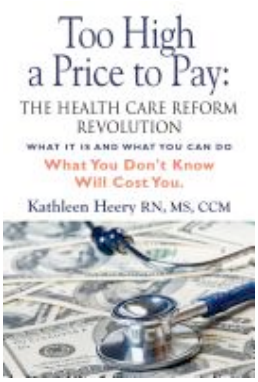
Too High a Price to Pay:

THE HEALTH CARE REFORM REVOLUTION

WHAT IT IS AND WHAT YOU CAN DO

What You Don't Know Will Cost You.

Kathleen Heery RN, MS, CCM



After many years in the health care and insurance industries, author Kathleen Heery MS, RN, CCM was struck by the reality that health care services could better align with health and that the chaos and expense in receiving these services could be better coordinated. The Affordable Care Act, also called Obamacare, began these changes but at what cost? A great shift in how we receive health care services is underway - one that places more responsibility on you for both cost sharing and decision making. While it may seem confusing and overwhelming, it is possible for you to learn about health care reform, why it had to change, where we go from here and most importantly what you can do. Obamacare continues to shake up the world of health delivery and to survive it you need a clear understanding of issues as well as focused approaches to negotiate health decisions, navigate health care systems and advocate for personal health needs. This book provides the roadmap to make these shifts with simple and organized directions. • Discover the 10 forces that brought the health care industry to its knees. • Identify the 12 major changes brought about by health care reform. • Adopt these eight (8) steps to help you navigate the new landscape and direct your personal health experiences.

Too High a Price To Pay

Too High a Price to Pay:
The Health Care Reform Revolution

What it is and what you can do

Inside:

- ⇨ How the healthcare system imploded.
- ⇨ Eight steps to regain your power
- ⇨ Where we go from here.
- ⇨ New protections for uninsured.
- ⇨ Tools and techniques to save you money.
- ⇨ Tools and techniques to save your life.

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Chapter 1

How We Got Here: Forces Beyond Your Control

Eighty-year-old Thelma lives alone and also lives with six medical problems, takes 15 medications, visits eight doctors and spent more than $4,000 in out-of-pocket costs for health care services last year. Thelma is on a fixed income from Social Security and a pension, and pays $1,000 a month for private help. Thelma doesn't need half of the medications she takes and sees too many physicians. In fact, once she stopped taking five of her medications, her ability to care for herself improved so much she was able to decrease her private costs by $600 a month.

Over the past 45 years, costs for health care services have continued to skyrocket, while insurance options, and how they operate, changed little. Throughout the years, there were cuts here and decreases there, yet none of those changes was either deep enough or meaningful enough to offset the escalating costs of health care services. In fact, many of these service cuts were often reversed by Congress due to political pressures of big money.

Even for people who have great health care insurance coverage, health insurance only pays for certain types of care and only for short periods of time. After that time limit is up, you are on your own. Unfortunately, during these short periods of time, I've seen too many people getting care they do not need or care that is given by untrained providers. Within these *health care games,* there have been winners and losers. The following is a scorecard.

The Winners

Special interest groups that manipulate politicians to vote their way. These groups, such as insurance and pharmaceutical industries, have been major power players more concerned with their own financial health than the health of the people they service. It is true; money controls the political agenda. Imagine if politicians would change their focus from the next election to the next generation, how different our health care systems would be today. So the winners here are big money.

The Losers

You and anyone who chooses to remain in the dark. Increasing costs have reduced access to primary care and forced many individuals and families out of the market. In the 1990s, managed care attempted to lower health care spending by cutting costs, but that only added another needless and faulty layer of bureaucracy to the problem. Why?

In response to managed care cost cuts, health care providers united into larger health care systems to gain market share and clout, which enabled them to raise their inflated prices even higher. And, blindly, insurers and Congress went along. Then, in 1997, another piece of legislation known as the Balanced Budget Act attempted to slash these ballooning costs, only to have them restored again in the early 2000s. So who are the losers? You and me.

Take Back Your Health

The warning lights have been flashing on health care dashboards for years. As a society, we pay more than $8,000 per person annually, have outcomes worse than Cuba, and still have health care costs that remain the number one cause of personal bankruptcy in the United States. Our country has been mismanaging health care investments due to excess profit-taking, inefficient administration, and poorly designed patient care systems.

FORCE NUMBER ONE: COLLIDING DEMOGRAPHICS AND ECONOMICS

Baby boomers are now in their 50s and 60s. According to the Institute of Medicine, the first members of the baby boomer cohort began turning 65 in 2011, and the last members will die around 2080. At least 9,000 people turn 65 each day, and this 65 and over population will double in the next 15 years from 40 million to 80 million—*doubl*e!

The 65 and over population will double in the next 15 years from 40 million to 80 million.

By 2020, roughly 20% of the population will be 65 and older, with those people over 85 the fastest-growing age group. Their sheer numbers

will both overwhelm our current systems as well as change the way we deliver health care services.

Why 65?

If our populations are aging, why was the age of 65 chosen as the "retirement age?" Why is 65 the point of entry into Medicare, as well as other benefits? In 1889 (more than 120 years ago), Germany's Chancellor Bismarck established an old age pension for individuals and farm workers at age 65. At that time, few people lived to be 65; in fact, the average life expectancy in 1900 was only 47. So ask yourself this question: does it make any sense that we keep this age as retirement and entry into entitlements, with populations living to 100 years and beyond?

Costs over Many Years

In addition to the increasing numbers of people growing older (9,000 a day turning 65), these older people are also living longer lives. This longevity means using health care services for longer periods of time. Think about it. When Medicare was enacted in 1965, the average age expectancy was 72 years, so people would be in the Medicare system for less than ten years. Today, our fastest-growing segment of the population is the 85-plus group, with more people now living well beyond 100 years. This reality translates into people using the Medicare system for 25–30 years and beyond. We have gained three decades of life in the past century, and people actually take more in benefits than they have paid into the system.

FORCE NUMBER TWO: LIVING LONGER WITH CHRONIC ILLNESSES

As populations age, so does the incidence of chronic illness. Almost one-half of the U.S. population (125 million people) has a chronic health condition. A chronic health condition is defined as a condition that lasts for more than three months, such as diabetes, dementia, heart disease, or asthma. Chronic conditions are now *primary drivers* for increasing health care costs and are best managed with lifestyle

A chronic health condition is defined as a condition that lasts for more than three months such as diabetes, dementia, or asthma.

changes and daily choices such as diet and exercise.

Additionally, many people have more than one chronic illness, and some have three or four conditions. Unfortunately, current medical models continue to apply acute care medicine to these chronic health care needs, which can cause tremendous harm. Why? People with chronic health needs often see four to five different physicians and often take more than ten medications a day. There is no one physician or person coordinating the care, so tests, procedures, and medications are duplicated, which costs more than just dollars; these errors can sometimes cost people their lives. Uncontrolled chronic care needs lead to disability, which in turn leads to loss of function, and then to increasing need for expensive services.

John's story*. John has diabetes, which he does not manage well. As a result of this poor management, his kidneys no longer work, and he requires dialysis three times a week. He is unable to get out of bed without help, and he needs assistance with his bathing and dressing on a daily basis. John sees five different physicians (primary care doctor, cardiologist, endocrinologist, podiatrist, and nephrologist), all of whom treat their specific organs, order medications, and do not communicate with each other. In addition to physicians, there are dialysis staff, home care staff, and hospital staff who do not talk to one another. These disconnected and uncoordinated services result in errors and get expensive quite quickly.*

Health Care Providers Treat Aging as a Disease

With aging populations living longer and living with more chronic illnesses, our society has not kept pace with understanding and responding to the natural process of aging. Rather than recognizing normal signs of growing older, our health care providers continue to treat aging as a disease. Why?

Unfortunately, aging is neither desired nor accepted in this country, and we've been conditioned to crave the latest cosmetic procedure to shave years off our appearances. We surgically trim off body fat instead of eating less fat, replace knees instead

Normal signs of aging are treated as diseases.

of changing lifestyles, and extend life at any cost, as long as someone else pays for it. I believe both professionally and personally that botox injections will come back to create another epidemic; it is not healthy to inject known toxins into the body.

Finally, we do not have enough people (doctors, nurses, and others) who are educated in the aging process. Until we do, we will continue to treat aging as a disease.

Find It, Fix It, and Forget It Approach by Providers

Medical professionals have been conditioned to find a diagnosis and then treat the problems with drugs and surgery. Once a diagnosis is made, it is coded, billed to insurance, and then insurers pay the provider.

Chronic illnesses are triggered by many causes and multigenetic factors and do not respond to just one type of treatment. In fact, one chronic illness can have many causes, and one cause can lead to many chronic illnesses. A pill or a quick fix is simply not effective. In fact, many pills are given to treat the side effects of the first pill. Heart disease is not caused by heart disease. It is the end result of many colluding factors such as ongoing inflammation, clogged arteries, toxic loads, etc. The effective method is to determine what is causing the inflammation or to reduce the toxic load. Medicine continues to identify and treat symptoms rather than uncover and treat causes.

Marla's story. *Marla had five different doctors, all of whom treated her different medical conditions with drugs, and none of whom coordinated her care with the others. Her high cholesterol was treated with drugs instead of testing for inflammation with a test known as CRP (a known contributor to heart disease). This would take more time and require the physician to talk with the patient about lifestyle. This lack of effective diagnosis and management was the main reason she was hospitalized three times over the past six months.*

Marla had five doctors, eight chronic conditions, and consumed fifteen medications every day.

FORCE NUMBER THREE: LACK OF INSURANCE COVERAGE AND ACCESS TO CARE

While the United States spends over $2.8 trillion for health care, well above every other industrialized nation, we rank below other countries in health outcomes. Reasons for this mismatch include out-of-control pricing, the overall fragmentation of current systems, and lack of insurance coverage for more than 40 million people. How did we get here?

The Journey

The beginning of our contemporary insurance crisis traces back to pre-World War II. Before the birth of modern medicine, hospitals were actually poorhouses where the indigent went to die. Health care services were bought and paid for in private markets. As more effective medicines came on the market (especially antibiotics) along with changes in medical school education, hospitals took on greater roles for their communities. Soon, the costs of care services began to increase rapidly, which meant people only used a hospital if really sick, not for routine care.

Hospitals continued to expand until the Depression in the 1930s, which pretty much wiped anyone's ability to pay for this care. Then came World War II, followed by postwar prosperity. The impact of World War II had created wage and price controls across the country, which froze employees' wages. To attract talent, employers began offering health insurance as a fringe benefit. In 1943, the federal government sweetened the deal as the Internal Revenue Service ruled that employer-based health insurance costs should be tax free. A second law in 1954 made these tax advantages even more attractive.

Add in the growth of unions and collective bargaining in this early postwar period, pushing for better pay and benefits, and employer-sponsored health insurance became the norm throughout the land. By 1965, with the addition of Medicare and Medicaid, most Americans had unfettered access to insurance and care services. So for the last three decades, health care costs grew and ballooned beyond anyone's ability to contain them. These out-of-control health care costs have been the focus of government and employer battles.

Consumer Driven Health Care (CDHC) is here to stay.

Enter the 21st century and Consumer-Driven Health Care (CDHC). CDHC refers to the high-deductible, increasing copay health plans we have today. These plans use health savings accounts (HSAs), health reimbursement accounts (HRAs), or similar medical payment products to pay routine health care expenses directly, while a high-deductible health plan (HDHP) protects people from catastrophic medical expenses.

High-deductible policies cost less, but the user (that's you) pays for routine medical claims using a prefunded spending account, often with a special debit card provided by a bank or insurance plan. CDHC moves more of the health care decisions and costs into your lap. The thought behind CDHC is if you pay more, you will use fewer non-emergency services. Therefore, costs will come down, as you will make better decisions about using and paying for certain services. CDHC plans are here to stay, and you will find them on health care exchanges across the country.

A final contributor to health insurance problems is the United States now competes in a global economy where most countries have national health insurance. For U.S. employers, the costs of employee health insurance place a financial burden on their ability to compete due to excessive costs of running a business.

Run for Cover

Americans pay the highest costs for mediocre quality. The United States spends a higher percentage of its gross national product on health care than does any other developed country. One problem with our current systems began when health insurance coverage became big business, with insurance companies focusing on profitability to stockholders and minimizing their financial risk. In other countries, insurance organizations exist to pay bills—period. They do not take a slice of the pie, they do not pay CEOs millions of dollars, and they do not have administrative overhead costs in the 30–40% range.

So instead of providing health security, the health insurance industry became *risk differentiators*, which means insurers sought to insure only people with good or normal health profiles and to exclude those

people considered likely to become unhealthy and therefore less profitable. This stubborn reality has led insurers to avoid the sick in order to reduce overall claims costs.

This morphing of insurance companies into profit centers led to denying coverage, avoiding preexisting conditions, limiting payments, and passing through increasing costs to subscribers instead of demanding lower costs from providers. And all the time insurance companies had avoided, denied, and limited care, health care premiums grew four times faster than wages. This reality translated into more and more people unable to afford basic insurance premiums, lacking any type of coverage, and delaying care until they were really sick.

Delaying care for fear of medical bills is a downward spiral that leads to ultimately higher health care costs for all of us. More than one third of uninsured adults say they have problems paying their bills, which helps explain why many of the uninsured don't seek out the care they need until the last minute or until they are practically dead.

Jason's story. *Jason was self-employed and, at 40, felt he could slide by without health care insurance. He had a preexisting condition (cancer six years ago) and could not afford to go to the doctor, obtain needed lab work, or purchase medications. Much of his story is not only related to his preexisting conditions (history of cancer and high blood pressure, to name two), but also due to the prices of health care services. Uninsured individuals pay retail costs, not having access to the clout of discounted bargaining that comes with having health insurance. One day, Jason ended up in the emergency room for problems related to his blood pressure and was hospitalized for four days, with a price tag of more than $30,000. Access to primary care, periodic lab tests, and basic medications could have prevented this admission.*

The downside of no health insurance often means postponing necessary care and foregoing preventive care, such as immunizations and routine check-ups. Because uninsured people usually have no regular doctor and limited

Many hospitalizations can be avoided.

access to treatment or medications, they are more likely to be hospitalized for health conditions that could have been avoided or at least minimized.

This means that nearly one-third of us face each day without the security of knowing that, if and when health care services are needed, medical care will be available. So many of us are just one pink slip, one divorce, or one major illness from financial disaster.

From the Neck Up

Insurance companies also separate, or "carve out," certain types of services, which are then managed by another company. Three of the more common services typically carved out are dental, mental, and eye health, hence the term *"from the neck up."* Even after health care reform, we continue to separate out various parts of the body like they are menu items. All this segmentation further fragments care and creates more overhead costs. It is important to remember that the body works as a whole, and when one part is out of balance, the whole body is out of balance. For example, gum disease is often linked to heart disease, and depression affects aspects of physical health such as blood pressure and stomach complaints. It is important to remember that the body is not just a sum of its parts, but an ecosystem in which everything works together.

FORCE NUMBER FOUR: VALUING QUANTITY OVER QUALITY

The way health care providers (hospitals, doctors, and others) have been paid is at the root of the cost problem. Health care providers are paid a fee for every service they give, whether it is needed or not.

Imagine building a house and paying contractors separately for every light fixture inserted, or every pipe connected, or for every window installed. The end product would be an array of individual products that may work well alone but do not work well together. You would have 50 well-functioning light fixtures, 70 pipes all in working order, and 20 windows that raise and lower without a problem. Yet these items are misplaced with too many light fixtures, pipes that lead to nowhere, and windows in the wrong places. Assembling a functional house requires

a blueprint, a plan, and a project manager to unite the efforts and produce the desired result. Assembling and managing personal health requires an assessment, a treatment plan, and coordinated care services. It is that simple.

Yet, the nonfunctional house blueprint story above mirrors exactly how health care providers have been paid and how the health care system has worked for decades. In fact, "health care system" is a misnomer. There is no *system*, which is the main reason health care costs are so out of control and unneeded hospital admissions so prevalent. Every physician, every hospital, and every provider is paid separately for every visit, every episode of care, and every test, without any coordinated approach to determine how it worked, how well it worked, or if it worked at all. How did we get here?

The Journey

In the 1700s, hospitals were largely used as isolation facilities for contagious illness. Those who could afford health care services received them at home. But by the end of the 19th century, health care services were getting complex and shifting into facilities. By the mid-20th century, and with the advent of publicly funded health care insurance (Medicare and Medicaid), the number of insured people and the number of hospitals exploded, along with health care costs. In 1870, there were only 178 hospitals in the United States; by 1970 (a century later), that number had mushroomed into 7,200 hospitals.

In the 1990s, managed care tried to tame exploding health care costs by limiting access to expensive care and limiting patients to certain providers. Through this time, inpatient care services declined while outpatient services grew. For a while, health care costs stabilized, but not for long. Hospital groups came together to form into integrated delivery systems that pushed back against managed care for limiting utilization. Then costs began to grow once again.

Now in the 21st century, the number of hospitals is declining once again, with fewer hospitals yet bigger networks of hospital groups. However, despite all the pushing and pushing back, health care costs continue their climb, and payment methods, particularly fee-for-service

(FFS), are largely unchanged. Providers continued to be paid by the number of services they offer, whether needed or not.

Fee for Service (FFS) Payment Method

Fee-for-service (FFS) pays health care providers for each service (an office visit, test, or procedure), regardless of whether the service truly benefits the patient. FFS is how most of the health care providers have been paid since the beginning of Medicare, with the incentive to do more, not less.

The fee-for-service payment system has caused much of the problem. It promotes too many tests, too many medications, and too much greed.

This method of payment pays for services, no matter the price or quality. FFS pays usual and customary fees based on diagnostic codes. Because payments are for patients with insurance, the incentive is to maximize services for those with the most lucrative insurance. Not only is there a flaw in the method; the entire model is flawed. Financial incentives are to do more and more tests and procedures, whether needed or not, a term referred to as “supply-side demand.”

Supply-side demand translates into a simple fact: the more hospitals and doctors there are in a given geographical area, the more services are done. For example, if you want to know which cities perform the greatest number of colonoscopies, just count the number of gastroenterologists. The higher the supply of doctors, the more procedures are done.

In just one year, health care providers in the United States do more tests, perform more surgeries, put people through more procedures, and prescribe more drugs than other countries do in a lifetime. Overuse of the system has helped push insurance premiums up 400%—-four times faster than wages. This volume-over-value problem sacrifices an important factor when dealing with health issues, especially chronic health issues. That factor is time.

Sacrificed Time

When we drill it all down, the key missing factor for safe health care practices and patient outcomes is *time*—time you as a patient have with your health care providers to find causes of problems and not merely treat symptoms with medication, time to identify some realistic lifestyle solutions, and time to acquire adequate instructions. In fact, a British study confirmed that a diagnosis and treatment plan can be obtained 90% of the time with simple lab tests and a thorough examination.

Jane's Story. *Jane is a 48-year-old woman with a new diagnosis of irritable bowel syndrome (IBS). She takes 14 medications a day and sees more than 8 physicians. None of these medications or doctors have been able to help Jane. IBS is one of those "wastebasket diagnoses" that have many causes and cannot be treated with one medication. Ironically, if Jane didn't get a prescription from her physician, she believed she wasn't being heard.*

So each physician saw Jane for a short period of time, prescribed medications, billed for services, and didn't speak to any of the other physicians. The increase in volume not only sacrificed time needed but led to an overall fragmentation of health care services for Jane.

A Whole List of Doctors instead of a Holistic Doctor

Each provider follows its own rules until you leave its care. Then there is no guide, no guidance, and little help.

The fragmented payment system creates a fragmented and overused delivery system where professionals practice in silos. Each member of the siloed system (hospitals, rehab facilities, home care agencies, physicians) means that each member has its own rules, regulations, and payment systems. For example, hospitals take care of you until you leave their doors; then their services stop, and so does the payment method for acute-level hospital care. Rehabilitation facilities manage your care while you are there, and then it, too, stops when you leave.

Each time you change levels of care, the payment methods also change. The confusion around payment changes is one not many

people understand, even professionals in the business. You may think because you have one insurance company, there is consistency, but nothing could be further from the truth.

It is within these spaces between care levels, known as transitions, where much of the needed information and support collapses. It is during these transitions where errors occur and individual providers take no responsibility for care. Why? Because health care providers are not paid to do it, and you are on your own. And payment across the care continuum is not the only problem.

Physicians are just as siloed as systems. We have specialists for every part of the body. For example, a cardiologist for the heart problem, a endocrinologist for the diabetes problem, a podiatrist for foot problems, a neurologist for head issue, a hospitalist when in the hospital, and on and on. Each one of these professionals is paid separately and no one is required to coordinate care or even pick up the phone to consult.

While many of you may have a primary care physician, he or she is not paid to coordinate your care. In fact, the United States' ratio of specialists (70%) to primary care doctors (30%) is backward from that of most industrialized countries, which have a 50/50 split. So instead of a holistic doctor who takes charge of your health, many of you have a "whole list of doctors"—a doctor for every ailment treated and billed separately.

Ed's story. *Ed had ten different medical problems (heart disease, diabetes, arthritis, kidney problems, and high blood pressure, to name a few). He also had eight different doctors, all of whom treated his separate medical conditions in isolation and none of whom coordinated his care with anyone else. He consumed twelve medications a day with no idea of how they interacted in his body. These problems were the main reasons he was hospitalized three times over the past six months. Ed represents a majority of chronically ill people who are treated by too many physicians, take too many drugs, and have no one coordinating their care.*

The managed care penetration in the 1990s, and the giant health care systems that formed in response to it, did little to unite the care

delivery process. In fact, these larger systems increase their ability to demand higher prices for services without any guarantee of quality service. So even if you have health insurance, this does not always translate into obtaining quality care services.

Avoiding the Economic Coronary

The United States spends most of its health care resources on hospital and medically focused care. Think about it. Over the course of your lifetime, you will spend less than 2% of your life in the hospital, and most of that cost will be in the last year of your life. Yet, hospital costs have become the biggest expense, not only for overuse but for needless spending with overpriced services. Two contributors to these escalating costs: lack of transparency and cost shifting.

Lack of transparency. A missing ingredient in health care today is price. How many of you actually ask the price of a service? Do you assume it is free? Have you ever bought a car and not known the final price for it? The reality is we have far more information available to us to compare and select a new car than we do to choose where to go for lifesaving health care. This ability to know the cost and benefit is called transparency. For example, if you have one MRI, and the price for that MRI is $6,000, then the cost is $6,000. However, if you have two MRIs (which is not unusual when you see a specialist who orders another one), then the cost is now $12,000. Health care providers increase prices that have nothing to do with costs of your care.

Cost shifting. When an uninsured person is in crisis and cannot pay, that burden falls upon the insured population, the hospitals, the doctors and the government. And these billions of dollars of “uncompensated care” drive up health insurance premiums for everyone, a process known as cost shifting. Cost shifting is a practice where hospitals actually “shift the cost of care” of uninsured people to those individuals who are insured.

As a condition to receive federal dollars, hospitals and emergency rooms have to provide care to people who need it, whether they are insured or not. However, the bill for their care does not simply vanish; it is passed onto everyone else in terms of higher fees to insurers, to business in terms of higher premiums, and to consumers in terms of

retail costs. Every provider in the health care system focuses on shifting costs rather than reducing them. The overall focus needs to be reducing costs.

The High Price of Ignorance

Over the past few years, many journalists have pulled back the curtain on inflated prices and the gouging of the American people. Exposés like the *New York Times* piece called "The Cure for the $1,000 Toothbrush" described how the lack of price transparency in health care contributes to its exorbitant costs and financial ruin for many Americans. The *Time* cover story entitled "Bitter Pill: Why Medical Bills are Killing Us" exposed the lack of price transparency in health care and the role of the "chargemaster" scam that penetrates hospital billing practices. The chargemaster is like a overcharged price list with fantasy figures set by the hospital alone. These are the $77 gauze pads, the $1,000 toothbrushes, the components that add up to the $200,000 joint replacement.

Americans pay more for almost every interaction with the medical system. As a nation, we are prescribed more expensive procedures and tests than people in other countries. Unfortunately, when we debate health care policy, we jump right to the issue of who should pay the bills, blowing past what should be the first question: Why are the bills so high in the first place?

Consider this. As computer technology became more ubiquitous, the overall costs came down. However, this principle does not work in the same way with medical technology, again due to supply-side demand. Just because it is available, should we expect society to pay for it? Think of all the motorized scooters you see advertised on TV along with a guarantee to get Medicare to pay for it. If Medicare is going to pay for it, then it must be medically necessary. And it is actually better for you to use a cane or a walker and regain function than to lose more function to a motorized scooter.

John's story. *John is a 77-year-old man with diabetes, poor vision, and heart problems, who was seen in the emergency room for chest pain. His physician put him in the hospital to run some tests. In fact, he was in the hospital for four days and became weak and unable to go*

home without significant help. The logical course would have been rehabilitation support before going home. But John was admitted under observation, which meant he would have to pay thousands of dollars for rehab, so he elected to go home. He received home care services (a nurse came for 30 minutes, twice a week) and some physical therapy (a therapist came three times a week for 45 minutes). John lived alone and needed help taking a shower and someone to get meals, shop, and take him to physician appointments. Those costs would have been $600 a week, so John elected to go without. He was readmitted to the hospital two weeks later. And during this time, his primary care doctor didn't even know he was hospitalized.

No one provider (hospital staff, home care staff) looked at the larger picture to help John obtain the services and supports he needed to succeed in his home independently. This reality plays out in thousands of homes daily across the country and is a main contributor to misuse of services and escalating health care costs.

No One Minding the Store

You would think that insurers who process the claims would read through them to determine if pricing is reasonable and that you are not paying $100 for one aspirin. But this practice does not happen, as no one takes ownership for these ridiculous costs. Insurance companies negotiate prices based on the inflated prices of chargemasters (which are made up). So if the hospital charges $100 for an aspirin, the insurance company negotiates it to $60, and you can buy it in a pharmacy for less than two cents a pill. These inflated prices are passed on to all of us in terms of higher premiums, deductibles, and co-insurance.

Insurance companies do not take ownership for inflated prices; they just pay the bill and passed the cost onto us in terms of higher premiums.

Too Much of a Not So Good Thing

While our health care system was originally designed to restore health, we have moved away from that mission. Over the past few decades, our health care industry morphed from a health-generating system into a wealth-generating system. Today, we spend $2.8 trillion on health

care, rank low in major health indicators, and have millions of people with no insurance.

Hospitals and health care services in general are very complex businesses. This makes their service quality opaque, with tremendous variation from provider to provider. This variation contributes to poor outcomes. For example, many of the known practices such as taking an aspirin tablet daily are not recommended, and outdated practices are prescribed daily. With new information doubling every five years, no one clinician can keep up with it all.

Today, our health care system is now a top-ten killer due to poorly coordinated care practices, lack of continuity of care, and inconsistency of information—not a comforting thought. Bigger health systems remain disconnected, and this lack of "connected care systems" leads to errors in important aspects of health care management—errors that have profound personal, economic, and health consequences.

A 1999 report from the Institute of Medicine revealed up to 98,000 people are killed each year from preventable medical errors—a situation that has not improved much over the past two decades. In fact, the latest Institute of Medicine report cites a leading study that quantifies the problem at nearly double the prior estimate (180,000 deaths) among Medicare beneficiaries alone, which would rank preventable harm as the number three cause of death in the United States after cardiovascular disease and cancer. One in four Medicare beneficiaries admitted to a hospital suffers some form of harm during his or her stay. Would you get in your car if you thought you had a one-in-four chance of being hurt during the drive? It is a fact that one visit in a hospital can lead to medication errors, deadly infections, and other mishaps. The story of unsafe hospital care has no villains; the breakdown stems from the incredible complexity of the system.

Staff in hospitals, nursing homes, and home care do not communicate with one another. Each organization gathers pieces of information needed to manage its own particular episode of care, with the focus on making money. The expectation is that the patient and family will

coordinate their own care and be able to fill in the missing pieces on their own. Imagine navigating the legal system without a guide.

FORCE NUMBER FIVE: THE OTHER DRUG WAR

If all you have is a hammer, then everything looks like a nail. As a culture, we've come to expect that for every ailment we have, there is a pill to fix it or at least improve it. Yet one in five prescriptions written for patients, especially elderly patients, are not needed. Common drugs used to treat allergies, depression, and pain are among the most overprescribed and also the ones most likely to produce adverse reactions. Too many of us take too many medications that cause too many side effects that lead to too many physician visits.

Polypharmacy and Your Life

Polypharmacy means the use of many medications at the same time by a person. The use of multiple, often unnecessary, medications, especially among older people, is an entrenched and mostly unexamined problem within our health care system today. Although medications can ease many conditions, multiple-drug use often exacerbates existing ailments and causes troubling side effects that are then treated with more drugs. In fact, the Institute of Medicine estimates that at least 1.5 million adverse drug events occur in the United States every year, thousands of them fatal. Approximately 30% of hospital admissions of elderly patients are related to medication toxic effects. Physicians often mistake physical responses such as memory lapse, fatigue, abdominal pain, swelling, or other ailments as a sign of worsening disease and not just a side effect. Actually, the solution is reducing the number of drugs.

How many of you take an acid-blocking medication for indigestion? Do you know that stomach acid is required for proper digestion, as well as absorption of vitamins C and B-12? Without these vitamins, you will develop other symptoms, such as tingling in hands and feet. And then this problem calls for other medications. It's endless and unneeded. Just stay away from crappy food that causes the indigestion.

Just Ask Your Doctor

Prescription drugs continue to consume larger pieces of the health care pie. In 1965 (prior to the enactment of Medicare legislation), prescription drugs consumed no portion of the health care pie; in 1990, the portion increased to 33% of the pie; in 2000, the portion had grown to 50% of the pie. And with the easing of direct-to-consumer (DTC) advertising in 1997, the "just ask your doctor" became the mantra for all and continues to drive up the use of unnecessary medications.

Emily's Story. *Emily took 28 pills a day, at five different times—some once a day, some twice, some three times, and some as needed. One pill had to be split in half for the morning dose but not for the evening dose. Some were taken with food, others on an empty stomach. She also used three different asthma inhalers plus a nebulizer, all on different schedules. Who can keep these types of medication regimens straight? Is it any wonder Emily has been hospitalized three times in the past year?*

Drugs in Search of a Disease

New drugs to sell a diagnosis such as obesity or GERD is known as "disease branding."

Thirty years ago, indigestion was treated with an antacid and recommended diet changes. People used to have heartburn; now it is called gastroesophageal reflux disease (GERD). Impotence is now erectile dysfunction (ED), and inattention is now attention deficit hyperactivity disorder (ADHD). These problems are now diseases, complete with a host of new drugs to treat them—drugs that have drastic side effects.

Unfortunately, biological changes such as wrinkles, impotence, obesity, inattention at school, and social anxiety have all become grist for the medical and medication mill. This reality begs the question: does the pharmaceutical industry manufacture diseases as well as drugs? The short answer is yes. Critics note that not every new disease for which the pharmaceutical business provides a drug is necessarily a major public health problem, but rather a venue for drug companies to increase revenues.

Disease Branding
To brand a disease is to shape public perception in order to attract potential patients or customers. This is usually done by telling people that the disease is taken seriously by doctors, that it is far more common than they ever realized, and that having it is nothing to be ashamed of. Fifty years ago, this kind of marketing was aimed mainly at doctors. Today, it is directed at you, the current and soon-to-be patient. In fact, drug ads are the most frequent ads seen on TV, right behind automobile promotions.

The Missed Opportunity
The Medicare prescription drug benefit, which passed in 2004 and became effective in 2006, handed millions of new buyers to the drug industry. At that time, the federal government had the opportunity to obtain discounts on prescription drugs due to the large populations that would now have coverage. Unfortunately, this legislation restricts the largest health care purchaser (Medicare) from negotiating with drug manufacturers for better pricing. Our seniors, the largest group and growing every day, pay the highest prices for medications in the world.

Consider this.The exorbitant drug pricing and the fact we have the most expensive drug costs in the world is due to one factor: pharma lobbyists influence health care legislation that prevents negotiating lower prices and prohibits U.S. citizens from buying drugs from other countries (drugs that Medicare will cover). It's disgraceful.

FORCE NUMBER SIX: POLITICS OF HEALTH CARE

Health care is a profitable business with too many procedures, producing mediocre results and contributing to someone's pocketbook rather than to a patient's health. It is the political calculus of the Medicare program that is a main contributor to our national debt problem. While there is a lot of rhetoric behind the scenes, there is no plan for managing aging populations and fixing the unsustainable costs of entitlement programs.

Washington owns the majority of the blame for putting the Medicare program on life support for the past 20 years. This insanity resulted from too many legislative acts that contained multiple loopholes

orchestrated by special interest groups. For too long and for too many years, politicians cut costs and restricted care instead of making the tough choices. Most legislation has been made on behalf of lobbyists from major interests groups and powerful stakeholders. These groups and stakeholders expect politicians to do their bidding, which promotes high incomes and return on investments for their companies. Imagine if politicians would change their focus from the next election to the next generation.

Too Much Patch and Pray

In addition to bowing down to special interest groups, too many important decisions made by Congress have been enacted in piecemeal fashion through unfunded mandates. For example, when the prescription drug benefit (passed in 2003 and effective in 2006) added millions of dollars in cost to the federal budget, there was no way to pay for it. Around the same time, taxes were cut for everyone. It is pretty easy to just decree that the world will have all its needs met and pretty difficult to choose which problems will be funded and which will not, based on limited resources.

Dying without Death

Finally, it is well documented that more than 60% of a person's total lifetime costs are in the last years of life. While dying is a natural process and a profound personal experience, it ends up being anything but natural. Most people want to die at home, yet sixty percent die in institutions. One of the main reasons people die in institutions is a lack of support. People at end of life require around-the-clock care, something beyond most families' ability to provide and ability to afford.

Most people want to die at home, yet sixty percent of people die in institutions. Where is your voice?

Peter's story. *Peter was a 78-year-old man who lived with his spouse in their home of 35 years. Peter had end-stage respiratory disease and was on oxygen 24/7. As his condition worsened, he and his wife decided to have him die at home. As he inched closer to death, his wife became frightened and called an ambulance to take him to the hospital. He did not have hospice support or people available to assist*

him. Effectively managing end-of-life care requires professional help, and had they known, this would story have had a different ending.

Most Americans don't deal with end-of-life issues and wishes. Ask yourself: have I completed an advance directive? Have I made my wishes known to my family? Do I know of resources available to help with this conversation, as well as with the care? Much of hospice care is covered by insurance, yet too many wait too long and then panic. The more you can address before a crisis, the more prepared you will be when it is time.

So there you have it. Six areas that led us to the health care asylum that we have today. Aging populations with finite resources, increased numbers of people with many chronic illnesses, too many uninsured people priced out of the market, ineffective pricing practices, supply-side demand, unneeded and overdosing on prescription drugs, too many errors without consequences, and the political nature of health care policy.

Chapter 3

Where We Go From Here: Health Care Insurance Reform

Fifty-four-year-old Benjamin had no insurance and no plans to be sick. However, he didn't count on the car that ran a red light and put him in the hospital for two weeks. Add the four-week rehab stay that followed and, in less than two months, Benjamin had run up a medical debt of more than $150,000. Prior to his accident, Benjamin had high blood pressure and diabetes, which was discovered at a free clinic, but since he didn't have insurance, these conditions were never treated.

Two activities known to improve health outcomes are insurance coverage and an ongoing relationship with a consistent source of care.

To navigate and understand the winding roads of health care delivery and improve your health, you need to have access to a quality insurance product and a consistent source of care—one in which you develop a positive and trusting relationship with local providers. This chapter reviews key aspects of the new law that standardizes health plan benefits, changes insurance industry practices, expands coverage to uninsured, and refocuses on prevention.

STANDARDIZING HEALTH PLANS

The Affordable Care Act (ACA) pulls you into the process of selecting and purchasing your own health insurance policies. To purchase an insurance policy that best fits your needs, you need a consistent way to compare health plans based on their benefits and costs. Standardizing plans allows you to compare them equally with an apples-to-apples approach.

Prior to 2014, insurers often used varying benefits in health plans to attract and enroll healthier people and avoid individuals with expensive health conditions. Low-cost plans attracted people, who bought these “mini med” plans that offered bare-bones benefits such as a $2,000

contribution to a hospitalization. Since a hospitalization can easily run over $30,000, this coverage is of little help when needed. However, people who bought these plans did not realize it until it was too late.
Now, all states must offer standard benefit categories and packages that provide choices of various plans, including monthly premiums, annual deductibles, annual out-of-pocket maximums, doctor visits, drug coverage, ER copays, and hospital coverage.

Coverage Levels
Insurance companies offer four levels of coverage, also known as coverage tiers: bronze, silver, gold, and platinum. Lower-priced premium plans (bronze) have higher deductibles and larger out-of-pocket costs; higher-priced premium plans (platinum) have lower deductibles and out-of-pocket costs.

- Bronze-Level Plans are required to cover 60% of costs. These plans have the lowest monthly premiums and higher out-of-pocket costs when you receive medical care. Bronze plans are a good option if you expect to use just a few health services during the plan year, such as getting an annual physical and a few monitoring tests, such as lab work.
- Silver-Level Plans are required to cover 70% of costs. Monthly premium is generally higher than premium of a Bronze-level plan, with moderate out-of-pocket costs when you receive medical care. A good option if you want to balance your monthly premium and out-of-pocket expenses.
- Gold-Level Plans are required to cover 80% of costs. Highest monthly premium, with lowest out-of-pocket costs when you receive medical care. A good option if you expect to use many health services during the plan year, such as procedures, doctors, and medications.
- Platinum-Level Plans are required to cover 90% of costs. Highest premiums**.** Lowest copays and deductibles. For heavy users of health care services.

Catastrophic Simple Plan. In addition, all states will offer a simple plan designed for individuals under the age of 30 or individuals who cannot afford a traditional health plan.

Pay Attention When Choosing

If you have high health care costs, there are significant implications for the plan level you choose. Gold and platinum plans will have lower deductibles, copayments, and co-insurance for health care services, but will have much higher monthly premiums. Conversely, bronze and silver plans will have lower monthly premiums, but could expose you to significant out-of-pocket costs for each health care service over time.
If you have high medical expenses, it is tempting to gravitate to platinum plans, because they cover more out-of-pocket costs. If you have few or no medical challenges, it is tempting to choose bronze plans, because the premiums are lower.

Subsidies for Low-Income People

The ACA provides assistance to low- and moderate-income people who need help paying insurance premiums and out-of-pocket expenses.

A subsidy is based on the *premium for the second-lowest cost silver plan* available. A silver plan will cover 70% of the average costs, with the enrollee paying, on average, 30%. However, if you decide to purchase a gold or platinum plan, you will need to pay the difference between the premium amount and the cost of the more expensive plan. This may be a good choice, since you will get a more generous level of coverage of 80% of costs (on average).

Buyer beware. Be careful of the terms *copayment* vs*. co-insurance.* Copayments are fixed dollar amounts paid at the time of transaction, for example, $50 for an ER visit or $35 for a physician visit. Co-insurance is a percentage of the total amount of the cost. For example, some plans require a 35% co-insurance for a hospital stay. So, if a hospital bill costs $20,000, then you owe $7,000 out of your own pocket. If a hospital bill climbs to $50,000 or $100,000 (which is not uncommon), then you may owe $17,500 to $35,000. There is a huge difference between a $35 copay and 35% co-insurance. Pay attention.

DEFINING ESSENTIAL HEALTH BENEFITS

The ACA makes a number of changes to private health insurance plans. One important protection is establishing a package of essential

health benefits. As you read earlier, many health plans offered, especially to low-wage workers, were considered “bare bones,” which does not provide adequate coverage when needed.

The ACA addresses both problems by requiring most health insurance to contain, at minimum, a set of core benefits called *essential health benefits*. Essential health benefits are intended to mirror those provided under a typical employer-sponsored health plan and include the following ten benefit requirements:

1. Ambulatory patient services, such as doctors’ visits and outpatient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services

While the ACA requires coverage for each of these categories, the law does not define the specific services that must be covered or the amount, duration, or scope of services. In addition, insurers must cover certain services as specified by state laws.

A word about reproductive health. At the time the ACA was passed and to date, controversy continues around coverage for birth control as well as abortion. This is a long-standing and complicated issue that will not resolve soon, if at all.

Cost Sharing with Essential Health Benefits

The ACA links the essential health benefits package to limits on cost sharing. So, health plans required to provide essential health benefits are also required to limit the amount you will pay out of pocket. Specifically, health plans will be prohibited from requiring consumers to

pay annual cost sharing that is greater than the limits for high-deductible plans linked to health savings accounts. This gets confusing, so check with your insurance carrier for specific details in your policy.

CHANGING HEALTH INSURANCE INDUSTRY PRACTICES

The passing of the ACA changes the way health insurance is purchased and is used by you, the consumer. While some of these changes began right away with popular benefits such as allowing parents to keep their adult children covered until age 26 and establishing temporary high-risk pools for the uninsured, many changes are phasing in over a ten-year period, from 2010 through 2020. In 2014, the more significant provisions began, and what follows is a summary of key changes.

Removing Barriers to Access

Starting in 2014, the law prohibits insurers from denying coverage to sicker people or imposing special conditions such as higher premiums or payments.

It is well documented that 80% of health care costs are concentrated to 20% of the population. Now, insurers are focusing on this 20% by allocating resources to keep them out of expensive places such as hospitals or emergency rooms and better coordinating care using case management techniques. This turnaround would not have happened without the health care law. Imagine the health care industry actively avoiding people who were really sick? It has been backward for a long time.

More money to actually pay for health care services not administrative costs and CEO bonuses.

Putting the Money Back into Care

The ACA narrows the medical loss ratio (MLR) limits for insurers. A *medical loss ratio* is the ratio of total losses incurred (claims) plus adjustment expenses divided by the total premiums earned. For example, if an insurance company pays $70 in claims for every $100 it collects in premiums, then its loss ratio is 70%.

The ACA requires that at least 80–85% of premium be spent on care services, depending on the size of the specific market. This means that large insurers have to spend at least 85 cents of every dollar on care. Prior to this mandate, insurers had no restrictions on the amount spent on care or the amount going to profit and administration.

Prohibiting Lifetime and Annual Caps

The ACA restricts the dollar limits a health plan can place on benefits. Before the health care law, many health plans set an annual limit (a dollar limit on their yearly spending for a person's covered benefits). Many plans also set a lifetime limit (a dollar limit spent on a person's covered benefits during an entire lifetime while enrolled in that plan). Once the limit was reached, individuals were required to pay all costs that exceeded those limits.

One exception to this change is that plans are still able to place an annual dollar limit and a lifetime dollar limit on spending for health care services that are not considered essential. Those essential benefits were described earlier.

Alleviating the Burden of High Health Care Costs

Over the years, the increasing costs of health care services, coupled with increasing cost sharing and lifetime caps on spending, forced many people into bankruptcy. *In fact, the number one cause of personal bankruptcy in this country is health care debt.* It is a sad commentary that the richest country in the world allows its citizens to go bankrupt due to medical bills.

The number one cause of personal bankruptcy in this country is health care debt.

These high health care costs are due to inefficiency and waste, as well as out-of-control pricing. While we continue to debate health care policy, arguing who should pay these bills, we blow past the key question that needs to be answered up front: why are the bills so high? This problem of high health care costs was not well addressed with health care reform. While the ACA was promoted as a way to reduce costs, the jury is still out on affordability.

BUYING INSURANCE THROUGH HEALTH INSURANCE EXCHANGES

If you are not getting insurance through your employer, a government program (such as Medicare or Medicaid), or other source, you are now required to purchase health care coverage through an exchange that has been set up in your state. An *insurance exchange* is an independent marketplace that compares plans from your state's major insurance carriers. Over the past couple of years, two types of exchanges have emerged.

1. Public exchanges are set up by federal or state governments and are part of the ACA. For states that did not set up an exchange, the federal government stepped in and set one up for them. Despite the rocky rollout in October 2013, the federal exchanges continue to sign up thousands of people every day.
2. Private exchanges are set up by private companies and mirror the public exchanges. The difference is that companies are moving their retirees into these privately run company exchanges, and more private companies could eventually move their current workers into the same model. These private exchanges are a result of companies looking to lessen the cost burden of employee and retiree health care coverage. The end result is that you now have to choose which coverage plan suits you best at a time of rising complexity in the health care system.

ENFORCING MANDATES

A major provision of health care reform will add about 40 million people to the coverage rosters going forward by expanding access to insurance for people currently uninsured. When the ACA was first passed in 2010, these mandates were challenged by 26 states and explored by the Supreme Court in its 2012 deliberations. The debate around this mandate centered on Congress's ability to regulate interstate commerce. However, the constitutionality of this mandate was upheld under Congress's ability to levy taxes and not under the commerce clause.

The Individual Mandate
The ACA mandates that most individuals have health insurance or potentially pay a penalty for noncompliance. According to the mandate, individuals will be required to purchase health insurance regardless of their situation, and maintain minimum essential coverage. Some individuals will be exempt from the mandate or the penalty, while others may be given financial assistance to help them pay for the cost of health insurance. The rationale is to build a larger pool of covered people (healthy and ill) to spread the risk around a larger number of people, known as risk-sharing.

The Employer Mandate
Companies with more than 50 employees are required to offer health insurance to their full time employees. Employers are complaining about how this cuts into their bottom line, so they are reducing staff under 50 or dropping their employees' hours to part time to avoid this expense. Until the overall costs of health care come down, it is unreasonable to require businesses to add that cost to their payrolls. The employer mandate continues to be delayed at the time of this publication.

EXPANDING COVERAGE TO THE UNINSURED

In addition to requiring all to have health insurance coverage, the ACA also expands Medicaid coverage to a larger number of people. When the ACA was first passed in 2010, this coverage expansion was also challenged by 26 states and was explored by the Supreme Court in its 2012 deliberations. The debate concerning this requirement was the mandate for all states to expand their Medicaid programs or lose all federal funding. The ACA expands Medicaid to a national eligibility floor of 138% of the federal poverty level (FPL) and provides significant federal funding for this new coverage.

Although the Medicaid expansion has received less attention in recent months, it remains a flash point at the state and federal levels. The issue has split the nation in half and has become a broader debate over the role and responsibilities of government. Medicaid was created as part of the same law that established Medicare. States were given the option to participate. Within seven years, all had joined except

Arizona, which did not climb aboard until 1982. Although states were required to cover certain groups such as low-income children, they traditionally have had broader leeway in running their programs.

The Supreme Court upheld this ruling as constitutional but limited the federal government's ability to enforce the Medicaid expansion, effectively making implementation of the Medicaid expansion a state choice.

Before the ACA, the federal government shared Medicaid costs with the states, with the federal government paying on average 57% of the total amount. The original language in the ACA required states to expand their Medicaid coverage up to 138% of the federal poverty level (FPL) or risk losing all federal funding. So now, states can choose not to expand yet keep that baseline federal funding match for current Medicaid recipients.

If individual states accept this provision to expand Medicaid, the federal government will cover the total cost for Medicaid expansion for three years. That's right, 100% match rate from the federal government from the current matching level, up to 138% of FPL. By 2020, the federal government will cover only 90% of the bill.

This reality questions how the federal government will pay for this expansion, as this essentially guarantees people at or under 138% of FPL access to health care services, with the federal government picking up the tab. Because of its roots as a welfare program, Medicaid has long had an image problem.

Medicaid is not an entitlement program; it is a welfare program

REFOCUSING ON WELLNESS AND PREVENTION

Talking about wellness and prevention reminds me of a story I heard decades ago, when managed care was in its early phase. Imagine people lining up at the top of a cliff, walking forward, and falling off that cliff. Ambulances were waiting at the bottom to take the ill and injured away after falling more than 100 feet from the top. The more people who fell off the cliff, the more ambulances that were needed.

But what if we prevented them from falling in the first place by erecting a fence? We would save people the pain and injury, as well as the expense of caring for those injuries.

Covered Preventive Services

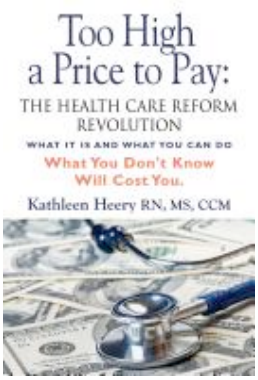
Under the ACA, there is no cost sharing for certain preventive health services recommended by the U.S. Preventive Services Task Force. This means that no health plan can apply a deductible or any cost sharing for certain *preventive health services*. Many screenings have been essentially useless for the uninsured, because if something was found, there were no resources to treat the problem. This incentive encourages all of us to obtain the screens we need every year.

Employer-Based Wellness Incentives

Under the ACA, businesses will be able to provide employees with carrots and sticks regarding their health care insurance. For example, workers who participate in wellness program activities such as health screenings or weight loss initiatives can be offered a premium differential. And, if the program is focused on preventing or reducing tobacco use, employers can be offered a reward. By law, incentivized wellness programs must be designed to improve health or prevent disease among employees, and companies reward workers with premium discounts, cash, gym memberships, and more, for their participation.

Nutritional Information

Buried in the middle of the ACA is a mandate that will require very visible changes at chain restaurants across the country. Chain restaurants with 20 or more outlets must post the caloric content of menu items on printed menus, menu boards, and drive-through displays, as well as provide more detailed nutrition information to customers upon request. The provision also applies to food and beverages sold in vending machines.



After many years in the health care and insurance industries, author Kathleen Heery MS, RN, CCM was struck by the reality that health care services could better align with health and that the chaos and expense in receiving these services could be better coordinated. The Affordable Care Act, also called Obamacare, began these changes but at what cost? A great shift in how we receive health care services is underway - one that places more responsibility on you for both cost sharing and decision making. While it may seem confusing and overwhelming, it is possible for you to learn about health care reform, why it had to change, where we go from here and most importantly what you can do. Obamacare continues to shake up the world of health delivery and to survive it you need a clear understanding of issues as well as focused approaches to negotiate health decisions, navigate health care systems and advocate for personal health needs. This book provides the roadmap to make these shifts with simple and organized directions. • Discover the 10 forces that brought the health care industry to its knees. • Identify the 12 major changes brought about by health care reform. • Adopt these eight (8) steps to help you navigate the new landscape and direct your personal health experiences.

Too High a Price To Pay