

## SATURDAY AM – 2<sup>ND</sup> PANEL

TOM MOORE: ... I'm an independent consultant on health care benefits and health policy to organized labor. My principal activities are focused in California although not exclusively. I work a large share of my time with the SEIU, Michael Allen's union, and with the ILW in San Francisco and other smaller unions. I've been doing this for a long time and I'm one of those people who have been doing it long enough that I'm probably partly to blame for the disastrous mess we're in. I was active in health politics when Medicare was passed and Medicaid were passed. I stood on the Capitol grounds when Pat Brown signed the implementing law for Medi-Cal. I've cheered along with several thousand people that the day had come when we would finally see a steady evolution toward a stronger public role in health care. Oh my God. 40 years later, we are farther behind and in worse condition than we were then in what seem to be highly dramatic and important steps we've started staggering down a wrong road – not the wrong road, there are many of those – but a wrong road, at a great pace.

I want to pick up on something that Michael said and without in any way denigrating or diminishing the importance of the comments made by Dr. Hammond or Ms. Coffey or Dr. Dozor, all of which were very valuable, but I want to pick up on something Michael said about the relevance of local action. Most of us have forgotten that nearly every major social legislation adopted in this country at a national level began as a local and then a state effort. Labor reform, workers compensation, unemployment insurance, the restrictions on working hours, overtime pay, all of them began as local initiatives. Most of our successful health care reforms – the Kaiser program, the On Lok Senior Health program in San Francisco, centers for independent adults in Oakland – were all local programs. The Group Health Cooperative of Puget Sound began with a faculty worker group in Seattle. We have again and again evidence of the growth of public policy out of successful local initiatives. Somehow that turned around in an era in which we had to seek national solutions in the Civil Rights Act, for example, and in voting rights. We seem to have lost some of the energy and some of the political thrust necessary to take either action locally or to translate it into national policy. But it clearly can be done and I'm convinced it's going to have to be done. To do it, we have to have, there's one resource that we lack. It isn't the will or the imagination or the intelligence or the skills, but there's one resource that we have been seriously short of in the last few years because of the nature of our health industry, and that is specific information about costs, quality, outcomes and impact of the local structures. We have an enormous amount of national data that's very important and very relevant. We have huge resources in research that give us national trends and in some cases regional and state trends. What we know too little about is what goes in Sonoma County, in Santa Rosa, Petaluma and the other communities, and what drives costs here; the health profiles of the population here, which of that 1% driving 40% of the costs, where they are, who they live and more importantly, in whose care are they? And what part of the health system is failing to respond to the medical needs and the opportunities for controlling costs and preventing more serious illness in the population? One reason for that is this absolutely irrational, broken, incompetent, inefficient business model that our health system has grown up around.

Now having said that, let me set aside Kaiser and the public sector for a moment and focus only on the private sector of insurance. This business model has one fatal component in it, which is the assumption that there will be, as there has been, a constant turnover in beneficiaries, a constant turnover in the population at risk. And the managers of these programs will tell you, if

they're candid, we don't invest in preventive care. Yes, we say we do. Every year we go before CalPERS and we go before the trust funds and we go before the purchasers and say, look at our disease management, look at our case management, look at our prevention programs. It's mostly marketing propaganda with very little substance. And the reason there's so little investment is, they will tell you in all candor, is that the patients we've got this year may not be here next year. If it takes two to three years to achieve successes in behavior changes, as Dr. Dozor's research indicated, we won't realize the benefits from it. The people who will enroll this year, next year they will enroll in another health plan. Next year they'll go down the street and enroll in another health plan. They may be the same providers but the organization at risk will change and for that reason more than any other, they have pled the excuse that these investments are not warranted, that they can't make them in a good business sense, they have to treat what presents itself to them in a systematic way at the renewal time, which is annual contracts. This is one of the reasons why CalPERS has gone from annual contracting and annual bidding its business to a longer range cycle. There are only two HMOs in CalPERS now. (CalPERS is the California Public Employer Retirement System. The campus here is a member, state employees and local agencies are members, it's over a million beneficiaries up and down the state.) One of the reasons that it went to that longer cycle is to begin to measure outcomes in both provider communities, Kaiser and Blue Shield. This will be the first time that a sustained effort will have been made to see what happens if you start from point A in a profile in a population, where you are in 2-3 years with changes in disease management and case management.

So the question is: What do we need to know? Well, we need to know what's happening, what the profile of the population is. And there are tools to do this. Beginning nearly 20 years ago, a researcher up at Dartmouth, a guy named Winberg, who is a physician with a great passion for numbers, went off to Scandinavia on a sabbatical or a trip or vacation or something, and came back with the observation that the Scandinavian health systems have a remarkably detailed information on who lives where, where they get their care, and what happens to them over a period of time, what diseases they get, how their providers perform. And they do it at the local level, what Winberg came to call "small area analysis." Winberg got a little money from a foundation and contracted with some employers in New England to do some similar studies. The studies ultimately became famous. He went to communities in New England, looked at populations and discovered that in one town the rate of hysterectomy was 4-5 times the rate it was in another town although the populations were about the same. The question was: why were the rates different? Well, it turned out it's because one town had a lot of OB-GYNs and the other town didn't. And he developed the formulas that are now widely known – we all understand this now – that surgery is not a function of the need for surgery in a population, it's the result of how many surgeons you have around. No surgeons, no surgery. I mean the common sense idiocy of that, in a way, tells the story. You want to reduce hospitalizations? Don't have so many beds. You want to reduce the consumption of drugs? Begin to restrict and control the prescribing patterns of physicians, etc., etc. That kind of information has never been a part of California's health industry's information base. They have never paid attention to either the patterns driven by resources or availability and they especially have never paid attention to local issues. Well, we have. In the last couple of years the unions have begun doing that. And with the help, by the way, of Karen Taranto's firm – this is not a commercial, it could be but she'd never pay me for it anyway so it's not a commercial – but with the help of her firm we did a study in just one little community, Amador County and Calaveras County up in the foothills. Two years ago, three years ago, the SEIU locals up there were handed – hold your breath – rate increases, premium

increases of 71%, 79% and 100% in these counties. Now these are small counties. 71, 79 and 100%. Blue Cross and Blue Shield were the two carriers, they were the guilty parties. So we went to them and said, how come the rates are so high, what on earth is going on? And their answer was – this is not an exaggeration – we don't have time to fool with accounts as small as you, the numbers are too small. We won't even turn on the computers to run a study of local costs or local patterns. Go figure it out for yourself. So we did. We went to OSHPA data and discovered, not too much to our surprise, that between the two counties the rates in elective surgery varied as much as 3-4 times. Now these are communities of 60-70,000 people. If you run up let's say 100 unnecessary surgical admissions at an average cost, let's just say, of \$30-50,000 apiece, now you're suddenly talking about hundreds of thousands of dollars distributed over a very small population. That was a lesson we began to translate in larger terms across the state. If we see these variations – and we do and you will see them here, I showed numbers a year ago for Sonoma County showing the very high spikes in hospitalization – you will see costs that will account for a large part of the per capital costs in this community. Beyond that, unnecessary treatment, unnecessary high tech elective treatment is not good for anybody's health. Hospitals are dangerous places and surgery is a dangerous business. The risks are high even under the best of circumstances and they should be avoided. One of the other things that Winberg learned over the years, contrary to the propaganda that comes out of the health industry at negotiation time when they tell us – I also do benefit negotiation like Al and Michael and here's the scene – along with Cindy and Deb Jenkins – here's the scene. The employer comes in with his or her actuary. The actuary in this case says, well, here's the story. Rates are up, costs are up, it's your fault so you're going to have to share more of the cost. There's no analysis, no forecast, no understanding of the real dynamics of costs in the community. So what I'm saying to you is this: The tools are available. There are very well established, well validated tools that will take the ordinary information used just to pay the bills, the claims and encounter data, and can give you very accurate profiles of the health status in a population. They can also tell you which providers are more efficient than others. They can tell you which providers may be engaging in significant hanky-panky in manipulating the bills, like the now notorious Tennant billing manipulation and the less notorious but equally financially devastating, what was going on in the Sutter system up across northern California. There are tools available, which if put in place, will give you a running record of what's going on in the population. So that along with the other steps that are absolutely essential – addressing behavioral issues, the lifestyle, the education of the community, and training our children to be better informed and more sensible in their eating and living habits – along with all of that, we have to come to an understanding, not necessarily of what's going on in Georgia or God knows or Los Angeles, but exactly what is taking place here and who's playing the game and in what way that affects both our health status and the costs of our health care. And I can tell you the tools are there, but we have to organize ourselves to get our hands on those tools and then use them in our common purpose. So that's the information data speech that I make regularly. Deb and Cindy have heard it a thousand times. You notice they start nodding off when I start this – they've heard it too many times. But you can't say it often enough. We are stumbling in the dark. Let me tell you, the buyers in this state are stumbling around in the dark, trying to feel our way to some answer to problems that the problems we can see, and the answers would be within our grasp if we'd simply put the right tools in place. Thank you very much.

KAREN TARANTO: As usual, Tom is a hard act to follow but let me tell you a couple of things and then when we get to the end of our program if there are questions, I can be more specific. Thank you for the endorsement. We do lots of that kind of work. If there's anything that I'd like

to leave with you today, it's that health plans are not evil people, they're just knowledgeable about what it is they want to do. They have their perspective, they have their actuaries, they have their profit margins, they know how they need to deal with Wall Street on, they have their facts, and they are the pricer. When you sit at a table where the table is not level and you don't know the components of that cost increase or the shift in the cost of benefits, if you're talking about wanting more preventive services, it has a price tag. When you want to know how many days per thousand by disease the people in this community are using, you need facts, and the only way you can sit across the table from the health plans and negotiate an equitable increase for them and a correct rate for you is to have facts. I mean I can't emphasize that enough to you. It may sound boring but in point of fact, it's not. You need to know what the population in Sonoma County is utilizing, what the disease entities are, what the cost for service is, what the readmissions rates are, what the utilization rates are for certain diseases, and then you can develop the kind of community programs that Bob Dozor was talking about, that Kaiser is doing, that would be able to start to address the reasons for some of that cost, on the one hand, and then also to negotiate with the health plans for a fair rate increase. Those of us who are old remember the language called community rating. You ought to be able to have your entire community rated so that the high cost person is not penalized when the low cost person isn't utilizing as much. So you need to look at what is the actuarial underpinning that the health plans are using when they are setting rates. Rate making is a very serious and very specific methodology that the health plans use, and they know how to do that, as do many of the consulting firms and some large labor unions know how to do this. You need to be sure that you have a statistical base that looks at who's in your population, where your costs are, what hospitals are being used, what's the outcome. I mean the Winberg study, if it taught those of us in the health care industry anything, is that the data does tell the story and you need your story and you need to look at what your impact you can make here in Sonoma County and in the adjoining counties. You're not going to make state or national policy, you just need to deal with your own community and figure out what it is you need to know so that you can be dealing in this very high escalating cost time in this community. With that, I'll turn it over to the next person.

JACK BURROWS: Thank you very much. Good morning. This is going to be an interactive speech, if I might. When I ask a question I would appreciate if the audience would give me an answer. My name is Jack Burrows. I'm the Director of Executive Services with the Association of California Health Care Districts. Does everyone know what a health care district is? You do? I am so delighted to hear that because I go all over the place and most people do not know what health care districts are. But I will just give a little bit of background if I might. Health care districts were formulated in the mid 1940s. The primary purpose was to provide medical care access to returning veterans from World War II and this was in rural areas of California. Today we have 74 health care districts. There are 42 health care districts that have 45 health care district hospitals, there are 32 health care districts that have community-based programs throughout the state. Sonoma County has five health care districts: Cloverdale which provides an ambulance service, North Sonoma County Hospital District, Palm Drive, Sonoma Valley Hospital and Petaluma Health Care District. And the reason I bring that to your attention, Sonoma Valley was the first health care district in the state of California. Last year I had the opportunity of coming up here and speaking or facilitating a panel actually, and I have had the opportunity of spending a significant amount of time in Sonoma County over the past year because of the health care district hospitals. So you have a little understanding of what the health care districts are. My background just for your information, I have a Masters degree. When I graduated with my MBA

I went into health care consulting on the East coast and after four years of consulting at four specific hospitals, I became the chief operating officer of hospitals ranging in bed size from 150 up to 731 beds, and I was also the chief operating officer of a health system that had three hospitals and a 150-bed nursing home. I've been the CEO of a small rural facility and I've also been the CEO of a 344-bed hospital. Because of all of this experience, Skip asked if I would talk a little bit about cost containment. So I will address cost containment, somewhat briefly though.

After Medicare was passed basically hospitals were all of a sudden very well reimbursed, and as a result of the good reimbursement and as a result of the insurance plans paying basically what hospitals were charging, hospitals grew in size dramatically. Their staffing grew in size somewhat dramatically also. And as a result, staffing levels in hospitals became somewhat out of control and until 1983 – does anyone know what happened in 1983? DRGs. See, I love coming up to Sonoma County because you are such an educated group of people. DRGs were passed. I happened to be working in a hospital, one of the 18 hospitals where DRGs were trial run between 1975 and 1978 and I saw how they were developed and it was relatively remarkable. They didn't have the slightest idea what they were doing. They sat down, they studied charts and they came up with what they thought would be reasonable costs for each individual diagnosis and there were 468 diagnoses at the time. But when they got to the more severe diagnoses, they were concerned. When they got to hearts, anything to do with the heart, they were concerned and they built in about 30-40% over and above what they thought the costs would be, just to make sure they didn't miss something. And as a result, when DRGs went into effect in 1983, hospitals that were doing heart work basically made a small fortune over the next 5, 7 or 8-9-year period of time, they were being paid probably 2-3 times what they should have been paid because of the fear these consultants had of coming up with a reasonable reimbursement for heart work.

When hospitals though had to start looking at their costs, because their reimbursement levels were being cut back, what does the hospital look at first when they are looking at reducing costs? Staffing, right. Salary dollars are the biggest expenditures that hospitals have. So in essence, they start looking at the staffing levels throughout the hospital and where do they look first? Not the boss – they don't look at the boss. Who said nurses? Nurses is absolutely right. Why do they look at nurses first? Biggest department, biggest number of dollars. So what we came up with is we came up with patient classification systems and in essence we identified how many hours or how many minutes were required by specific patients throughout the hospital. And that was a relatively good concept, but it tightened it down and it tightened it down and it tightened it down. And all of a sudden, nursing became a little offended. They were being picked on. And they were truly being picked on. And all of a sudden nurses didn't like being nurses anymore, and really for about in the mid '80s basically we had a nursing shortage, because people were downplaying nursing, people were talking about how difficult nursing was and in essence how it wasn't fun any longer. And then they had to do something in the late '80s to bring nursing back and they brought it back, but still it wasn't as much fun as it had been in the past. And then in the '90s in essence, they had enough nurses for a short period of time but they still kept on looking at the nursing departments and cutting the nursing departments back to the point where nurses got fed up again and they discouraged people from going into nursing programs. And something else happened very significantly. The unions went after nursing and now they have created a situation where what do we have in California now that is going to drive up the cost of health care specifically? Patient ratios. Absolutely. Because of what was done in the mid and late '80s and the early '90s, nursing unions said we have to have some guidelines as to what is fair and

reasonable regarding patient care and we now have staffing ratios, and there's been a big fight over the past 2-3-year period of time with regard to staffing ratios. But however it's resolved over the next year or two, costs in health care are going to be going up dramatically because of the staffing ratios and because of the shortage in nursing. And nursing is now being paid a more realistic wage level than they had been in prior years. And it's going to continue going up until we do have enough nurses in the state of California. California probably has the greatest shortage of nurses. The average age of a nurse in California is 47 years of age. Does anyone know what the average age of a nurse in the OR is? Do you? 56 years of age. That's kind of a remarkable number.

So we talk about cost containment. I have 50 ways for cost containment and I don't talk about nursing cuts, because I think that we killed ourselves by creating a problem in that area. There are a number of ways hospitals can save money and I do have 50 ways that they can save money. One is, they can refinance existing debt. I mean, refinancing charges are very low at this particular point in time. They can review the cost of their purchasing programs. The purchasing programs, often times they're not reviewed by anybody for a number of years. The materials manager just keeps on dealing with the same people year after year after year. They should be looking at those on an ongoing basis. And I'm not going to go through all 50. Review on call policies within hospitals and change on call policies basically. On call policies are killing hospitals. Don't pay interest charge to vendors. Review health insurance premiums on a regular basis. How much is the hospital paying for their health insurance? Because believe it or not, that's a significant component of hospital costs. Workers compensation is a significant component of hospital costs today, and you'd better review your workers compensation insurance premiums on a regular basis. But I said I'm not going to go through all 50. There are numerous ways that hospitals can contain their costs if they stick to some of those.

Another way to contain costs, and this is always an interesting point to bring up. Did you all see the graph as you walked in? 30% of the people receive 80% of the dollars, or something like that, in health care. Are you familiar with how many, what percentage of the dollars are spent in a human being's last six months of their life? (AUDIENCE: 80%). Okay, I've got one 80. Anyone else? 90%. Anyone else? Actually I think it's a little lower. It used to be 50%. I haven't heard the number in the last year so I was going to go with a 50% level. But 80 or 90%, 50%, whatever – it's a ton of money. It's too much. What are we going to do about it? I don't know. Oregon has tried to address it, they haven't had great success and as population ages, many of us are going to say, gee, we don't want to change that. Spend as much as you have to to keep me alive. But I think you're going to see changes in that area over the next 20-30-year period of time.

I want to talk a little about the importance of competition. Competition in health care is extremely important. I'm here today representing three health care district hospitals in Sonoma County – Healdsburg, Palm Drive and Sonoma Valley Hospital. Those are good hospitals. Their patient satisfaction levels on the surveys that are being done statewide, their patient satisfaction levels are higher than the larger health system hospitals. People like to go to those places because they're being taken care of by neighbors and friends, people who care. And that's very important in your health care.

Reimbursement levels at your health care district hospitals are inordinately low. Now this is something that we were not aware of up until 2 1/2 years ago when Sutter Santa Rosa sent a

contract profile to one of our health care district hospitals by mistake, and the CEO looked at it and said, my God, they're being paid \$1714 for a med-surgical day. We're being paid \$950 for a med-surgical day. And she shared it with another CEO because once that contract profile was sent, it became public information. She shared it with another health care district hospital CEO and he was being paid \$1025 for a med-surgical patient day. And he was shocked and very disappointed. The real shock was on your skilled nursing patient days, your SNF areas. When an acute care patient is in the hospital but doesn't require acute care anymore, they try to move them out to save some money into a SNF unit. Sutter was being paid \$869 for their SNF patients. And that was whether it be a level 1, a level 2 or a level 3 SNF patient. The health care districts were being paid \$165 for a 1, \$185 for a 2, and \$225 for a 3. Does anyone know why the health care district hospitals are being reimbursed so much less than Sutter Santa Rosa? Negotiating clout. That is it, right on the button. And actually, I will talk a little bit about the negotiating clout. Sutter has a whole array of contract specialists that sit down in Sacramento and all they do is crunch numbers all year long for all of their hospitals. They sit down with the health plans and they don't discuss one little hospital at a time, they discuss all their hospitals. They may have different rates at their hospitals but they do discuss all of their hospitals at the same time, and if the health plan doesn't want to pay this hospital so much, they say, well then you can't contract with this hospital. If you don't pay us what we want over here, you can't contract with this hospital. It's unfair. And Sutter has a vast array of physicians in Sutter Medical Group. Are you aware of the fact that hospitals can't hire physicians in the state of California? That's no longer the case, because of your wonderful Senator, Senator Wes Chesboro. Last year he passed a bill, SB376, he was the author, he was the sponsor, and health care districts can now hire physicians in the state of California. We had to fight tooth and nail with the California Medical Association because they were totally opposed to it, and we had to compromise on a pilot project and 21 of our 45 health care district hospitals can hire physicians at this point in time. They can hire up to two physicians, but they can't hire in total more than 20 physicians during the pilot project. So what we have got to do is we have got to get our health care districts who are truly interested in generating more volume and more revenue to hire the health care districts and then prove to the Assembly and the Senate how this is benefiting the hospitals. And we are in the process of doing that. We are going to get to the point where health care district hospitals and rural hospitals, other than health care district hospitals, can hire physicians because we've got to preserve these organizations so there is a competitive place in the market. Without these hospitals, there is no competition and the large health systems can drive up the rates wherever they want, and you have no control over them.

What we're trying to do is develop a collaboration, develop a good working relationship, a rapport with the health plans. We really are. We're trying to get next to them, we're trying to make them recognize the importance of health care district hospitals. And Aetna has stepped forward, and I have to say Aetna has stepped forward because of a gentleman in this room, Norm Sheehan, who is a part of NOCAHU. He heard my speech last year and was absolutely amazed at how the health care districts were being taken advantage of, and he came to me and promised he would do whatever he could to help us. He went to Aetna and spoke to Aetna. And Aetna, as a result of his communications, basically, made a contribution to Santa Rosa Junior College. This shows you how amazing things can work around here when you talk to one another and you develop these type of relationships and you network. They made a contribution to Santa Rosa Junior College so Santa Rosa Junior College would put nursing students into the health care district hospitals for their clinical training. So we have now five student nurses in our health care

district hospitals receiving their clinical training. Do you know how important that is to the health care district hospitals? What's going to happen with these five student nurses when they graduate? They're going to work in our hospitals because they're going to realize how much more fun it is to work in a small local facility than it is to work in a large health system. They're going to be absolutely, the people that are there right now are loving it, and we do anticipate that we are going to reduce the shortage of RNs. You know what happens when you have a shortage of RNs? What do you do? How do you replace that RN that you don't have? Registry. Who said registry? How much does a registry nurse cost? Twice as much as an RN. That's crazy. I mean let us pay the RNs appropriately, let's get the number of RNs we need, and let's treat them nicely so we do have good relationships with our RNs. Because I'll tell you, the worst thing in the world is to have an RN tell her children that being an RN is no good, because then we don't have any more RNs coming out. I hear you. But I've got more.

There's so much good that's happening. I do want to talk about some of these things. As a result of Santa Rosa Junior College making a contribution to our facilities or giving these nurses to our facilities, I learned more about Santa Rosa Junior College and Dr. Jen. Dr. Jen is an absolutely phenomenal individual and you should be proud of him being in your community and running your health sciences program at Santa Rosa Junior College. He does a fantastic job. He has a dental program up there where he's providing dental care for indigent children throughout Sonoma County. He goes to the school systems and is providing this. I have a health care district down in Central Valley of California that is doing the same exact thing he's doing and they are making a significant amount of money because they're able to bill Medi-Cal for the dentist's performance and also for the use of an operating room when they are required to do operations, and you'd be amazed at how much operations there are being done on younger children. 78% of the children in the state of California never receive any dental care until they're 14 years of age. That's atrocious, that is atrocious. And as a result, I thought he would be able to make some money on this, he can't make money on it, but he is looking at doing the surgical work in one of the health care district hospitals and they'll get money for the reimbursement of their operating room for that.

We're trying to develop a relationship with Blue Cross and with Blue shield and with Health Net. And it's interesting, in trying to do so we're not having that much success. I thought Tom's quote earlier was a remarkable quote: "We don't have time to fool around with you, you're too small." You know what they said about one of our health care district hospitals? We're not going to negotiate with you, you're budget dust as far as we're concerned. The CEO testified to that in the Senate, and the reaction was remarkable. We were trying to get fair equitable reimbursement and it passed through the Senate like that. Unfortunately the health plans went to Governor Davis and they'd been contributing a significant amount of money to Governor Davis and he turned everyone against the equitable reimbursement bill, but we're still fighting that one.

This year, the governor, Governor Schwarzenegger, is trying to cut Medi-Cal. And I've got to go back to last year, and Skip, I apologize, but last year Governor Davis was trying to cut Medi-Cal. He was trying to have significant cuts in Medi-Cal as far as skilled nursing facilities and we fought that and we fought that. And we had limited success. There were going to be 15% cuts and there were going to be cuts in eligibility and it would have been devastating to small rural independent, stand-alone facilities. I had the opportunity of meeting Alan Davenport – I couldn't remember his name earlier but he is the legislative person down in Sacramento and he is an

SEIU person. And we talked and basically, SEIU put 50 people on the street every single day for about a month and a half and they defeated the governor on that cut and we praised SEIU. And it's very unusual for a hospital association to praise SEIU. We praised SEIU for all of the work that they did and we are still working very well with them at this point in time.

Two more minutes. This year Governor Schwarzenegger is trying to cut FQHCs. Does anyone know what an FQHC is? (AUDIENCE: Federally qualified health care.) Yes, and they're also trying to cut RHCs, rural health clinics. And the desire is to cut \$72.2 million from these programs. And that will devastate these programs. They are the basis for health care in rural and frontier California. They feed their feeder systems into the rural hospitals, into the health district hospitals in rural areas. If a tourist goes to rural California, and we do have a lot of tourists and they get hurt, where are they going to go if there are no FQHCs or RHCs or rural hospitals? They're in deep trouble. So Governor Schwarzenegger is trying to cut Medi-Cal. Everyone wants to cut Medi-Cal. Do you realize the cut of \$72.2 million will save the taxpayers of California \$36.1 million. The other \$36.1 million, where do you think that's coming from? Federal government for crying out loud. Right now we get 77 cents on every dollar we send to the federal government. Why are we trying to cut more dollars from the federal government? We should get every single penny we can get from the federal government.

Last year when we went to the senators and to the assembly people and said we want to avoid cuts in Medi-Cal, they said tell us where we can cut. And we were stretched. We didn't have an answer. This year we have an answer and we have a very specific answer. When we said don't cut Medi-Cal, don't save that \$36.1 million, we said – let me ask you, are any of you aware of problems with the correction facilities in California? Are any of you aware of the fact that they spend over a billion dollars on health care in the state of California? Are any of you aware of the fact that they spend \$300 million on contracted work out to large health systems like Tennant, and they pay premium dollars to those places? We want them to send public dollars to public hospitals and we have 10 to 15 hospitals in the state of California that would turn their bottom line around by doing that and I have a document here I'm going to e-mail this to Skip and he's going to disseminate that to all of you. And I apologize, Skip, but I did have a lot to say.

BOB SHIRRELL: My name is Bob Shirrell, and I have been in the health business in Sonoma County for a little over 50 years so I've seen a great deal of what's been discussed here today. And I do want to tell you that there are no villains in this business. The insurance companies are not villains, they're looking out for what they have to do. The providers are not villains and the people buying insurance are not villains. Everyone is to some extent looking after his own interest. And what we have to do is just kind of get things under control. I had the pleasure of speaking to one of Skip's classes, and at the opening class when I spoke I told them that health insurance was in a perfect storm. And at the end of the course, I came back and spoke again and I said I was way too optimistic. Health insurance is in a death spiral. And I think that's where we are. One of the reasons is that we have the finest health care in the world. It's so good that we can't afford it and we're living beyond our means. And it's going to have to be dealt with very quickly. The County just announced that their self-insured program is going from a \$200 deductible to a \$400 deductible, the employee rate will be \$500, the two-party will be \$1,000, and the family rate will be \$1,400. The County is bankrupt and so I imagine the employees are going to have to pick up that increase.

Health care – and I guess subsequently health insurance – is going up right now at anywhere from 12-25% a year. Wages are going up anywhere from zero to 2%. I had the pleasure of writing the city of Santa Rosa their first group plan in 1957 and the City Council wouldn't buy it at first because it was so horribly expensive. It was \$4.41 per person per month, and it was just too expensive. I ran that forward on a compound interest at about 9 1/2 or 10% and you get right to where we are today. But then I took their wages, which were about \$350 a month and ran that forward at 10%, and they're making \$19,000 a month, which I think is probably not true. So that's a long way from '57 to here. The answer is that those lines are going to cross at the rate we're going now. And so what Tom and people are saying is we have to get a handle on it but it's fairly difficult. I think lifestyle is one, but you know, lifestyle is not a mystery. People know you shouldn't smoke, people know you shouldn't be overweight, everything in moderation as long as I get to decide what moderation is, I have no problem with that. So I think we need to concentrate on prevention. We need to concentrate on getting diabetics into classes, getting people with high blood pressure into classes. After all, 80% of the expenses occur for 20% of the people. And that chart out front I think will show you rather graphically, and that came out of a book that Myrna Dillon from Kaiser gave me and it's a very true chart, and if we can't deal with that 20% group then we can't make it. Competition has its good and bad points. If Memorial Hospital gets a new \$3 million machine, Sutter's got to have one and both of them will be underused. At one time I think I counted that we had 5 MRIs in Santa Rosa or in Sonoma County. There are whole provinces in Canada that don't have one. Yeah, it's a lot cheaper. If we could get together and decide one hospital would do this and one hospital would do something else, we could keep all of them totally busy and that efficiency would be a great savings. However, I offered when I spoke to the class last I said, we need a czar to run this thing and I'll volunteer for it. And I didn't get any great enthusiasm from the class. One young lady said, "I think it should be run by a computer." But I think we really may come to that where you're going to have districts and you say, okay, here's what's going to happen: Sutter is going to have all of the children who are in trouble, Memorial is going to have this, some can be shared. And I brought that up and I've got scars to prove it. This is not a very good topic to bring up with hospitals because they are very competitive with each other. And I think some of that's going to have to be moderated if we're going to get a handle on the costs. But the costs since '57 have been going at a compound rate of 10% and as I say, wages are going 0-2% and those lines are going to cross, and when your health insurance costs more than your salary we may have some problem with it. Thank you.