

EXPOSING THE HEALTH CARE PARADOX

HIGHLIGHTS FROM THE 2011 COLUMN BY WENDELL POTTER
Senior Analyst for the Center for Public Integrity



THE CENTER FOR
PUBLIC INTEGRITY

Prepared for:

RITA ALLEN
FOUNDATION



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Introduction

November 2011

Dear Board Members of the Rita Allen Foundation:

You hold in your hands a first-ever compilation of the columns of Wendell Potter, a health care industry whistleblower whose popular column is a high point for our readers. We've prepared this book to introduce you further to the healthcare reporting available on www.iwatchnews.org News, the website of the Center for Public Integrity.

Wendell Potter is a key staffer in our healthcare reporting. He is without a doubt one of the most powerful voices on American healthcare issues. His insider and revelatory column provides a refreshing “reality check” on the tall tales and exaggerations put out by the spin-miesters of the healthcare industrial complex.

He brings two decades of insider's experience to his role as senior analyst at the Center for Public Integrity. The former CIGNA executive-turned-whistleblower writes about the ongoing battle for health reform with authority and depth.

After a 20-year career as a corporate public relations executive, Wendell left his job as head of communications for one of the nation's largest health insurers and became a vocal critic of insurance company abuses.

In widely covered testimony before the Senate Commerce, Science and Technology Committee in June 2009, Wendell disclosed how insurance companies, as part of their efforts to boost profits, have engaged in practices that have resulted in millions of Americans being forced into the ranks of the uninsured. Wendell also described how the insurance industry has developed and implemented strategic communications plans, based on deceptive public relations and advertising and lobbying efforts, to defeat or weaken reform initiatives.

During his business career, Wendell held a variety of positions at Humana Inc. and CIGNA Corporation. When he left CIGNA in May 2008 he was serving as head of corporate communications and as the company's chief corporate spokesperson.

Wendell was a reporter before his career in public relations. A former Washington correspondent for Scripps-Howard newspapers, he covered Congress, the White House and Supreme Court and wrote a weekly political column. We were thrilled when he joined the Center for Public Integrity in January 2011 to write an ongoing column on health insurance.

His first book, *Deadly Spin: An Insurance Company Insider Speaks Out on How Corporate PR Is Killing Health Care and Deceiving Americans*, was published in November 2010 by Bloomsbury USA. The paperback edition, with a new foreword by Sen. John D. Rockefeller IV, was published this fall. I've provided two copies to Elizabeth Christopherson in preparation for your board meeting.

We at the Center for Public Integrity are truly honored that the Rita Allen Foundation is considering an investment in the health reporting of the Center for Public Integrity. As you read Wendell's columns, you'll see that there is much to be done in making America's health care system better—more efficient, transparent, and compassionate. Enjoy this sampler of Wendell Potter's work and look for his new columns twice a week at www.iwatchnews.org.

—**William Buzenberg**,
Executive Director,
Center for Public Integrity

The Insurers' Real Agenda For Change

By Wendell Potter February 8, 2011

The media had lots of health care news to obsess about last week. A federal judge ruled the health care reform law unconstitutional, and Senate Republicans tried in vain to repeal the law. But most of the press paid virtually no attention to a potentially much more important development — a multi-pronged effort by five major insurers to strip from the law key regulations and consumer protections that aren't to their liking.

The insurers do not want the bill repealed or declared unconstitutional. Congress gave them exactly what they wanted by including in the legislation a requirement that all Americans not eligible for Medicare or Medicaid buy coverage from a private insurance company. That provision alone will result in hundreds of billions of dollars in revenue and profits the insurers otherwise would never see.

Officially, the insurers are maintaining neutrality on the court challenges to the law and the repeal efforts. They understand that Republican attorneys general who filed the lawsuits and the Congressional Republicans who voted to repeal the law — most of whom received campaign contributions from the insurers' political action

committees — must go through the motions to satisfy “the base.”

The court challenges and repeal efforts are, in reality, a useful smokescreen for the big insurers, whose real agenda is to gut the law while preserving the mandate. Expect a big lobbying and PR campaign — financed by our insurance premiums — to persuade us that the new regulations and consumer protections will make those premiums skyrocket.

The story much of the press missed was the revelation that the CEOs and lobbyists for the five biggest for-profits — UnitedHealth, WellPoint, Aetna, CIGNA and Humana — have been meeting frequently to plot their attack on the law.

The big insurers have formed such coalitions to defeat reform initiatives or to persuade the public and lawmakers to see things their way.

Bloomberg's Drew Armstrong reported that three committees formed by the group have been meeting almost weekly. While Armstrong didn't indicate what those committees are doing, I can speculate from previous experience as an insurance company executive that the committees are developing strategies in these areas: lobbying, strategic communications the formation of alliances with other political and business groups and the creation of fake grassroots, or “Astroturf” organizations.

Bloomberg and The National Journal also reported that the for-profits have solicited proposals from

three big PR firms that have done extensive work for the industry: APCO WorldWide, Weber Shandwick and Public Strategies. It sounds familiar. While I was serving as head of corporation communications at CIGNA, I hired APCO and Weber Shandwick to help direct similar efforts and to enhance CIGNA's reputation.

The for-profits reportedly formed the new coalition — as yet unnamed — because they were upset that America's Health Insurance Plans (AHIP), their umbrella trade association, had been unsuccessful in keeping the new regulations and consumer protections out of the law in the first place.

So they're going back to a familiar and successful playbook. Over the past two decades, the big insurers have formed such coalitions to defeat reform initiatives or to persuade the public and lawmakers to see things their way.

So this new grouping is just the latest variant on an oft-used tactic to influence public opinion and public policy. This time, however, the stakes are even higher, for both the insurers and for consumers.

When the Clinton reform plan was being debated in 1993 and 1994, Aetna, CIGNA, Prudential and United formed the Alliance for Managed Care (AMC) to argue for a "market-based" solution — managed competition, as it came to be called — as an alternative to broader government involvement in health care. The AMC described itself as "a private-sector approach to health care system reform that uses the marketplace and the power of informed consumer choices to achieve better coverage, while improving quality and cutting costs."

The AMC later joined a broader coalition that included the U.S. Chamber of Commerce and the National Association of Manufacturers to defeat the Clinton plan.

A few years later, within weeks of being named as defendants in two massive class-action lawsuits, the for-profits formed a new group, America's Health Insurers (AHI), designed to redirect scrutiny away from them and toward the trial lawyers behind the suits. Attorney Richard "Dickie" Scruggs alone cost the companies billions of dollars in market capitalization when the Wall Street Journal reported on Sept. 31, 1999, that Scruggs was planning to file charges against the insurance firms. On that day, stock prices of Aetna and United alone had plunged nearly 20 percent by the time the closing bell rang at the New York Stock Exchange.

I was CIGNA's main representative to America's Health Insurers. My counterparts from other big insurers and I met secretly in hotel conference rooms in Washington and elsewhere with APCO to plan the PR strategy. The idea was to "reframe the debate" — shift attention away from the reasons the insurers were being sued — onerous policies and cheating doctors out of payments— and toward those trial lawyers who were getting filthy rich filing "frivolous" lawsuits. The lawyers — not the insurers — were the real villains. APCO reactivated the front group it had created for the tobacco industry—the Coalition Against Lawsuit Abuse—to generate letters-to-the editor and op-ed pieces in cities where the lawsuits had been filed — particularly Miami, where suits were eventually consolidated. The intent was to influence both the federal judges and potential jurors. (The suits were ultimately settled, with the defendants agreeing to change many of their practices and to pay the plaintiffs hundreds of millions of dollars.)

I was also CIGNA's representative to yet another organization — the Coalition for Affordable Quality Healthcare (CAQH) — that the big insurers created later. We mounted a huge PR and advertising campaign designed to restore Americans' faith in managed care, which had taken a beating in the press for such well-publicized practices as "drive-through mastectomies" and "drive-through deliveries."

So this new grouping is just the latest variant on an oft-used tactic to influence public opinion and public policy. This time, however, the stakes are even higher, for both the insurers and for consumers.

What don't the companies like? Well, for starters, the rules that now require insurance firms to devote at least 80 percent of what we pay in premiums for actual medical care.

But their sights are also on other provisions of the law that might impair profits. AHIP spokesman Robert Zirklebach provided a glimpse of what insurers really want when he told a reporter last week that industry lobbyists have embarked on a campaign to "educate" members of Congress about 'flaws' in the law. For instance, the industry will be trying to persuade lawmakers that young people, many of whom are being charged too much already, will see their premiums go sky high. How

do you fix that? The insurers, of course, have an answer: get rid of the requirement that insurers can only sell policies that meet minimum benefit requirements and jettison the prohibition against charging older Americans any more than three times as much as young people. They want to charge them five to ten times as much.

If the latest coalition of big for-profit insurance firms meets its objectives, many of us will eventually be convinced — through sophisticated, behind-the-scenes PR campaigns — that those protections are not in our best interests after all. If those campaigns help the big insurers eliminate such protections, that would be ideal for their bottom lines — but devastating for consumers. ♦

Death Panels, Fact and Fiction

By Wendell Potter March 21, 2011

“Death panels” are back in the news and Congress is turning its attention to them once again. The problem is, lawmakers are looking in all the wrong places.

The House Energy and Commerce Committee, now headed by Republicans, sent a letter to Health and Human Services Secretary Kathleen Sebelius last week demanding to know how a controversial provision that was excised from last year’s health reform bill wound up — briefly — in a government “rule” on physician reimbursement.

The proposed provision would have allowed Medicare to pay doctors to counsel patients about their end-of-life medical wishes. That idea originally had bipartisan support, but when the provision was brought to Sarah Palin’s attention, she accused Democrats of wanting to create “death panels” that would decide when to pull the plug on granny and grandpa.

The claim was utterly false, but it was such an irresistible sound bite that Palin posted it on her Facebook page. She and many other Republicans quickly made it a central part of their efforts to scare people away from health care reform. They were so successful — it spread like wildfire through the online and cable news worlds — that PolitiFact.com, the fact-checking website of theSt. Petersburg Times, chose it as the “Lie of the Year” for 2009.

Worthy as the idea of paying for end-of-life counseling might be, cowed Democrats pulled it from the reform bill before it reached President Obama. Last November, however, the provision was included in a rule that was issued by Medicare on physician payment rates. When the rule became public, Republicans pounced once again.

The Obama administration pulled the provision immediately, dropping it like the political hot potato it had become.

In their letter to Sebelius last week, Republicans on the Energy and Commerce Committee charged that the administration had attempted “a political maneuver designed to avoid public scrutiny.”

Raising this issue again is part of a larger strategy by Congressional Republicans to further erode public support for reform, to keep it alive as a divisive political issue. Meanwhile, the business of real death panels is proceeding as usual, outside of any public scrutiny or apparent interest on Capitol Hill.

Yes, death panels do exist. They exist inside the big health insurance corporations that every day make decisions on whether or not people enrolled in their health benefit plans will get the care their doctors believe might save their lives. I know this firsthand from nearly two decades inside the insurance industry.

You don’t have to take my word for it. Just ask Hilda and Grigor Sarkisyan, who very possibly would be helping their daughter, Nataline, plan her 21st birthday about now had a corporate medical director not refused to pay for a liver transplant Nataline’s doctors believed would save her life.

Nataline was diagnosed with leukemia at 14. Initial treatments were successful and the disease went into remission. It came back a couple of years later, though, and the sort of treatments she’d had previously were not working. She had to have a bone marrow transplant, which weakened her liver. In mid-December 2007, her doctors at UCLA Medical Center said she needed a liver transplant. They asked for prior approval from her insurer, CIGNA, to pay for it. Nataline’s doctors said they believed she had at least a 65 percent chance of living five years or longer if she had the procedure.

What I do know is that medical directors at insurance companies are corporate executives, just as I was. When you work for an investor-owned insurer, you're aware that you must do your part to assure that the firm meets Wall Street's relentless profit expectations.

A CIGNA medical director 2,500 miles away in Pittsburgh disagreed. To the astonishment of Nataline's doctors, he ruled the transplant "experimental." Insurers almost never pay for procedures they consider experimental, so this corporate medical director's decision meant that the Sarkisyans would have to pay for the transplant and all related care out of their own pockets. Not being wealthy enough to do that, Nataline's parents launched a campaign to rally public support and media interest in the case. It worked. CIGNA eventually agreed to cover the transplant. Unfortunately, so much time had passed since the original request had been made that Nataline's other organs began to shut down. She died a few hours after the family got the news that CIGNA had changed its mind.

As chief spokesman for CIGNA at the time, I was on the receiving end of hundreds of calls and emails from reporters and also from regular folks who were outraged that CIGNA had initially refused to pay for Nataline's transplant. The Sarkisyan family sued CIGNA, but the case was thrown out because of a Supreme Court precedent that shielded employer-paid plans from damages resulting from their decisions.

I wish I could say that Nataline's story was unique. In the course of my 20 years in the industry, however, I handled media inquiries involving many cases in which coverage had been denied by a corporate medical director for one reason or another. I probably will never know how many of those people died as a result of not getting the care they needed, and I will never know if

Nataline would have lived if she had gotten the liver transplant when her doctors wanted to do it. I will also never know if she might have gotten the transplant if she had lived in Canada or England or France, countries that do not permit doctors at for-profit corporations to make such decisions.

What I do know is that medical directors at insurance companies are corporate executives, just as I was. When you work for an investor-owned insurer, you're aware that you must do your part to assure that the firm meets Wall Street's relentless profit expectations. Medical directors don't get memos from the CEO saying they have to deny a certain number of transplants every month, but they do get the message that if they don't help the company keep medical spending down, they can forget about getting a raise or bonus or stock options at year's end.

Last year, when Democrats were in charge of Congress, the House Energy and Commerce Committee conducted an investigation into denials of coverage in the private insurance market, although the investigation was limited to denials for pre-existing conditions. The committee found that over a three-year period, the four big insurance companies it investigated had denied coverage to more than 600,000 people who had been treated in the past for a broad range of medical conditions and that the number of coverage denials had increased significantly each year. The lawmakers found that one of the companies maintains a list of 425 medical diagnoses that it uses to refuse health insurance coverage permanently to many applicants.

The results of that investigation led lawmakers to include in the health care law a provision barring insurers from using pre-existing conditions to deny coverage.

If the lawmakers who are now leading that committee were truly interested in looking out for the best interests of their constituents, they would drop their politically motivated probe into the end-of-life counseling provision and launch a

new investigation of the death panels inside private insurance companies.

One of the people they might want to call to testify is the former chief medical officer at Aetna, Arthur “Abbie” Liebowitz. In an interview for a report written last year for the Center for American Progress, Liebowitz explained the pressure that is exerted on corporate medical directors -- medical directors who now report to regional business managers, rather than chief medical officers, as was previously the norm.

“The concept was that business leaders had P and L (profit and loss) responsibility for the region,” Liebowitz was quoted as saying. “The business guys said if I have responsibility for profits and losses I have to control for the things that account for my costs. The biggest things affecting cost was medical cost delivery.”

Liebowitz said he fought the change in reporting relationships “until the very end.” He left Aetna in 2001.

“I didn’t think that people should be making medical decisions based on business needs.”

Neither do I. I saw the life and death consequences of that on a regular basis. If the House Energy and Commerce Committee doesn’t think this is important enough to look into, maybe the Senate will. ♦

Analysis – Pay much attention to the insurers behind the curtain

By Wendell Potter April 6, 2011



Rep. Paul Ryan's budget proposal would radically reshape both the Medicare and Medicaid programs. J. Scott Applewhite/Associated Press

Democrats who think Paul Ryan and his Republican colleagues have foolishly wrapped their arms around the third rail of American politics by proposing to hand the Medicare program to private insurers will themselves look foolish if they take for granted that the public will always be on their side.

Rep. Ryan's budget proposal would radically reshape both the Medicare and Medicaid programs. It would turn Medicaid into a block grant, which would give states more discretion over benefits and eligibility. And it would radically redesign Medicare, changing it from what is essentially a government-run, single-payer health plan to one in which people would choose coverage from competing private insurance firms, many of them for-profit.

Poll numbers would seem to give the Democrats the edge in what will undoubtedly will be a ferocious debate over the coming months and during the 2012 campaigns. An NBC/Wall Street

Knowing that a campaign publicly identified with the industry would have little credibility, the executives endorsed a strategy that would use their business and political allies—and front groups—as messengers.

Journal poll conducted February 27-28 showed that 76 percent of Americans considered cuts to Medicare unacceptable. The public is almost as resistant to cutting Medicaid, at least for now: 67 percent of Americans said they found cutting that program unacceptable as well.

According to a story in Politico this week, Democrats “with close ties to the White House” think Ryan has handed them a gift that will keep on giving. They believe the Ryan blueprint will enable them to portray Republicans as both irresponsible and heartless, hell-bent on unraveling the social safety net that has protected millions of Americans for decades. That message will be the centerpiece of the Democrats’ advertising and fundraising efforts, unnamed party strategists told Politico.

Perhaps. But know this: Ryan et al would never propose such a fundamental reshaping of those programs unless they were confident that corporate America stands ready to help them sell their ideas to the public. Like big business CEOs, Congressional Republicans wouldn’t think of rolling out Ryan’s budget plan without a carefully crafted political and communications strategy and the assurance that adequate funding would be available to carry it out.

Republicans know they can rely on health insurance companies—which would attract trillions of taxpayer dollars if Ryan’s dream comes true—to help bankroll a massive campaign to sell the privatization of Medicare to the public.

Four years ago, in a secret insurance industry meeting in Philadelphia, I saw numbers that were

similar to those in the NBC/Wall Street Journal poll. The industry’s pollster, Bill McInturff of Public Opinion Strategies, told insurance company executives, who had assembled to begin planning a campaign to shape the health care reform debate, that Americans were rapidly losing confidence in the private health insurance market.

For the first time ever, he said, more than 50 percent of Americans believed that the government should do more to solve the many problems that plagued the U.S. health care system. In fact, he said, a fast-growing percentage of Americans were embracing the idea of a government run “Medicare-for-All” type program to replace private insurers.

The executives came to realize at the meeting that the industry’s very survival was dependent upon the successful execution of a comprehensive campaign to change public attitudes toward private insurers. They needed to convince Americans they “added value” to the health care system, and that what the public should fear would be more government control.

Knowing that a campaign publicly identified with the industry would have little credibility, the executives endorsed a strategy that would use their business and political allies—and front groups—as messengers.

The main front group was Health Care America It was set up and operated out of the Washington PR firm APCO Worldwide. The first objective was to discredit Michael Moore’s documentary, SICKO, which was about to hit movie screens nationwide. Moore’s film compared the U.S. health care system to those in countries that had “Medicare-for-all” type programs run by governments. The American system, dominated by private insurers, did not fare well in Moore’s cinematic interpretation.

The front group painted Moore as a socialist but also went about the larger task of scaring the public away from “a government takeover of the health care system.” Part of that work involved persuading Americans that any reform bill expanding

Medicare or including a “public option” would represent a government takeover.

The industry knew it had to enlist the support of longtime allies such as the U.S. Chamber of Commerce, the National Federation of Independent Business and the National Association of Health Underwriters to repeat the term “government takeover” like a mantra. It also had to get conservative talk show hosts, pundits and politicians to play along. And play along they did. In the debate preceding one key House vote involving a public option, a parade of Republicans took to the floor to repeat the industry’s favorite term: government takeover.

To help make sure the term stuck, America’s Health Insurance Plans (AHIP), the insurers’ lobbying group, funneled \$86 million to the Chamber of Commerce to help finance its advertising and PR campaign against any reform legislation that included the public option. It worked like a charm. Polls showed during the course of the debate that public opinion was increasingly turning against the Democrats’ vision of reform. By the time the bill reached President Obama in March 2010, the public option had been stripped out, and public support for reform was well below 50 percent.

As a testament to the success of the industry’s campaign, PolitiFact, the St. Petersburg Times’ independent fact-checking website, chose “a government takeover of health care” as its “Lie of the Year” in 2010. (The 2009 Lie of the Year was the fabrication that the Democrats’ reform bill would create Medicare “death panels.”)

While they were leading the effort to torpedo the public option, the insurers were lobbying hard for a provision in the bill requiring all of us to buy coverage from them if we’re not eligible for a public program like Medicare or Medicaid. They won that round, too. That provision alone will guarantee billions of dollars in revenue the insurers would never have seen had it not been for the bill the president signed.

But even that is not enough for the insurers. For many years, they’ve lobbied quietly for privatization of Medicare, with significant success. They were behind the change in the Medicare program in the 1980s that allowed insurers to offer what are now called “Medicare Advantage” plans. The federal government not only pays private insurers to market these plans, it pays them an 11 percent bonus. That’s right: people enrolled in Medicare Advantage plans cost the taxpayers 11 percent more than people enrolled in the basic Medicare program.

During the Bush administration, the insurers persuaded lawmakers to allow them to administer the new Medicare Part D prescription drug program. That has been a major source of new income for the many big for-profit insurers that participate in the program.

Rest assured that insurers have promised Ryan and his colleagues a massive industry-financed PR and advertising campaign to support his proposed corporate takeover of Medicare. If Democratic strategists really believe that Ryan has all but guaranteed the GOP’s demise by proposing to shred the social safety net for some of our most vulnerable citizens, they will soon be rudely disabused of that notion. The insurers and their allies have demonstrated time and again that they can persuade Americans to think and act—and vote—against their own best interests. ♦

Ryan's Medicare Plan Would Be a Windfall for Insurance Companies

By Wendell Potter April 21, 2011

After he was banned from Medicare in 2007, Maryland podiatrist Larry Bernhard was caught submitting some \$1.1 million in fake bills to Medicare Advantage, including treatment of a double-amputee's feet.

Rep. Paul Ryan's plan to privatize Medicare would accelerate a trend started several years ago by corporate CEOs and their political allies to shift ever-increasing amounts of risk from Big Business and the government to workers and retirees.

If enacted, the Ryan plan would represent a windfall of unprecedented proportions for insurance corporations and other businesses.

For millions of average Americans, many of whom already are finding it impossible to save for retirement, it would represent financial calamity. The nation's middle class would pay dearly for Ryan's proposed shredding of the social safety net that Medicare currently provides.

Ryan, chairman of the House Budget Committee, wants to dismantle the Medicare program and replace it with a system of vouchers. Starting in 2022, the government would give the average 65-year-old Medicare beneficiary \$8,000 a year to buy coverage from a private insurer. That's the amount health care analysts estimate will be what the Medicare program will spend on every 65-year-old in 2022 if the government doesn't turn it over to private insurance companies.

While that might sound fair on the surface, it would actually be a very bad deal for people who turn 65 that year, compared to those who turn 65 in 2021. That's because commercial insurance plans are much more expensive, and operate far less efficiently, than the current Medicare program.

The amount of money commercial plans actually spend to pay medical claims has been declining rapidly over the past several years while the amount they spend on administrative activities such as marketing and underwriting—and to pay executives and reward shareholders—has been increasing. That's why Congress included a provision in last year's health care reform law to require insurance firms to spend no more than 20 percent of their policyholders' premiums on overhead. By contrast, the current Medicare program spends just 3 percent of its budget on administration.

The nonpartisan Congressional Budget Office says the \$8,000 voucher won't be nearly enough for seniors to buy comparable coverage from private insurers and pay the additional out-of-pocket costs that those insurers would require them to pay. The amount the average 65-year-old would have to shell out to buy private insurance in 2022, according to the CBO, will actually be \$20,510. Seniors would have to pay the difference—\$12,510. If Medicare is not privatized, the difference would be \$6,150.

Here's why this would be a dream-come-true for the insurance industry: The more health plan enrollees have to pay out of their own pockets, the less insurers have to pay for medical care. The money that insurers avoid paying out in claims goes straight to their bottom line—and into shareholders' pockets.

The problem is, most Americans have far less skin to put in the game than CEOs like Rowe and Hanway or even Rep. Ryan, who makes \$174,000 as a member of Congress.

Insurers have been shifting more and more of the cost of care to their policyholders over the past several years by enticing—or pushing—they into plans with ever increasing deductibles. This trend is part of what Yale professor Jacob S. Hacker called “the personal responsibility crusade”—making people more responsible for the management and financing of the major economic risks they face—in his 2006 book, “The Great Risk Shift.”

This crusade has been led by Republicans and insurance company executives who have been saying for years that the best way to control medical costs is for Americans to have more “skin in the game.” That’s an expression that former Aetna CEO Jack Rowe used often before he retired in 2005, the year he made \$22.2 million. It was also a sound bite favored by the CEO I used to work for, CIGNA’s Ed Hanway, before he retired in 2009. Hanway’s total compensation that year was almost \$111 million.

The problem is, most Americans have far less skin to put in the game than CEOs like Rowe and Hanway or even Rep. Ryan, who makes \$174,000 as a member of Congress. The median household income in the United States was just \$49,777 in 2009, which was down \$335 from 2008.

That decline, by the way, was the continuation of another trend that began as the Clinton era was ending and the George W. Bush era was beginning. Median household income in the United States peaked in 1999 at \$52,388 (adjusted for inflation).

It fell more than \$2,000 during the eight years of the Bush administration.

During that time, health costs rose dramatically. According to the Kaiser Family Foundation, the average annual health insurance premium for family coverage increased from \$5,791 in 1999 to \$13,770 in 2010. The average amount that workers contributed out of their own pockets for family coverage increased from \$1,543 to \$3,997.

With household incomes declining, Americans have had far less money to put into retirement. According to a recent survey conducted by Opinion Research Corp. for America Saves and the American Savings Education Council, less than half of current workers are saving enough to have a “desirable standard of living in retirement.”

If workers are having this much difficulty saving for retirement, where in the world will they find the money to pay what Rep. Ryan would make them pay for Medicare coverage when they turn 65?

Ryan’s “blueprint” is one that will take America back to the pre-1965 days when senior citizens were losing their homes and their farms to pay for medical care. They were becoming destitute—and dying much earlier than they are today—because insurers would not sell them coverage because they were too much of a risk to insure, and there was no safety net for them.

That’s exactly the same place future senior citizens would find themselves if Ryan’s plan to privatize Medicare ever becomes public policy. ♦

Insured profits

By Wendell Potter April 28, 2011



On Monday, I wrote about the good fortune of UnitedHealth Group, one of the big seven for-profit health insurance companies, and its CEO, Stephen J. Hemsley. Last week, UnitedHealth pleased Wall Street so much with its report of earnings during the first three months of this year that investors clamored to buy the company's stock.

By the time the New York Stock Exchange closed last Thursday, shares of UnitedHealth's stock had shot up more than 8 percent and reached their highest value in more than three years. The company's shareholders, including Hemsley, now the highest paid CEO in America, were suddenly much wealthier.

Owners of health insurance company stock have continued to get richer this week. On Tuesday, Humana Inc. announced that its first quarter earnings would be so much better than Wall Street expected that it was raising its full-year profit outlook and instituting a dividend. The company's stock price jumped 5.5 percent after disclosing that fabulous news.

The good news, at least for shareholders, just keeps on coming. Yesterday, WellPoint Inc., which

To make this kind of money, insurance companies have to spend far less paying their policyholders' medical claims than anyone thought possible.

operates more than a dozen Blue Cross plans across the country, announced that it, too, had exceeded Wall Street's expectations during the first quarter—by an astonishing 48 cents per share.

When I was handling financial communications at CIGNA, I knew investors would be pleased if the company exceeded their expectations by even a penny a share. During my nearly two decades in the industry, I never saw insurers blow past what they had been expected to earn by such wide margins. WellPoint's shareholders must be pinching themselves today to make sure they're not dreaming.

To make this kind of money, insurance companies have to spend far less paying their policyholders' medical claims than anyone thought possible.

They've been able to do that so far this year, despite the new health care reform law, by shifting many policyholders into plans that force them to spend more from their own pockets before coverage kicks in. Insurance firms also fatten their bottom lines by denying more claims.

What are the real-world consequences?

Let me share portions of just three e-mails I received this week to give you a hint. I wish I could say that such e-mails are rare.

The first came from a man who actually sells policies for one of the above-mentioned firms on a part-time basis. He decided to write me after visiting a family that was on the verge of bankruptcy because of what they have to pay for insurance coverage and out-of-pocket expenses.

He told me that the head of the family was a small business owner who was still working well into his late 60's because it was the only way he was able

to provide insurance for himself, his wife and a daughter suffering from mental illness. He was paying \$28,800 in annual premiums and had just been notified that he would have to pay 25 percent more when the current term of his policy expired.

Even though he was paying more than \$2,000 a month for coverage, it was far from adequate. It did not cover his daughter's three-times-a-week visits to her mental health doctors, which meant that he had to pay an additional \$300 per visit out of his own pocket. On top of that, he had to pay \$1,000 every month for her prescriptions.

"It truly disgusted me, and I had no idea what I could do to help them," he wrote.

The irony is that the part-time insurance salesman who sent the email was uninsured. He couldn't afford coverage himself.

The second e-mail came from Molly Poole, a woman I had met in March in Lancaster, Pa. She was writing to tell about a new website — www.LetScottLive.com — that she created to help raise money for her husband's care. While Stephen Hemsley and a handful of other insurance company executives are becoming billionaires, Molly and Scott Poole who has Lou Gehrig's disease, are now effectively beggars. They wrote asking me to help spread the word about their plight and to assist in their efforts to raise money.

Here's what Molly wrote:

"In short, we have been terrorized since spring 2009 with a variety of insurance company games. First we were told (by Highmark Blue Cross) that we were about to hit Scott's million-dollar lifetime cap 'in the next month or so.' That was wrong, but that didn't stop them from calling every few months to give us another 'you're hitting your cap soon' scare and giving a vague date a few months out. They were always wrong in the end, but that did nothing for the panic level at the time."

Molly wrote that Scott had been transferred to COBRA on Nov. 7, 2010, after losing his job. As that coverage was about to expire, the Pooles

applied for an extension. A case manager for their insurer said it would be a waste to apply for the extension because Scott was rapidly approaching the lifetime coverage limit. After battling with the insurer for weeks, the Pooles finally got the extension, but only for a short while.

“We only have coverage through May 7, Molly, wrote, “so that’s why we’ve created a website to try to raise funds. We need to come up with approximately \$400,000 a year to cover nursing and other medical costs. God forbid a hospital stay. What savings we have left are what’s running the house. We start tapping them, we lose the house.”

Molly ended her e-mail with this: “The illness itself has been a walk in the park compared to the insurance hassles. Can you imagine something that makes dealing with Lou Gehrig’s disease a breeze compared with what they are putting you through?”

The third e-mail I got was from Stan Brock, the saint who founded Remote Area Medical (RAM) to provide care to people in isolated villages in less developed countries.

He started by flying doctors to nearly inaccessible places along the Amazon River in South America. Today, most of RAM’s “expeditions” are in the United States, and increasingly they are to locations that are not at all remote. I went to a RAM expedition in Wise County, Va., a few years ago. The experience changed my life and contributed to my decision to quit my job and start speaking out about the abuses of the U.S. health insurance industry.

Stan wrote to tell me about RAM’s most recent two expeditions in California.

The crowds for the pair of expeditions “were similar to those you saw in Wise County, VA. We could have seen more patients had we been allowed to bring in volunteers from out of state,” he wrote.

“I am convinced that if federal laws were changed so that doctors could cross state lines to provide

free care, that RAM-type operations would begin to spring up nationwide and make a significant difference for health care for the underserved at no cost to the government or taxpayer. We really need an economics expert to make those sort of projections on a nationwide basis with volunteer clinics going on weekly in every state; not just by RAM but by numerous other charitable organizations and civic groups,” Stan said.

These three emails are just the most recent I’ve received out of many over the past several months.

I will continue to share some of them with you — and fill you in on how incredibly rich a few executives and shareholders are becoming while Americans are being reduced to begging for help to pay for health care or waiting for one of Stan Brock’s expeditions. ♦

Are Insurers Writing the Health Reform Regulations?

By Wendell Potter May 5, 2011

One of the reasons I wanted to return to journalism after a long career as an insurance company PR man was to keep an eye on the implementation of the new health reform law. Many journalists who covered the reform debate have moved on, and some consider the writing of regulations to implement the legislation boring and of little interest to the public.

But insurance company lobbyists know the media are not paying much attention. And so they are able to influence what the regulations actually look like—and how the law will be enforced—with little scrutiny, much less awareness.

At a January meeting of several hundred patient and consumer advocates in Washington, a top aide to Health and Human Services Secretary Kathleen Sebelius all but pleaded with those in the audience to bombard the Obama Administration with messages insisting that the law be implemented as Congress intended. Rest assured, he told them, that the insurance industry's lobbyists were relentless in their demands that the regulations be written to give them the maximum slack.

One example: a section of the law expanding the rights of consumers to appeal adverse decisions made by their health plans.

“The Affordable Care Act will help support and protect consumers and end some of the worst insurance company abuses,” read an Obama administration fact sheet read from last summer.

The fact sheet went on to assure us that the new rules would guarantee consumer access to both internal and external appeals processes “that are clearly defined, impartial, and designed to ensure that, when health care is needed and covered, consumers get it.”

“In implementing this law, we have worked to end the worst insurance company abuses, preserve existing options and slow premium increases,” an administration official said. “Through it all, protecting consumers has been -- and remains -- our top priority.”

“There is a clear pattern of leaning toward the insurance industry more than consumers”

The rules, originally scheduled to go into effect July 1, 2011, were actually written by the National Association of [State] Insurance Commissioners (NAIC), which was tasked by Congress to develop several important regulations required by the law. If the law is implemented as the NAIC recommends, patients will be able to get an external appeal of a broad range of coverage denials, including denials that result from an insurer's decision to rescind, or cancel, a patient's policy—not just denials made on the basis of “medical necessity” as determined by the insurer.

The NAIC's standards also say that insurers must provide consumers with clear information about their rights to both internal and external appeals and that the companies must expedite the appeals process in urgent or emergency situations.

Well, surprise, insurers don't like being told what to do by regulators. So they're pushing back hard. Consumer advocates who have been in meetings at the White House in recent weeks say they believe the administration is bending over backward to accommodate the insurers.

"We have reason to fear that the external appeal regs won't be very consumer friendly," said Stephen Finan, senior director of policy for the American Cancer Society Action Network.

Finan and representatives of several other consumer and patient rights organizations, including Consumers Union, the National Partnership for Women and Families and the American Diabetes Association, wrote officials in the Departments of Labor and Health and Human Services in late January pleading with them to "stand firm for consumers" in rejecting several of the insurance industry's demands.

They expressed concern that the final regulations would allow insurers to stack the decks against patients by allowing health plans to deem a second-level internal appeal of a denial as meeting the requirement for an independent external appeal. They're also worried that health plans will not be required to provide clear and understandable information to policyholders about their denial decisions, that the plans will not provide adequate translation of written communications into other languages (insurers are claiming this would be too burdensome), and that they will be able to take as long as 72 hours (instead of the recommended 24) to decide an urgent appeal.

Equally as frustrating for the consumer advocates is the administration's indication that they will give

the insurers until January 1, 2012, rather than July 1, 2011, to comply with the regulations.

Consumer advocates say the administration has told them that the reason it is proposing to delay the effective date of the new rules for half a year is to accommodate the health plans' enrollment cycles and marketing needs. Health plans do need adequate lead time to make changes to their systems and to prepare materials to inform their customers of new procedures, especially in multiple languages, so some of their push back is understandable. The new regulations will also add to the insurers' administrative costs, and the new law limits how much they can spend on overhead.

But the consumer groups believe the administration itself has caused some of the problems by taking so long to finalize the regulations. The NAIC got its work done comparatively swiftly.

"There is a clear pattern of leaning toward the insurance industry more than consumers," one of the patient advocates told me.

The consumer advocates, most of whom not so long ago were applauding the Democrats for getting reform enacted, even if it fell short of their original goals, are becoming increasingly discouraged, partly because there are so many more lobbyists for the insurers than for consumers. It's hard to compete with them.

"We're outnumbered 100 to 1," said one of the consumer advocates.

It's clear," he added, "that the insurers are willing to make life more difficult for patients" by trying to weaken and delay the consumer protections.

It's also clear that, at least for now, the insurers seem to have the upper hand in dealing with the White House. ♦

Frustrated Small Business Owners Among Single-Payer's Biggest Fans

By Wendell Potter May 31, 2011

Of the many supporters of a single-payer health care system in the United States, some of the most ardent are small business owners who have struggled to continue offering coverage to their workers.

Among them are David Steil, a small business owner and former Republican state legislator in Pennsylvania who earlier this year became president of the advocacy group Health Care 4 All PA.

Another supporter is Vermont Gov. Peter Shumlin, who last Thursday signed a bill that sets the stage for the country's first single-payer plan. If all goes as Shumlin and the bill's many backers hope, all 620,000 Vermonters will eventually be enrolled in a state-run plan to replace Blue Cross, CIGNA and other private insurers whose business practices have contributed to the number of Vermonters without coverage—approximately 60,000 and growing.

Both men told me last week that their feelings were shaped by their backgrounds. Their experiences as businessmen convinced them that a health care system controlled by private insurers cannot be sustained, regardless of attempts to force those insurers to provide affordable access to care for all Americans. They are both skeptical that the Obama administration's Affordable Care Act will provide

the fix the country needs, even with the new regulations and consumer protections.

Steil, president and owner of a small manufacturing company in Bucks County, Pa., told me he grew increasingly frustrated about having no leverage in dealing with private insurers, which demanded double-digit premium increases every year.

Shumlin, who along with his brother took over the management several years ago of a travel business their parents founded, echoed the same frustration. Shumlin, who also served as a legislator, shared another frustration with Steil: not being able to help political constituents, many of them farmers and small business owners, who called begging for help in finding coverage.

“During my 16 years in the legislature, my staff and I were frustrated time and again trying to help people who had lost their coverage and couldn't find a single insurer willing to offer them a policy, usually because of a preexisting condition of some kind,” Steil said. “We could deal with almost everything else, but this was one thing we could not solve. There simply was no solution.”

I know exactly what he means. I have spoken to hundreds of groups about the health insurance industry over the past two years, and invariably at least one person—and sometimes several—will grab me afterwards to ask for my advice on obtaining coverage. They assume that someone who spent two decades as an insurance company executive ought to be able to help them out.

Unfortunately, I have no better answers than Steil or Shumlin had for those constituents. If you've

been sick in the past, or have a spouse or child who has been treated for one of hundreds of conditions insurers consider “preexisting,” about the only way you can get coverage is to convince an employer that still offers health care benefits to hire you. Good luck pulling that off in this economy.

You can't keep shifting more of the cost of both coverage and care to people—and also make them pay increasing amounts of tax dollars in subsidies that will go straight to private insurers—and not expect people to eventually stage a rebellion.

And if you would much rather work for a small employer or become your own boss, be prepared to remain in the ranks of the uninsured.

The number of employers of any size still offering coverage dropped from 69 percent to 60 percent between 2000 and 2009, according to the Kaiser Family Foundation. The decline has been much steeper among small businesses with 10 or fewer workers. In 2009, far fewer than half of them were still offering coverage.

The Affordable Care Act, which provides tax breaks to small employers if they offer coverage and subsidize premiums for their workers, might at least slow that trend. Some of the big insurance companies have reported a recent uptick in the number of small businesses offering coverage—many for the first time—as a result of those tax breaks.

But even with financial help from the government, most small companies are still finding it difficult to pay what insurance firms are demanding. Another Kaiser Family Foundation study found that health insurance premiums employers paid for their workers in 2010 stood at \$13,770 for family coverage—more than double what they paid just 10 years earlier.

In a Crain's magazine survey of 300 small businesses in Michigan earlier this month, 24 percent said they had considered cancelling their group policies in 2011, primarily because of rising premiums. Several employers in Michigan did drop coverage.

Of those that decided to offer benefits for at least another year, a growing percentage are making employees pay a heftier share of the premium, and they're shifting them into plans with higher deductibles. A survey this month by PriceWaterhouseCoopers (PwC) found that 17 percent of employers offered high-deductible plans, up from 13 percent last year. PwC says that if the trend continues—and why wouldn't it?—high deductible plans will be the most common type of coverage by 2014.

Low income individuals and families will become eligible that year for subsidies from the federal government to help them pay their premiums. But even so, Steil and Shumlin don't believe the current system, dominated by private insurers, is sustainable in the long haul. You can't keep shifting more of the cost of both coverage and care to people—and also make them pay increasing amounts of tax dollars in subsidies that will go straight to private insurers—and not expect people to eventually stage a rebellion. Private insurers, say Steil and Shumlin, have had their chance to control costs and expand access and have failed miserably. It is time, they believe, to replace them with a single payer—the government. ♦

Employer-Based Health Care System is Crumbling Fast, May Not Survive

By Wendell Potter June 16, 2011

Columnist Wendell Potter says U.S. health insurers are trying to weaken or abolish the health care law's requirement that insurers spend at least 80 percent of premiums on medical care. The industry ultimately wants to convert consumers to profitable high-deductible plans like health savings accounts.

The global consulting firm McKinsey & Company set off a firestorm when it released a report last week suggesting that 30 percent of U.S. businesses will stop offering health care benefits to their employees after most of the provisions of the Affordable Care Act go into effect in 2014.

The White House was quick to challenge the validity of the report, noting that McKinsey has so far refused to provide any details of the methodology used to reach its conclusion. All McKinsey will say is that its report was based on a survey of 1,300 employers and "other proprietary research."

White House deputy chief of staff Nancy-Ann DeParle, who previously headed the president's office of health care reform, called it an "outlier" and cited other studies predicting that that few if any employers would drop coverage because of the Affordable Health Care Act.

Congressional Republicans were just as quick to defend the McKinsey report, which they are citing as fresh evidence that the new federal law — crafted in part to protect the employer-based system — will have disastrous consequences.

Who's right? Well, pardon the cliché, but only time will tell. What we can say with certitude right now is that the hubbub over the McKinsey report has obscured a reality neither side is acknowledging. What is indisputably true is that the employer-based system has been crumbling for several years. And, with or without the Affordable Care Act, it's very possibly on its last legs. Repealing the law, as every GOP presidential candidate pledged to do during the debate in New Hampshire Tuesday night, would probably only hasten its complete collapse.

When I began working in the insurance industry in 1989, the vast majority of Americans — well over two-thirds of the population — got their coverage through employers. Just about every year since then, the percentage has been declining.

According to the Economic Policy Institute, the share of Americans with employer-sponsored health insurance declined from 64.2 percent in 2000 to 58.5 percent in 2008. Most of that decline occurred during the Bush Administration, and before the most recent recession began.

The figure is undoubtedly lower today because millions of workers lost their jobs — and along with them, their health insurance — during the recent economic downturn. When the recession officially began in December 2007, the U.S. unemployment rate was just 5 percent. It peaked at 10.1 percent

in October 2009, four months after the official end of the recession, but it is still more than 9 percent today.

Another factor in the decline of Americans with employer-sponsored coverage is that the number of businesses still offering it has also dropped precipitously in recent years. The Kaiser Family Foundation, which keeps track of health insurance trends, found that the number of firms offering coverage fell from 69 percent in 2000 to 60 percent in 2009. The erosion was even more pronounced among companies with fewer than 10 workers, falling from 57 percent to 46 percent during the same period.

According to Gallup, the situation has only gotten worse since 2009. In a November 2010 Gallup poll, just 44.8 percent of American adults reported having health insurance provided through their employer.

One of the less obvious reasons for the unraveling of the employer-based system is that an ever-increasing number of workers are taking a pass on the coverage even if their employers still offer it, according to the Employee Benefit Research Institute. Why? Because employers are requiring that their workers pay a bigger portion of the premiums, and they're making them pay more out of their own pockets in the form of higher deductibles and co-payments. Many workers simply can't afford to take on the additional financial burden.

The insurance industry has also played a leading role in the decline of the employer-based system. The reason more and more small employers are no longer offering coverage is because many of them have been "purged" by their insurance carriers. Insurers routinely "purge" employer customers they believe have become too much of a risk to profits. All it takes is one employee of a small business — or the spouse or child of one employee — to get critically ill for the company's insurer to jack up rates so high that the business owner has no choice but to drop coverage for everyone.

A survey conducted last month by Crain's Detroit Business of 300 Michigan small businesses found that 24 percent considered canceling their health care coverage this year, primarily because of premium increases demanded by their insurance carriers.

Behind all these numbers are real people. In the coming weeks, to take us from the abstract world of figures to the real world of American-style health insurance, I will be writing about the experiences of several small business owners who say they want to continue offering health care benefits to their employees but are finding it increasingly difficult to do so. ♦

Insurers' bait and switch

By Wendell Potter June 30, 2011

More and more Americans are falling victim to one of the most insidious bait-and-switch schemes in U.S. history. As they do, health insurance executives and company shareholders are getting richer and richer.

This industry-wide plot explains how health insurers have been able to reap record profits during the recent recession as the ranks of the uninsured and underinsured continue to swell.

It also explains why the insurance industry and its allies are pulling out all the stops to kill a measure in the California legislature that could protect state residents from losing their homes and being forced into bankruptcy if they get seriously sick or injured.

On June 2, the California Assembly passed AB 52, a bill that would give state regulators the authority to reject excessive health insurance rate increases. Similar legislation has been introduced in other state legislatures, but nowhere are the stakes higher than in California—not only because AB 52 would allow the insurance commissioner to turn down requests for unjustifiably high rate hikes, but also because it would enable the commissioner to reject increases in deductibles as well.

Over the past several years, insurers have been implementing a strategic plan to “migrate” (their term) all of their policyholders out of traditional indemnity and managed care plans into so-called “consumer-driven” plans, which feature high deductibles. They have been luring people into these plans by setting premiums for high-

deductible plans lower than HMOs and PPOs, at least initially.

At first glance, these plans appear to be a good deal to a lot of people. Not only are the premiums relatively more affordable, but also the deductibles usually appear to be manageable—again, at least at the outset.

Insurers are aggressively marketing high-deductible plans, and one of the marketing ploys used by some of the biggest for-profit insurers is the “do-as-we-do” sales pitch. CIGNA and UnitedHealth started a trend in the industry a few years ago of going “full replacement,” meaning they forced all of their employees out of their HMOs and PPOs and into high-deductible plans. They want their employer customers to do the same.

I was still serving as head of corporate communications at CIGNA when the company went full replacement. If we wanted to continue receiving subsidized coverage, we had no choice but to leave our HMOs and PPOs and enroll in a high-deductible plan. Many employees, especially those in jobs that paid far less than the executives who made the decision to go full replacement, protested to the human resources department, but to no avail.

The industry's long-term strategy is to move all Americans into high-deductible plans, and they're well on their way to achieving that goal.

One of the rationales for going full replacement is that if employers don't do that, workers who are older or who have chronic conditions requiring expensive care will stay in their low-deductible managed care plans rather than to switch

voluntarily to a high-deductible plan—at least as long as they have that choice.

As young and healthy people happily desert managed care plans for high-deductible options to take advantage of lower premiums, the folks who remain in the HMOs and PPOs will see their premiums skyrocket, eventually making those plans unaffordable for both employers and their workers.

Former California Insurance Commissioner and now Congressman John Garamendi saw this coming several years ago and did his best to halt the growth of high-deductible plans, but he had no real power to do so. He told reporters in 2005, while still serving as insurance commissioner, that high-deductible plans would eventually result in a “death spiral” for HMOs and PPOs. This would happen, he predicted, as insurers and employers initially cherry-picked the youngest, healthiest and richest customers while forcing managed care plans to charge more to cover the sickest patients.

Garamendi, regrettably, was prescient, although probably even he would be amazed at how fast the forced exodus from HMOs and PPOs would be and how soon the day would come when plans with affordable copayments would be a thing of the past.

The industry’s long-term strategy is to move all Americans into high-deductible plans, and they’re well on their way to achieving that goal. America’s Health Insurance Plans, the industry’s PR and lobbying group, bragged earlier this month that high deductible plans coupled with a health savings account (HSA) grew 14 percent last year alone.

Many of the people who made that statistic possible undoubtedly had experiences similar to my son, Alex, who was initially enrolled in a Blue Cross PPO. To take advantage of lower premiums, he switched in 2009 to a “consumer-directed” plan with a \$500 annual deductible. When that policy came up for renewal at the end of the year, Blue Cross notified him and thousands of other policyholders that their monthly premiums would

increase by 65 percent unless they switched to its “Personal Choice Value HSA.” Alex couldn’t afford to pay 65 percent more in premiums, so he switched to the HSA, only to find out later that he would be facing a tenfold increase in the annual deductible, from \$500 in his old plan—which, by the way was being discontinued—to \$5,000 in the “Value” HSA. On top of that, Blue Cross had also eliminated some of the benefits he had been using in his old plan.

Stella said he and his wife pay nearly \$1,000 a month in insurance premiums, and they must spend \$17,000 a year—more than his annual salary—on premiums and medical care before their Anthem policy starts to cover their costs.

I noted in a previous column that Kaiser Permanente, California’s biggest insurer, was part of an industry-led effort to kill AB 52 in the state senate. Kaiser, which pioneered managed care plans in the 1930s, joined the high-deductible bandwagon a few years ago to stay competitive. A substantial percentage of its policyholders are now enrolled in such plans. And like many other insurers, Kaiser is now demanding that many of the policyholders who were enticed into those plans with the promise of lower premiums fork over much more money this year. People throughout California who enrolled in Kaiser’s high-deductible plans in years past are facing rate increases of up to 24.8 percent this year, according to the company’s filings with the California Department of Insurance.

And once insurers have people locked into these plans, they are free in most states to raise the deductibles to astronomical heights, as Anthem Blue Cross has done in Maine and Indiana.

Earlier this year, many people enrolled in Anthem’s plans in Maine, especially its high-deductible

plans, told then-insurance superintendent Mila Kofman that they already were barely able to make ends meet because of what Anthem was forcing them to pay.

Campground owner Mike Stella told Kofman that all of his salary and part of his wife's goes to health insurance. "Another rate increase is probably going to put us over the top," the Portland Press Herald quoted him as saying.

Stella said he and his wife pay nearly \$1,000 a month in insurance premiums, and they must spend \$17,000 a year—more than his annual salary—on premiums and medical care before their Anthem policy starts to cover their costs.

Another small business owner, John Costin of Kennebunk, said Anthem had notified him that the monthly premium for his \$30,000-deductible family policy—yes, \$30,000—would be going up from \$580 a month to \$624 this year.

"We ration our health care," he said. "We do whatever we need to for the kids (but) my wife and I delay trips to the doctor. We don't fill prescriptions."

Matters could be even worse for the Stellas and Costins if they lived in Indiana, where Anthem's for-profit parent company, WellPoint, is based. In Indiana, annual family deductibles for Anthem's CoreShare Plan go as high as \$50,000. Just stop for a moment for that to sink in. There are not many American families that could spend \$50,000 a year out of their own pockets for care and not face bankruptcy. More than half of American families don't even earn \$50,000 a year.

So now you see why insurance companies are spending millions of their policyholders premium dollars lobbying federal lawmakers to weaken last year's health care reform bill to allow them to continue marketing these outrageous plans at the same time they're lobbying state lawmakers to kill legislation that would empower regulators to reject excessive increases in rates and deductibles.

By being able to shift more and more of the costs of care from them to American families, they will continue to rack up record profits. Good luck finding a single insurance company executive or shareholder who will express any concern—or even any interest—in the lives of millions of people ruined by such greed. ♦

It's time to get outraged

By Wendell Potter July 5, 2011



Photo by digital cat

One of my favorite bumper stickers reads, “If you’re not outraged, you’re not paying attention.” That’s sort of how I feel about the health care debate. If more Americans paid attention to the fate of neighbors and loved ones who have fallen victim to the cruel dysfunction of our health care system, they would see through the onslaught of lies and propaganda perpetrated by special interests profiting from the status quo.

Since I started speaking out against the abuses of the insurance industry, I have heard from hundreds of people with maddening and heartbreaking stories about being mistreated and victimized by the greed that characterizes so much of the profit-driven American health care system.

Many other people send me links to articles or broadcasts they have seen. When I worked in the insurance industry, we called them “horror stories,” and for good reason. The circumstances people often found themselves in were nightmarishly horrible. As an industry PR guy, my mission was to keep as many of those horror stories out of the media as possible. We didn’t want the public to know.

It occurred to me recently that Americans are not sufficiently outraged because they either don’t hear these stories or, if they do, don’t believe how commonplace they are or that anyone they know

could experience the same misfortune. Or they might hear that more than 50 million Americans don't have insurance because they can't afford it or, in many cases, can't buy it even if they can afford it, but they don't stop to think that real human beings make up that abstract 50 million figure.

The reality is that these stories are indeed commonplace. Almost all of us—regardless of our age, income, job or political affiliation—are just a layoff or plant closure away from being uninsured, or a business decision beyond our control from being underinsured, or an illness away from being forced into bankruptcy and homelessness.

I hope I can help her, but there is no assurance that either I or a broker or anyone else for that matter can help her get the coverage and access to care she needs.

My life changed when I really started paying attention a few years ago. I now have a new mission—to help people become aware of and understand what is going on around them. So, starting today, I will be sharing on an occasional basis some of the horror stories like the ones I used to work so hard to keep out of the press. My hope is that people will begin to remember why reform is so necessary and why repealing “ObamaCare,” despite its shortcomings, is not a real option.

You might have heard about this first one. Even if you have it bears retelling. A few weeks ago, a man in North Carolina was arrested for robbing a bank for \$1 so he could get government-provided health care in prison.

Fifty-nine-year-old Richard Verone has a tumor in his chest and two ruptured disks, but no job or health insurance. He is one of those 50 million Americans I mentioned earlier. Verone told reporters he asked for only a dollar to show that his motives were medical, not monetary. Because of his “preexisting” medical conditions, no private

insurer will have anything to do with him. He wasn't destitute enough to qualify for Medicaid, the government program for low-income Americans, or old enough to qualify for Medicare, the government program for people 65 and older.

Verone and millions of other Americans who have a history of illness are considered by private insurers to be “uninsurable.” Insurance company underwriters consider them an excessive risk to profits. Even insurers that operate as nonprofits, like many Blue Cross plans, refuse to sell coverage to a third or more of Americans who apply because they've been sick in the past. Many of the people they turn down are children who were born with birth defects.

Shortly after Verone staged his robbery, one of the contestants in the Miss USA pageant revealed during a nationally broadcast interview that she is homeless. Why? Her sick mother could not pay both the rent and her mounting medical bills. Twenty-three-year-old Blair Griffith was evicted along with her mother and brother just weeks after she won the title of Miss Colorado.

“I didn't know what to think” when sheriff's deputies started putting the family's belongings in garbage bags, she said. “It was shocking. And then I saw my mom on her knees crying and begging them, ‘Please don't do this to me’ and then looking up at me and saying, ‘I'm so sorry.’”

Blair's mother, a widow, lost her health insurance soon after suffering a severe heart attack. She was unable to get another policy. She and her children eventually had no choice but to join an untold number of other Americans who are homeless because they can't pay their medical bills. Many are bankrupt as well as homeless. Medical debt is the leading cause of bankruptcy in the United States.

The third story I want to share with you hasn't made headlines. Most such stories never do. A few days ago a young woman who said she'd been raped sent me an e-mail to ask if I might be able to help her find insurance.

“I am in the process of hiring a broker to help me find insurance, but it is just very overwhelming and sad,” she wrote. “I have been denied by three major companies or had riders attached that will not cover anything related to HPV, cervical cancer, medications, or treatments. Basically they will do nothing for me.”

She wrote, essentially, to beg for help.

“I have never talked about what happened (to me), but I am learning that this is too big to handle on my own. There are so many barriers, and while I consider myself an intelligent person, I am by no means an expert when it comes to dealing with insurance agencies. I will take and am grateful for all the help that I can get.”

I hope I can help her, but there is no assurance that either I or a broker or anyone else for that matter can help her get the coverage and access to care she needs. She is an apparent victim not just of rape but also of an unjust system that has devolved into seemingly intractable dysfunction while we were not paying close enough attention.

These are just three people whose lives have taken a tragic turn because of America’s profit-driven private health care system. There are literally millions of other stories, many of which are even more maddening and heartbreaking.

When the Affordable Care Act (ObamaCare) is fully implemented in 2014, the number of uninsured Americans will be reduced by 30 million, and many of the insurance industry’s most egregious practices—including refusing to sell coverage to people with preexisting conditions—will be outlawed.

Let’s hope that there will be far fewer horror stories after 2014. But the new law is just the beginning. We still will have a long way to go before we have universal coverage, like every other developed country in the world.

Universal coverage, in my view, is the ultimate goal we all should share. Remember this if nothing else: Until we achieve it, you and your loved ones could easily be facing your own horror stories. ♦

Insurance Exchanges Tilted Toward Health Insurers, Not Consumers

By Wendell Potter July 14, 2011

The insurance industry made it abundantly clear this week that it is in the driver's seat—in both Washington and state capitals—of one of the most important vehicles created by Congress to reform the U.S. health care system.

The Affordable Care Act requires the states to create new marketplaces—“exchanges”—where individuals and small businesses can shop for health insurance. In the 15 months since the law took effect, insurers have lobbied the Obama administration relentlessly to give states the broadest possible latitude in setting up their exchanges. And those insurance companies have been equally relentless at the state level in making sure governors and legislators follow their orders in determining how the exchanges will be operated.

When Health and Human Services Secretary Kathleen Sebelius announced the proposed federal rules governing the exchanges on Monday, insurance executives must have been doing high fives all over the country.

Insurers had several main objectives. First, they did not want the feds to require states to negotiate with health plans on price and benefit design. And they did not want plans that failed to meet certain criteria to be excluded from the exchanges. Insurers did want the states to feel free

to appoint people with ties to the industry to run the exchanges.

Consumer advocates didn't think they had much of a chance of denying insurers their first two wishes. But they hoped HHS would at least agree that allowing health insurance executives to serve on exchange boards would create a 'foxes-guarding-the-hen-house' disaster that lawmakers never intended.

Nowhere are consumer groups more dismayed by the Obama administration's proposed rules than in Colorado, where lawmakers passed a bill that explicitly prohibits the state exchange from negotiating with health plans and where the governor and legislators have just packed the exchange board with industry executives and allies.

I can't say I'm surprised with most of these developments. During a visit to Denver in March, I heard a member of one of the legislative committees that helped draft the bill say at a public forum that Colorado's exchange should offer the state's residents “bad choices as well as good ones.” The state had no obligation, in her view, to inspect all the apples in the health insurance barrel and throw out the bad ones.

In every state that has taken up legislation to create exchanges so far, insurance executives have said that no one could possibly know the marketplace and the needs of consumers better than they do. That's nonsense.

A majority of her colleagues agreed with her. As the bill worked its way through the legislature, free market ideology trumped the real world need to protect the state's residents from unscrupulous and profit-motivated insurers.

I was surprised, though, when Gov. John Hickenlooper, a Democrat, joined Republican legislators in appointing industry executives to the exchange board. Hickenlooper got to appoint five of the nine board members, and several of his appointees, actually, tilted the board solidly in favor of insurers.

Five of the nine board members appointed by the governor and legislative leaders have either direct or indirect ties to the industry. Of the other four, one is an accountant and another is a doctor who has been a vocal critic of health care reform and the very idea of state exchanges. (As you might guess, he was appointed by a Republican, Senate Minority Leader Mike Kopp, who also was opposed to creating a state exchange.) Only two of the nine have been active proponents of reform and champions of consumer interests.

What is especially dismaying to Colorado consumer advocates is that Hickenlooper seems to have bought—hook, line and sinker—industry claims that the exchanges couldn't possibly meet the needs of consumers if insurance company executives don't hold seats on exchange boards, that only by having insurers on the board can consumers be assured of "choice and competition."

In every state that has taken up legislation to create exchanges so far, insurance executives have said that no one could possibly know the marketplace and the needs of consumers better than they do.

That's nonsense, and I suspect Hickenlooper knows it. It's hard to believe that in all of Colorado, he couldn't find qualified candidates who understand commercial health insurance to balance industry executives with obvious conflicts of interest. I know from my years in the industry that insurers will protect their market share at all costs, that what they consider competition is competition



Colorado Gov. John Hickenlooper. Photo: Flickr user jkarsh

among existing players and that the choices they want consumers to have are the choices they decide to offer. What are the chances that the industry-dominated Colorado exchange board will allow a new insurer to get a toehold in the market? Not much, I'd bet.

Colorado has many fine colleges and universities with faculty members who have deep knowledge of health insurance and health policy. Surely at least one or two of them would have been willing to serve on the exchange board.

And what about former state insurance regulators? Few people know the industry and individual companies as well as they do. I got to know and respect Colorado's former insurance commissioner, Marcy Morrison, when I served as a consumer representative to the National Association of Insurance Commissioners last year. If I were Hickenlooper, I would have begged and pleaded Morrison to serve on the board.

Hickenlooper could have ensured that the board tilted more toward consumers than

insurers. Instead, three of his appointees have industry ties. One is the CEO of Anthem Blue Cross, another is CEO of United Healthcare of Colorado and one is vice president of TriZetto, an information technology company that serves some of those insurers and has two insurance company executives on its own board of directors. (Other members appointed by legislative leaders include the president of Rocky Mountain Health Plans and the executive director of Colorado Health Partnerships.)

At least two consumer groups in the state have called on the TriZetto executive to resign, in part because of what he wrote in a trade publication about how the exchanges would affect insurance business practices and profit margins. He wrote that exchanges would be “bad” because they would be “competitive marketplaces where payers will have to differentiate themselves based on brand, price, customer service and more—all while cutting costs and increasing efficiencies.”

One can't help but wonder what the governor was thinking—if he was thinking at all about the best interests of his constituents—when he appointed someone to the board who had written just a few months ago that all of that would be bad. Hello, Governor, that's exactly what the exchanges are supposed to do.

Lorenz Meinhold, Hickenlooper's deputy policy director who helped review and recommend candidates for the board, was quoted recently as saying that all of the board members “had made a commitment to creating an exchange that will increase affordability of, access to and quality of health care while increasing competition in the market.”

Of course they made that commitment. Foxes don't get jobs as henhouse guards by revealing their true intentions. ♦

Bachmann's Iowa Blame Game

By Wendell Potter August 18, 2011



Michele Bachmann Charlie Niebergall/AP

If NBC's David Gregory had asked just a couple follow-up questions of Michele Bachmann on Meet the Press last Sunday, he would have found that her anecdote about how "Obamacare" will lead to economic ruin doesn't stand up to scrutiny.

In fact, he would have found that the financial problems of the Iowa employer she cites to bolster her point are far more likely the result of the economic policies of former President George W. Bush.

In answering Gregory's question about how she would "turn the economy around within several months" if elected president, as she recently

promised to do, Bachmann pledged to repeal both the health care reform law and the Dodd-Frank Act, which Congress enacted last year to reform the way financial institutions are regulated.

"I'll tell you the biggest job killer right now, because I'm all across Iowa asking people, business people tell me it's Obamacare and it's the Dodd-Frank law," Bachmann said. "Dodd-Frank is drying

up credit for businesses. And I have the repeal bill for Dodd-Frank.”

She went on to promise to repeal health care reform, too.

“People want that gone. It is absolutely without a doubt a job killer. I was just at a business in Indianola, Iowa. They’ve let half of their workforce go, over 100 employees.”

The implication, of course, was that the employer had to let all those workers go because of health care reform.

Gregory didn’t challenge her, so I started trying to find the Indianola employer that had axed so many jobs because of Obamacare.

I was especially curious because the portions of the law that will have the greatest impact on some businesses have not even taken effect yet. A provision that has gone into effect, which provides tax credits to small businesses that offer health care coverage for employees and help subsidize it, has actually been a boon to many firms.

While there are no final numbers yet on just how many of America’s four million small businesses eligible for the tax credit have actually taken advantage of it, reports by insurers indicate that many have done so since the tax credit became available on Jan. 1, 2010.

It is true that in 2014, large employers that don’t provide coverage to their employees will have to pay a “shared responsibility” fee, but the law exempts all firms that have up to 50 workers. The government estimates that no more than two-tenths of one percent of all firms are likely to have to pay the fee. That’s because 96 percent of all U.S. businesses have fewer than 50 employees, and most of those with more employees already offer health insurance.

Of course, Bachmann didn’t mention any of that during her Meet the Press interview.

Because Bachmann didn’t identify the Indianola company, I decided to make a few inquiries myself. My first call was to the Indianola city manager’s office. The layoff story didn’t ring a bell with anyone there, but they said someone at the local Chamber of Commerce might know something about it.

The folks at the Chamber were at a loss, too, but they did recall that a company called Cemen Tech Inc., which makes mobile concrete mixing trucks and dispensers, had laid off workers a few years back.

I called both Cemen Tech and the Bachmann campaign in hopes of digging out a few bits of information that didn’t make Meet the Press. When my calls were not returned, I did an online search for Cemen Tech. And now I know why Bachmann didn’t offer up any details.

A July 11 story in the Des Moines Register reported that Bachmann would be doing several televised interviews that afternoon “from a makeshift stage on (the) manufacturing floor of Cemen Tech, which employs 115.”

The story went on to report that Republican state Sen. Kent Sorenson, Bachmann’s Iowa campaign director, had asked Cemen Tech Inc. chairman Gary Ruble to host an event for the candidate. The story said that while Ruble remained undecided, “he likes what Bachmann has to say, especially about cutting government regulations.”

Ruble then is quoted as saying that Cemen Tech “was diminished by half because of lay-offs that began in late 2009 and is surviving on exports to Mexico, Russia and other countries.”

My online search then led me to a story on the Web site of Des Moines television station KCCI, dated Oct. 10, 2008, which reported that an Indianola manufacturing company had been forced to lay off nearly 60 of its 180 employees “because of the rocky economy.” That company was Cemen Tech.

Cemen Tech executive Tom Palme told KCCI the layoffs were necessary because the “economic crisis and tight credit market have taken a toll on new orders.”

So the big layoff at Cemen Tech apparently did not occur in late 2009, as Ruble reportedly said, but more than a year earlier—and a month before Obama was even elected president.

It turns out that Cemen Tech actually laid those workers off during the last year of the administration of George W. Bush and did so because of the recession and the credit crisis that resulted from one of the recession’s primary causes, the near collapse of big banks and mortgage companies. Federal Reserve Chairman Ben Bernanke and others have said the primary cause of the recession was the inadequate regulation of those financial institutions. The Dodd-Frank Act was an attempt to increase regulatory scrutiny of those firms to reduce the chances of a similar economic catastrophe in the future.

Even though newly announced GOP presidential candidate and Texas Governor Rick Perry this week essentially accused Bernanke of treason because of his monetary policies, it is important to remember that Bernanke has his job thanks to

George W. Bush. Bush tapped Bernanke in June 2005 to chair his Council of Economic Advisers. Bush was so impressed with Bernanke that just a few months later he named him to succeed Alan Greenspan as head of the Fed.

So it appears that Obamacare and Dodd-Frank had little if anything to do with the problems at Cemen Tech. In reality, Cemen Tech’s problems stemmed from failed economic policies and insufficient oversight of financial institutions that occurred during the Bush years.

Let’s hope that the next time reporters get a chance to interview Michele Bachmann—or any other presidential candidate for that matter—that they ask a few pertinent follow-up questions. A little probing might force them to actually be honest with us. ♦

The Profit In Keeping You Ignorant

By Wendell Potter October 31, 2011



If you have no idea what you're paying good money for when you enroll in a health insurance plan, there's a good reason for that: insurers profit from your ignorance. And they're waging an intense behind-the-scenes campaign to keep you in the dark.

In my first appearance before Congress after leaving the insurance industry, I told members of the Senate Commerce Committee that insurers intentionally make it all but impossible for consumers to find out in advance of buying a policy exactly what is covered and what isn't and how much they'll be on the hook for if they get sick or injured. Insurers are quite willing to provide you with slick marketing materials about their policies, but those materials are notoriously skimpy when it comes to useful information. And

the documents they provide after you enroll are so dense few of us can understand them.

In the months following my Senate testimony, lawmakers drafting health reform legislation included a provision requiring insurers to both provide comprehensible disclosures of health plan benefits and make that information available to anyone shopping for coverage. Despite repeated attempts by industry lobbyists to get that provision stripped out of the final bill, the Affordable Care Act as signed by President Obama last year

requires that all private health plans provide consumers with a concise and understandable Summary of Benefits and Coverage (SBC) form. In addition, they must provide a uniform glossary of medical and insurance terms.

If you think that sounds like a reasonable request, you're not an insurance company executive who is rewarded more for meeting Wall Street's profit expectations than assuring that consumers know what they're buying.

If the administration caves to the insurers' demands on this, we'll know who really is calling the shots when it comes to implementing health care reform.

Now the Obama administration is trying to figure out how to enforce this new requirement, and so health insurers and their allies have launched a full-court press to persuade government officials to gut it by exempting policies sold where people work. Because the vast majority of Americans who have coverage get it through their employers, this would mean that most of us would, for all practical purposes, continue to have to buy a pig in a poke.

Fortunately there are several organizations, including Consumers Union, publisher of Consumer Reports, that are fighting the good fight. They're demanding that Obama officials write the regulations to apply to all health plans, regardless of whether they are sold on the individual market or through employers, unions or other groups. They insist that Congress intended for the standard form, which would allow "apples-to-apples" comparisons of health plans, to apply across the board.

As Consumers Union noted in comments sent to the administration, the booklet describing benefits that most employers currently provide their workers "is a bulky, legalistic document

that few consumers can understand." It cited one study which concluded that the typical benefit description document provided by employers is written at a college reading level. Most Americans have trouble understanding information written above the 6th to 8th grade level.

Insurers and their corporate allies, including the U.S. Chamber of Commerce and the National Association of Health Underwriters, are claiming in comment letters to the administration that providing a uniform, simplified and understandable version of those documents would cost so much money they would have to increase premiums.

America's Health Insurance Plans (AHIP), the lobbying and PR group for insurers that says it represents more than 1,300 health plans covering 200 million people, contends that the cost of implementing the proposal would be \$188 million. In addition, AHIP says, the annual cost of providing the information would be \$194 million. Would insurers consider absorbing those costs? Of course not.

"The benefits of providing a new summary of coverage document, in addition to what is already provided to consumers, must be balanced against the increased administrative burden that drives up costs to consumers and employers," AHIP said in its letter.

Nonsense. Consider this: the five largest insurers (UnitedHealth, WellPoint, Aetna, CIGNA and Humana) over the past week have reported profits exceeding \$2.6 billion for just the three months that ended September 30, 2011. Over the past 10 years, those five companies have recorded profits of more than \$50 billion. Imagine what the total would be if you added in the profits of the other 1,295 health plans AHIP says it represents.

The industry could even pass a hat among the CEOs of those big insurers and come up with the additional money without any one of them giving until it really hurt. UnitedHealth's Stephen J. Hemsley is the highest paid CEO in America,

according to Forbes magazine. He hauled in more than \$100 million last year alone. When H. Edward Hanway, my former CEO at CIGNA, retired at the end of 2009, he walked out the door with \$111 million. When you consider the money those two guys have made over the years, they alone could cover the cost of providing consumers with information they can understand.

I'd advise everyone to keep their eyes on this skirmish. If the administration caves to the insurers' demands on this, we'll know who really is calling the shots when it comes to implementing health care reform. ♦

Losing the Public Relations War

By Wendell Potter November 7, 2011



Accompanied by health care professionals, President Barack Obama speaks about health care in the east Room of the White House. Alex Brandon/AP

Support for ObamaCare has fallen to just 34 percent of the American public, according to the Kaiser Family Foundation's most recent tracking poll. That's down from 41 percent in just one month.

Can't say I'm surprised. Just as they did during the debate on health care reform in 2009 and 2010, the special interests who profit from the status quo have been winning the messaging battle in their ongoing effort to scare people away from the new law. They have a well-planned and executed

strategy to mislead people so thoroughly they will vote next year for candidates who promise to repeal the law, even if that means they will be voting against their own best interests. The strategy of the law's backers — if indeed there is one — is simply not working.

One reason reform advocates cite for the decline in support: relentless attacks on the law by GOP presidential candidates, especially during those free-for-all debates. At one of the recent get-togethers, Newt Gingrich even resurrected the biggest of the big lies — that the law creates government-run death plans that will decide when to pull the plug on sick Medicare beneficiaries. Supporters can't expect debate

moderators to challenge the candidates on such baseless accusations, and they don't have comparable forums to communicate how the law is helping millions of Americans. At least not yet.

Another factor in falling support for ObamaCare is that opponents are outdueling supporters in placement of op-ed commentaries and letters to the editor. While I haven't seen detailed analyses of the op-ed placement war, my own observation, as someone who reads a lot of newspapers, is that the critics have gotten way more ink than the fans.

The law gives the uniquely American multi-payer system, controlled by large for-profit insurance corporations, a new lease on life.

That doesn't surprise me, either. During my years as a health insurance industry PR guy, I helped craft and implement plans that involved recruiting seemingly ordinary folks to send letters and op-eds that had actually been written by industry flacks.

Lies about the reform law have also gone viral on the Internet. That's not new, but it appears from emails that friends and acquaintances forward to me that the dissemination of bogus information has picked up.

A few days ago one of those friends passed along one such email with the subject line: "What a Bombshell!"

The stop-the-presses news was about the results of a survey by the United Nations International Health Organization that had supposedly just been published by Investors Business Daily. It revealed that people who live in England and Canada fare much worse than Americans when it comes to surviving cancer, being treated for diabetes, getting a hip replacement when needed and getting an appointment with a specialist.

The inference, of course, was that ObamaCare would lead to a rapid deterioration in access to quality of care.

Well, it turns out that there is no such entity as the United Nations International Health Organization and no evidence that such a survey was published by Investors Business Daily. Editorially, that newspaper has been a critic of the reform law, so it was plausible, but a search failed to turn up such a story.

Another big problem with the "bombshell" is that ObamaCare creates nothing like the single-payer health care systems in England and Canada. In fact, to the great disappointment of many reform advocates, the law gives the uniquely American multi-payer system, controlled by large for-profit insurance corporations, a new lease on life.

The alleged "bombshell" has been circulating in the ether for two years. While its unclear who first sent it, I was able to find versions of it dating back to December 2009.

It is true that in a number of measures, the U.S. does do better than other developed countries, including England and Canada. But it is also true that we do far, far worse in many other measures, and we are falling further behind.

That was borne out in the results of a real report by Commonwealth Fund's National Scorecard on U.S. Health System Performance for 2011. The authors of the report wrote that "access to health care (has) significantly eroded since 2006. As of 2010, more than 81 million working-age adults were uninsured or underinsured, up from 61 million in 2003. Further, the U.S. failed to keep pace with gains in health outcomes achieved by the leading countries. The U.S. ranks last out of 16 industrialized countries on a measure of mortality amenable to medical care (deaths that might have been prevented with timely and effective care), with premature death rates that are dramatically worse than in the best performing countries. Some 91,000 fewer people would die prematurely if the U.S. could match the rates in leading nations.

The Commonwealth Fund report hasn't gone viral. But it should. And supporters of reform better get on the stick and pay attention to what opponents are doing if they expect the reform law to be implemented as Congress intended. ♦