than what LAUSD is paying Anthem for its useless EPO coverage.

Medications in the Anthem EPO should cost exactly the same ($10 for a 90 day supply) as in the Medicare Advantage plans LAUSD offers. **The reimbursement from Medicare D should be returned to the Health Benefits budget, not LAUSD's General Fund.**

When President Lyndon Johnson signed the Medicare Bill into law in 1965, he traveled to Independence, Missouri, where Harry Truman lived, to honor the former president, then 81. About Medicare, Truman observed, "This is an important hour for the Nation, for those of our citizens who have completed their tour of duty and have moved to the sidelines…These people are our prideful responsibility and they are entitled, among other benefits, to the best medical protection available."[17]

Whether by lawsuit or institutional self-correction, this travesty must not be allowed to stand. What's been done is monstrous, and budget crisis or not, LAUSD and it unions cannot practice elder abuse. We cannot earn the respect of children if we mistreat our parents and grandparents.

Notes

[1] "Don't Get Sick: The Benefits LAUSD Employees Have Lost" may be downloaded at:
http://www.lausd.net/Fairfax_Magnet_HS/Don'tGetSickPt.1.pdf
"Don't Get Sick, Part II: The Devil's in the Details" may be downloaded at:
http://www.lausd.net/Fairfax_Magnet_HS/Don'tGetSickPt.2.pdf

[2] *Merriam-Webster's Collegiate Dictionary* (11th Edition) offers a broad definition of *algorithm* as "a step-by-step procedure for solving a problem or accomplishing some end esp. by a computer."

[3] Groopman, Jerome. *How Doctors Think*. Boston: Houghton Mifflin Co., 2007. p. 5.

[4] *Ibid*., p. 5-6

[5] I do not mean to imply that the medicine practiced at Kaiser is invariably or that medicine practiced outside of Kaiser is consistently better.

[6] For details see *Medicare & You 2010*. It's a large download available at:
http://www.medicare.gov/Library/PDFNavigation/PDFInterim.asp?Language=English&Type=Pub&PubID=10050

[7] The remarks by Presidents Johnson and Truman may be found at:
http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/650730.asp