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# Defining the Problem and Searching for Solutions: Health Care Providers and Consumers

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## VI. DEFINING THE PROBLEM AND SEARCHING FOR SOLUTIONS: HEALTH CARE PROVIDERS AND CONSUMERS

RICHARD BUXBAUM  
FRANK KIMBER  
HENRY MANNING  
DAVID W. VAN HEECKEREN, M.D.  
Moderator: NANCY ROTH

### A. PROFESSOR WEINSTEIN

Thank you very much, Bob. We are now going to move to the first of our morning panels on defining the problem and searching for solutions. This panel consists of health care providers and consumers, and I will ask the panel members to please come forward as I call your name and introduce you. First, we have Richard Buxbaum, Senior Vice President, Greater Cleveland Hospital Association; Frank Kimber, Associate Director of the Federation For Community Planning, and Director of the Commission on Health and Services; Henry Manning, President and Chief Executive Officer of the MetroHealth Medical Center; Dr. Daniel W. van Heeckeren, Physician at University Hospitals and the past President of the Academy of Medicine of Cleveland, and our Moderator is Nancy Roth, Executive Director of the Health Systems Agency of North Central Ohio.

### B. NANCY ROTH

The Health Systems Agency has been interested in health care for the uninsured since its inception in 1982, specifically in terms of the relationship of cost and access issues. For that reason, it's a great pleasure to be part of this Conference today. The panel seated here has been charged with the task of defining the problem of the uninsured from the perspective of health care providers and consumers.

Our first speaker is Dick Buxbaum who is Senior Vice President of the Greater Cleveland Hospital Association. The Hospital Association has been monitoring the impact of providing health care for the uninsured for several years and was involved with the Health Systems Agency evaluation of legislative options for the uninsured and with the Federation for Community Planning's demonstration project which we will discuss later.

### C. RICHARD BUXBAUM

Good morning. Thank you Nancy. It is a pleasure to be here this morning, and I want to especially thank Alan Weinstein for inviting me to speak to you today. The subject matter, "Ohioans Without Health Insurance: How Big A Problem? Are There Solutions?" certainly is an important one for the hospitals which my organization represents. I want to try to tell you what kind of a problem this issue is for hospitals this

morning. The Greater Cleveland Hospital Association represents approximately fifty hospitals in an eighteen county area in Northeast Ohio. For the most part our members are located in Cuyahoga County and adjoining counties. In the past several years the Association has played an increasingly active role in advocating points of view of our members on various issues.

Traditionally, the Association, which is one of the oldest in the country, having been founded in 1916, has been very active in efforts to contain hospital costs through shared service programs, an example of which would be our continuing programs in group purchasing, insurance and related matters. We do know that some of those programs have laid a base upon which others have built. We also have very active programs for hospital trustees. GCHA's long term care affiliates have been working in the fields of trauma, quality measurement, allied health care and nursing. However, a particularly persistent problem has been what we call uncompensated care, what the public has come to know and understand as charity care.

## 1. THE UNCOMPENSATED CARE CRISIS

In 1988, the Greater Cleveland Hospital Association membership provided 129.8 million dollars of so-called uncompensated care.<sup>1</sup> Several years ago we published a report entitled "The Uncompensated Care Crisis. Ten Questions for Northeast Ohioans," and a copy of that report, as I understand, is in the packet you received today. You can read that at your leisure. In that publication, we indicated that uncompensated hospital care is care for which no one pays directly. Hospitals classify some of this as charity care, and such charity care was about fifteen percent of that total in 1988.<sup>2</sup> And bad debt is the rest. That remainder, the bad debt, is the cost of providing care for those patients who are presumably able to pay, but who do not. And much bad debt results when insurance coverage is inadequate to meet the high cost of catastrophic illness or because a patient can not afford required co-payments or deductibles. Bob Eckardt mentioned that it is an increasing problem as insurance companies require patients to pay part of their responsibilities.

## 2. THE COST-SHIFTING PHENOMENON

Hospitals have usually passed this uncompensated care on to patients who pay their bills either individually or through their insurance program, the so-called "cost shifting phenomenon." So, in other words, paying patients subsidize those who do not. I should be quick to add, however, that the social mission of hospitals throughout the country—and certainly in Northeast Ohio and Cleveland, especially for those hospitals that are organized on a not-for-profit-basis, which include ninety-nine percent of the hospitals in Northeast Ohio—includes providing free care. However, the situation that we have now is such that uncompensated care rose

from \$113.9 million in 1987 to \$129.8 million in 1988, about a 14.5% increase. Especially in the inner-cities, we've come to understand that hospitals will not turn folks away who come to the emergency room or selective clinics. So, we have a social mission that says hospitals that are organized not-for-profit will provide the care and, traditionally, as a rule, will not turn the uninsured away for emergency treatment.

### 3. THE UNCOMPENSATED CARE BURDEN

On the other hand, with the 14.5% increase from 1987 to 1988—to \$129.8 million, this philosophy is increasingly being scrutinized.<sup>3</sup> In fact, this \$129.8 million is over one-third the state-wide uncompensated care burden which hospitals assume. And so, while it is also true that some recent attempts to address this problem have been initiated, for example, the so-called "care assurance program," which last year in the state legislature provided an influx of about 27 million dollars annually to area hospitals, there still remains a significant and growing portion of this uncompensated care.<sup>4</sup> I might add that the care assurance bill was philosophically opposed by our hospital members as a tax, just on hospital patients, in which case we felt the problem was more a societal problem that should, if there is a tax, be spread more evenly. On the other hand, these funds were matched by the federal government, and no hospital was held liable, so that certainly was a help. As a matter of fact, the number of greater Clevelanders without any health insurance increased 35.5% to over 213,000 individuals between 1980 and 1988.<sup>5</sup> So this problem is pressing the health care system to the limits in the amount of care that can be provided.

### 4. HOSPITALS CONCERN FOR LONG-TERM FISCAL SOUNDNESS

We have been telling the media, from the Association base, that the cost of the increasing amount of uncompensated care due to the unwill-

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<sup>1</sup> See generally KIMBER, KURANT & CARLSON, UNCOMPENSATED HEALTH CARE IN CUYAHOGA COUNTY, FEDERATION FOR COMMUNITY PLANNING (1985).

<sup>2</sup> See generally AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS 1988 EDITION, DATA FROM THE AMERICAN HOSPITAL ASSOCIATION 1987 ANNUAL SURVEY (1988); Blendon, Aiken, Freeman, *Uncompensated Care by Hospitals or Public Insurance for the Poor: Does It Make a Difference?* 314 NEW ENG. J. MED. 1160-63 (1986). See generally SULVETTA & SWARTZ, THE UNINSURED AND UNCOMPENSATED CARE: A CHARTBOOK, NATIONAL HEALTH POLICY FORUM (1986).

<sup>3</sup> *Id.*

<sup>4</sup> OHIO REV. CODE ANN. § 3702.04-06 (Baldwin 1988).

<sup>5</sup> See also GENERAL ACCOUNTING OFFICE, HEALTH INSURANCE: A PROFILE OF THE UNINSURED IN OHIO AND THE NATION (1988). See generally Austrian & Cleeton, THE MEDICALLY UNINSURED: A FOCUS ON THE CLEVELAND SMSA. THE CENTER FOR REGIONAL ECONOMIC ISSUES (1989).

ingness of third-party payers — be they government, or private insurance, or Blue Cross/Blue Shield or a commercial insurance — to absorb cost-shifting to the paying patients has increased hospitals' concern for their long-term fiscal soundness. Whereas, hospitals may be incorporated on a not-for-profit basis, this does not mean that they do not operate without targeting sums necessary for replacement capital and for clinical programs. As someone said, "we're not for profit but we're also not for loss." In the recent past, hospitals in Ohio, after adjusting for inflation, have been experiencing a minus two percent net gain over-all from patient revenue. These figures were developed by the Hospital Financial Management Association under the supervision of Professor William Clev-erally of Ohio State University.

As Bob Eckardt has also explained, there has been an alarming increase in our rate of hospital expenses, and these were expenses over the years of 1978 and 1988. This data is indicative of the alarming rate of increase in hospital expenses, as reported by the American Hospital Association, of hospitals in the statistical metropolitan area of Cleveland.

In an attempt to focus on their problems this past year, the Association, in conjunction with the Federation of Community Planning, commissioned an analysis of the medically uninsured. This was performed by the Center for Regional Economic Issues at Case Western Reserve University,<sup>6</sup> and in a minute I'm sure Frank Kimber will tell you more about the analysis initiated by our combined initiative with the Federation and the County for a demonstration project to provide benefits to the low-income working poor, that large sector in the service economy, that Bob Eckardt described as working, but having no health insurance. We think this will be a particularly effective way of proceeding and certainly in line with what the Administrator of the Health Care Financing Administration, Gail Wilensky, proposed in her speech a year ago here in Cleveland. Dr. Wilensky indicated that she felt strongly that the best approaches were those which were "incremental" and tailored to regional communities. So, what works in Dayton may not necessarily work in Greater Cleveland.

## 5. MANDATING EMPLOYER BASED HEALTH INSURANCE COVERAGE

We are especially mindful of the fact that mandated, employer based insurance coverage, for example, which was introduced in Massachusetts, is attractive to some elements.<sup>7</sup> But we are also mindful of the fact that the hospitals in Massachusetts supported that program on the basis that

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<sup>6</sup> *Id.*

<sup>7</sup> See Sager, Hiam & Socolar, PROMISE AND PERFORMANCE: FIRST MONITORING REPORT ON AN ACT TO MAKE HEALTH SECURITY AVAILABLE TO ALL CITIZENS OF THE COMMONWEALTH AND TO IMPROVE HOSPITAL FINANCING (1989); see also *Fight Looms over Mass. Plan*, 19 MODERN HEALTH CARE 4 (Aug. 4, 1989); *Massachusetts Legislators Debate Fate of Universal Plan*, 23 BUS. INS. 1 (Sept. 4, 1989).

the state promised a contribution to the uncompensated care fund for hospitals. However, when the going got rough, the state ledger was in peril, and what we saw was that Governor Dukakis, who was in the midst of the campaign for the presidency, came home to Massachusetts and was quick to evade that promise. Hence, the hospitals are having to sue the state for that promise not kept. So, the question that no one seems to be able to answer effectively is just who should be paying the tab and in what amount. The insurance industry and business concerns certainly have made their positions clear, and the federal government's response has been largely to defer responsibility to the states. The result has been a patchwork of solutions ranging from risk pools to direct subsidies. Other approaches that have been proposed include the use of lottery proceeds, income tax checkoffs and so called "sin taxes" on alcohol and tobacco.<sup>8</sup>

## 6. A CRITICAL JUNCTURE

We feel that the time has come for a hard look, and if hospitals are to be left to solve the uncompensated care problem on their own, and insurance programs and/or the business community, and/or the states are not going to assume hardship approaches, hospitals are going to be forced to initiate cuts in services. And, as has been publicized in the local press recently, hospitals are doing their share to streamline their organizations, as evidenced by the layoffs in personnel that you have been reading about. Few cities in America realize better than Cleveland what the impact of a financially sound health care system has on its citizens. We have built a reputation for quality and excellence that has enabled us to enjoy a superior level of care, at least for those persons who are treated in the hospital. Increasingly, hospital care is rendered on an out-patient basis, and that will be part of the challenge for the future. However, let me again emphasize the critical nature of our plight. Last year, the National Committee for Quality Health Care issued a report titled "Critical Conditions: America's Health Care in Jeopardy." I want to show you a chart the Committee published in that report. This chart indicates that in about 1986, there was a severe downturn, and it was projected that profit margins for hospitals would reach the minus three percent level in 1989. Actually, it is below that mark now. So, unfortunately, we are ahead of schedule in terms of the net operating gains that hospitals are achieving from patient revenue. In short, that report's forecast has come to fruition more quickly than expected.

## 7. THE NEED FOR A PUBLIC POLICY APPROACH

The report stated, as a matter of fact, that we must develop a public policy assuring adequate access to health care for all our citizens; and to

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<sup>8</sup> See *Congress to Study Health Plan Tax, Many Other Issues*, 24 BUS. INS. 1 (Jan. 22, 1990); see *Politics Kills Indigent Care "Sin" Tax and Lottery*, 63 HOSP. 70-72 (Sept. 5, 1989); see *States Use Pools and Tax Credits to Help Uninsured*, 31 AM. MED. NEWS 31 (Sept. 9, 1988);

do this, we must of course rule out fraud, waste and abuse of the system. But that would not alone be sufficient; we must also provide adequate funding for all of our health care providers. Last year in Washington, the Association attempted, along with other hospital associations throughout the country, to acquire the resolution of selected Congressmen and Senators on a proposal to limit additional cuts in Medicare. Incidentally, Medicare does not pay the full cost of care. This certainly has been part of the problem vis-a-vis the bottom line—some hospitals having been paid the standard way, some fifteen percent less on the dollar than the actual cost. As testimony to our members' willingness to work with our various constituents to come to appropriate solutions, I would like to note several actions that the Association has initiated.

First, as I mentioned briefly — and Frank will talk about in a minute, I am sure — our joint project with the Federation to provide a low income benefit package for the working poor. Second, our sponsorship of various state bills to provide risk pooling. And third, our recent work with the Health Action Council and Cleveland Tomorrow on the assessment of the quality of care in hospitals in order to allow large business purchasers to make intelligent decisions about where they wish their health care benefits to be rendered. We have some cautious skepticism about the business point of view in that regard. However, insofar as the business community might wish to reduce its expenses, it is not necessarily taken *a priori* that those savings will go to the indigent care problem.

In summary, our hospitals' highest priority must be to continue providing hospital care to both patients who do pay, and those who do not. However, an equitable approach to funding uncompensated care will be found when all parties involved — and that includes government, insurers, the hospitals and patients — work together towards a solution. This may require some commitments from certain segments of the community and some accommodations by the hospitals to render care in slightly different ways. We feel it is also fitting that reforms in the health care industry are instituted in a cooperative effort with these various parties, and that these can, in fact, be a model for the nation, starting from this base right here in Northeast Ohio. Thank you for your attention. I look forward to the rest of the Conference.

#### D. NANCY ROTH

Our next speaker is Frank Kimber, Associate Director of the Federation for Community Planning, and Director of its Commission on Health Concerns. The Federation has been involved in addressing problems associated with health care for the poor for ten years and has sponsored the development of several programs, including the outreach health program for homeless men, women and children. Moreover, the Federation was recently funded by the state to operate a demonstration project for the employed uninsured.

### E. FRANK KIMBER

I'd like to do three things. First, to share some observations from the consumer side of the uninsured problem. Second, to suggest taking an incremental approach to addressing the problem of the uninsured in Ohio. And finally, to present an overview of the local demonstration project for which the Federation has been funded in cooperation with the Greater Cleveland Hospital Association and the Board of County Commissioners. Gail Wilensky, (health policy analyst with Project Hope and now HCFA Administrator) suggests an incremental approach to this complex problem. For purposes of formulating policies and strategies, the uninsured population can be segmented into three sub-groups.

#### 1. CONSUMER SIDE OF THE UNINSURED PROBLEM

The first group are the uninsurables; those people with pre-existing medical conditions that nobody wants to cover, at any price. That's a separate group. In Ohio, we are talking about eight to ten percent of the uninsured population falling into that medically-high-risk uninsurable category.<sup>9</sup> The second group is comprised of mostly single adults not in the work force. That group includes our homeless here in Cleveland—some 10,000 people at any given point in time; the chronically unemployed; and uninsured adult students. Cleveland has a high concentration of uninsured college and university students. A population without insurance for a variety of reasons.

Then we come to the third group: people who are working at low wages or the working poor and uninsured. That is the largest group. We are talking about seventy percent of Greater Cleveland's uninsured in the category we call *the working poor*.<sup>10</sup>

Who are these people? You see them on Saturday when you go to the shopping malls. They are the laundry workers, retail clerks; they are shoe shop repairmen, security guards, and other low salaried workers. They work in small service industries, as Bob Eckardt indicated, and those industries, for a variety of reasons, do not offer health benefits of any kind. They make up the most significant segment of the uninsured population.

Another contributing factor in this complex issue is the high cost of health insurance premiums. Bob Eckardt noted, and Dick Buxbaum con-

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<sup>9</sup> See also Laudicina, *State Health Risk Pools: Insuring the "Uninsurable"*, 7 HEALTH AFF. 97 (1988). See generally GENERAL ACCOUNTING OFFICE, BRIEF REPORTING TO COMM. ON LABOR AND HUMAN RESOURCES, U.S. SENATE HEALTH INSURANCE: RISK POOLS FOR THE MEDICALLY UNINSURABLE, (1989).

<sup>10</sup> See F. KIMBER, OHIO/GREATER CLEVELAND'S MEDICALLY UNINSURED: THE CONSUMER SIDE OF THE PROBLEM 1 (1989); see also GENERAL ACCOUNTING OFFICE, HEALTH INSURANCE: A PROFILE OF THE UNINSURED IN OHIO AND THE NATION (1988); see also Austrian & Cleeton, *The Medically Uninsured: A Focus on the Cleveland SMSA* (1989).



ceded that rising health care costs have paralleled escalating costs of insurance premiums in Cleveland. For example, according to the 1988 General Accounting Office Study, over a ten year period, health care premiums costs in the Cleveland market increased 280 percent for the employers.<sup>11</sup> That's a very real barrier to affordable health benefits for the working poor.

## 2. THE WORKING POOR AND THE HIGH COST OF ILLNESS

Poor people, especially working poor people, like non-poor people, value some kind of protection against the high cost of illness. They value some kind of health benefits, if they are going to work. We have to look at health benefits not as a luxury but as a necessary support that enhances people's ability to function in society. Poor people have some of the same values as non-poor people. They want protection against the costs of health care. They want it for themselves and for their children. We did a 1987 study of 600 welfare mothers to try to learn something about their attitudes, practices and behavior with respect to health care.<sup>12</sup> One of the most significant findings, was that forty-one percent of these mothers said, "Yes, I think I could find a job on my own to make enough to live on so that I could get off of welfare, *but only* if I can keep my Medicaid card."

I think that is very instructive from a policy perspective. Most poor people want to work, but they also want the same kind of benefits that all of us who work have had for the past forty years. Beginning in 1950 up to 1980, eighty-seven percent of all Americans had some kind of insurance.<sup>13</sup> And seventy-five percent of those insured Americans were covered at their place of work—not unlike you and me. Poor people want the same.<sup>14</sup> When poor people get sick in this town, care is available. There is little evidence to document widespread denial of care. Denying or delaying needed health care are not widespread practices here, as has been reported in other communities. Poor people may not get care at the appropriate time and the appropriate place, but for the most part, they receive care.

Where do they get it? Some use hospital OPD's as their source, others use health clinics: Hough-Norwood, Clements, city health clinics on the West Side and East Side. But they too face the same kind of financial problems that hospitals face. They can no longer afford to absorb increased numbers of non-paying or unsponsored patients any more than the hospitals sector. We did a study in 1986 of selected ambulatory facilities in Cleveland. Of the sick people going into those selected ambulatory facilities within the central city of Cleveland, only twenty-three percent of

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<sup>11</sup> See GENERAL ACCOUNTING OFFICE, HEALTH INSURANCE: A PROFILE OF THE UNINSURED IN OHIO AND THE NATION (1988).

<sup>12</sup> Sterin, *Ohio's Medicaid Consumer Survey*. (The Federation For Community Planning) (1988).

<sup>13</sup> See F. KIMBER, *supra* note 10, at 6.

<sup>14</sup> *Id.*

sick patients had health insurance of any kind, private or public. Among these sick patients showing up for ambulatory care, only sixty percent could afford to pay anything toward the cost of care.<sup>15</sup>

As the problem of the uninsured increases in this community, public subsidy for care of indigent or charity patients has leveled off. Cuyahoga County subsidizes the Metro Health System but that level of subsidy has stabilized. United Way Services subsidizes certain non-profit hospitals for so-called charity care to help defray some of the costs. That has stabilized. Meantime, the problem has escalated.

### 3. JOINT PILOT PROJECT TO INSURE THE WORKING POOR

Now, some brief comments about the local initiative. It is a modest approach. It is a joint partnership effort between the Greater Cleveland Hospital Association, the Board of County Commissioners, with the Federation serving as fiscal and project management agent. Its goal is to test feasible ways of insuring the working poor on a demonstration basis. Why the working poor? There are good reasons for targeting that segment of the uninsured population. First of all, most of the poverty level workers (200 percent poverty level or \$24,000 for a family of four, as the benchmark) don't qualify for any government program. They are ineligible for Medicaid, or for General Assistance. They are not old enough or disabled enough for Medicare. They can not afford the escalating premium costs, all by themselves. They tend to, as Bob Eckardt mentioned, work for small service dominated industries with marginal profits. Finally, since the working poor and their dependents make up three-quarters of the uninsured problem, it makes good public policy sense to target this subgroup. Also, to focus on the working poor has important political implications.

The uninsured are not a homogeneous group. It is not a problem of the central city. It is not a problem of poor blacks or poor whites. It is a problem of a cross-section of Ohioans. They live in central cities, the suburbs, the small towns, and rural Ohio. It is not another program for those on welfare since they are covered by Medicaid and, although Medicaid covers only one-third of Ohio's poorest of the poor, they are covered by something.<sup>16</sup> We are talking about working poor people who are not poor enough to be eligible. Thus, we think that is a good strategy. We're talking about 730,000 plus, Ohioans who fall into this category: working poor, no insurance, not eligible for government subsidized programs. One-third of them are children.<sup>17</sup>

### 4. UNIVERSAL HEALTH INSURANCE UNREALISTIC TODAY

Some of you may say, let's push for Universal Health Insurance as Bob Hagan has proposed in House Bill 425. That's a laudable goal and I

<sup>15</sup> See Kimber, Kurant, & Carlson, *Uncompensated Health Care in Cuyahoga County*, (1985) (Federation For Community Planning).

<sup>16</sup> See Sterin, *supra* note 25.

<sup>17</sup> See F. KIMBER, *supra* note 10, at 7.

subscribe to it completely. But it is both fiscally and politically unrealistic, today, in my judgment. Also, I think the national budget deficit will tell us that a national health plan in this century is not likely. I think what you will see, bubbling up across the country, are incremental approaches as in Ohio, Massachusetts, Wisconsin, Illinois—models testing what is financially feasible. We think that is good policy for Ohio. It is a policy that recognizes that the foundation of Ohio's economic growth is its workforce, its working people. In Cleveland, fifty percent of the new jobs created are low paying jobs in the service sector. This "new" workforce is a big segment of the economy of this community. So, a policy that targets that population seems to make economic sense as well. Also, that policy is consistent with the state's strategies to do something about welfare reform: to enable people to be trained, to find jobs, to stay on jobs and to *get off welfare*. Welfare reform will get underway in Cuyahoga County, beginning in 1990. We propose some kind of health benefit package that props these people up as they move from welfare to work. Such a strategy has a compassionate side. One-third of the uninsured are children, and over half of the uninsured are young adults under the age of thirty with children.<sup>18</sup> Therefore, the opportunity to do preventive care early with children and young adults is presented.

Let's run through a brief history of the local demonstration project recently funded by the state. In 1987, the Federation drafted legislation and got it introduced in the form of House Bill 24. It passed, and last summer monies were made available. It made available 4.1 million dollars statewide for the purpose of testing different options, different approaches to providing health benefits to working poor Ohioans. Our project in Cleveland is targeted to working poor. It seeks to test employer's and employee's interest in a low-cost, no-frills health benefits package that's really not on the market today. Keep in mind that in Cleveland a big problem is escalating costs of premiums. We wanted a modest benefit package. We think we have that. We'd like to test that in the demonstration project. Five hundred workers that fit that category will be recruited, along with their dependents. The study population will be 1200 to 1500 enrollees. We anticipate that twenty percent of enrollees will be former welfare recipients, former AFDC recipients in transitions from welfare to work. We have subcontracted with Personal Physician Care, Inc., a not-for-profit individual practice association type HMO in town.

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<sup>18</sup> See also Short, Monheit, Beauregard, *A Profile of Uninsured Americans*, NATIONAL MEDICAL EXPENDITURE SURVEY, RESEARCH FINDINGS 1. NATIONAL CENTER FOR HEALTH SERVICES RESEARCH AND HEALTH CARE TECHNOLOGY ASSESSMENT (1989); see also GENERAL ACCOUNTING OFFICE, HEALTH INSURANCE: A PROFILE OF THE INSURED IN OHIO AND THE NATION (1988); see also Chollet, *Uninsured in the United States: The Nonelderly Population without Health Insurance, 1986* (1988) (Employee Benefit Research Institute); see also Kasper, Walden, Wilensky, *Who Are The Uninsured?* NATIONAL HEALTH CARE EXPENDITURES STUDY, DATA PREVIEW 1. NATIONAL CENTER FOR HEALTH SERVICES RESEARCH (1988); see generally Austrian & Cleeton, *The Medically Uninsured: A Focus on the Cleveland SMSA* (1989) (The Center for Regional Economic Issues).

They will provide and manage health care services; collect and report project data to the Federation. The Cleveland project and the other state-funded projects will be evaluated by an independent evaluator.

A project policy committee will monitor the project and develop recommended strategies for use by state officials as they seek long term solutions to the uninsured problem in Ohio. We would welcome your input in this process, and we look forward to it. Thank you.

#### *F. NANCY ROTH*

Henry Manning is our next speaker. He is the President and Chief Executive Officer of the MetroHealth System which is the major provider of health care for the poor in the state of Ohio. In addition, MetroHealth is an important resource in this community for medical education. Henry is also Chairman of the Board of Trustees of the Ohio Hospital Association and Chairman of the governing Council of the American Hospital Association's Section for Metropolitan Hospitals.

#### *G. HENRY MANNING*

I do not want to take much time from what we have remaining because we should save some time for Dr. van Heeckeran. I feel we are terribly consumed in our thinking by this single economic issue—who pays for the poor—to the point that we get sidetracked from the real job that we have, which is medical care—indigent care and unreimbursed care notwithstanding. I hope that through this conference and other debates that we can soon dispose of the issue and can get on with what we do best, which is organize and make available good, competent medical care for the general population.

I do not mean to dismiss the importance of the issue. At the last meeting of the American Hospital Association, the hospital issue that was considered of gravest importance among many urban hospital leaders was uninsured care.

One aspect of the problem unrelated to finance is how we provide indigent care. I don't think most of us have a notion of how that actually happens. It happens primarily at teaching hospitals in teaching clinics and emergency rooms. For most poor people, the care they receive takes place at teaching hospitals because teaching hospitals have the staff to provide large-scale services—the staff being residents in training.

### **1. PRICE COMPETITION AS A DRIVING FORCE**

The reason this issue is seen as a big problem for urban hospitals is that through price competition, those of us who administer teaching hospitals see the problem as a sort of double jeopardy because our economics are now driven by cost/price competition among hospitals. We find it very difficult to compete on price with hospitals who bear relatively little of the cost for care of the poor or for training doctors.

Both the private sector and the government sector are now declining to pay our cost for salaries and benefits of residents and other costs of medical education. MetroHealth recently sent a check to Medicare for over a million dollars to reimburse the government for payments made to us but denied by new regulations. This diminishes our ability to maintain the same numbers of residents and, hence, the amounts of indigent services.

The MetroHealth System has as its primary mission the care of the poor. The system also offers service to the general public and recovers most of its cost through payments from patients and their insurers. Because of our underlying mission, the system has built over time enormous capacity for providing both medical and social services to disadvantaged members of the community. This means that the system cares for a large number of people for whom there is no third party insurance or who have minimal insurance and no financial capacity to pay for uncovered services.

## 2. UNREIMBURSED CARE

A significant part of our cost structures for the support of this population is deployed to meet the unusual social needs that arise from poverty and cannot be ignored as an aspect of medical treatment. These are such programs as child abuse, nutritional support, home care support, travel vouchers to and from clinics, etc. MetroHealth has the largest department of medical social workers of any hospital in the State of Ohio. Because MetroHealth is the core community system for the needs of the poor, we receive a substantial subsidy from the county government. Currently, the appropriated subsidy amounts to 27 million dollars and has just this week been reappropriated for the coming year. While we sought a necessary increase in the subsidy that was not approved, we are pleased that the county has at least sustained last year's level of support. We calculated the actual cost of unreimbursed care exclusive of bad debts to be approximately 37 million dollars. You can see, therefore, that the hospital, in addition to the county subsidy, also shifts some of the cost burden to the paying public.

The categories of unreimbursed care by amounts are as follows:

- a) Acute inpatient care - 24.6 million dollars
- b) Medicaid outpatients - below cost - 2.4 million dollars
- c) Uncompensated long-term care costs - 8 million dollars
- d) Other uncompensated and community service programs - 2.2 million dollars

In terms of the number of people served, we provided 90,000 outpatient visits, 2,000 acute care inpatient discharges, and a partial subsidy for all the care of Medicare and Medicaid skilled nursing care cases.

These numbers are sufficiently large to be impressive. On the other hand, quoting numbers is not completely useful in describing the humanitarian purposes of indigent care programs at MetroHealth and other major teaching hospitals in the country.

To close my remarks, I would like to describe two discharges from The MetroHealth System that I have personally reviewed for purposes of

approving a write-off of the charges in both cases. One case involved a sixty-two year old widow without means who suffered a fracture of the leg and incurred hospitalization charges of \$61,000. The other case involved the premature birth of twins to a young couple, who because of prematurity, incurred charges for intensive care of more than \$200,000 and a write-off of over \$150,000. (Mr. Manning described the social and employment situation of the two families in each of these instances.)

I believe I should stop here to allow time for Dr. van Heeckeren's presentation.

#### *H. NANCY ROTH*

Dr. Daniel van Heeckeren is a respected surgeon at University Hospitals which provides the second highest amount of health care to the poor in the state of Ohio, and he is also the past president of the Cleveland Academy of Medicine. The Academy is in the process of establishing project "Open" which will provide free physician services to low-income persons over the age of sixty-two who are not eligible for Medicare or Medicaid. Dr. van Heeckeren will present the physician's view on the insurance issue.

#### *I. DR. van HEECKEREN*

I see a lot of lawyers here, and I don't know how much comfort I take from that. There are not a lot of people from health care. But you write a lot of rules for us and hoops for us to jump through.

When I first came to University Hospital in 1971, we had only a daily charge, and there was no surcharge for drugs or equipment used and so forth. And the insurance industry came to us and said that that was very irresponsible and they wanted to be billed separately for each item. So, we put in place an accounting section, and we started to bill for the penicillin and for aspirin and for the bandages. And not too long ago Medicare came to us and said that was terrible because there was no incentive for us to be cost effective, and they said we want to give you this "diagnosis related group" (DRG) payment, and it will give you a lump sum no matter what you do. But we want to put a lot of cost controls on this, so, on top of this, we now have a second layer of employees who are not delivering health care, but who are on the payroll. All the while we are looking at the escalating cost of medical care. I think all you lawyers who write the rules for us ought to keep that part in mind also.

We had somebody talk about a national health care system. Well, of course that's anathema to organized medicine. I was in Louis Stokes' office this fall at the time they were debating the repeal of the Catastrophic Care plan, and that's a very interesting issue to address because the same people who initially were all for it suddenly found that "the buck stopped with them." They were going to have to pay something for the benefits they would get, and that took them by surprise. They thought there was a free lunch somewhere, somehow, someway and there wasn't;

so they screamed and it was repealed. That repeal, by the way, will cause many more problems, because allocations for numerous other programs were scaled-back in the expectation that the funds would then come from the Catastrophic Care bill. So, we have large problems, but I'm not sure that a national health system is the best solution.

I am reminded of the story up in Maine where two farmers would meet each morning in a field on the way to tend their cattle. And, one day, Cyrus asked Sam: "What'd you give your cow for the glanders?" Sam said, "Kerosene." Cyrus said "Kerosene?" Sam said, "Yup," and then the two went on their way. A few days later, when they met again, Cyrus called, "Sam, you did say kerosene?" Sam said, "yup." Cyrus said, "Well it killed my cow." Sam replied: "It killed mine too." You can go elsewhere for advice, but you have to be sure what you get with the advice.

For example, if we are talking about the Canadian health care system — there is no such thing. Many of you probably know this. Each province in Canada has its own health care system, and they are all unique, and they all try to address locally each system's needs. So this means that in Quebec the doctors are told, each quarter they can deliver so many dollars worth of services, no matter what their population needs, and so the third month of each quarter a lot of doctors take time off because they have exceeded their quota. They are not going to be compensated for any further care they give, and so there's no incentive to stay. You might as well go. They also don't pay their personnel at the same level in different areas. So, the nurses in Quebec went on strike because in Ontario the nurses were getting two or three dollars an hour more. And that brings me to the point Henry was making, which is that when you look at any hospital's budget you find somewhere around seventy percent of the budget is payroll<sup>19</sup> and, of course, you say payroll is expensive and you've just got to cut back on the salary you pay. But should people from working class backgrounds have to be subsidizing the health care system by working for a substandard wage? I say no. But that's the problem. If you start laying them off to cut costs, you increase unemployment and perhaps increase the pool of uninsured and underinsured people.

From the doctors' perspective, we have initiated in this county and in this state two things, and they really don't cover a heck of a lot, but they do something. Now project "OPEN" is Ohio Physicians for the Elderly Need. If you fall below the federal poverty level, and you can document it — we use social service agencies to provide documentation — we have signed-up doctors who will give you care free of charge. Sounds great, but the limitation is that if I send you to a lab to get a cardiogram, am I going to pay for that cardiogram or are you, as a patient, still going to be stuck with that? If you need an x-ray, am I, the doctor, going to pay for that? Well, maybe the radiologist will, but again we cannot cover that. I don't think we want to put out money, but we are happy to contribute

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<sup>19</sup> See generally AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS 1988 EDITION, DATA FROM THE AMERICAN HOSPITAL ASSOCIATION'S 1987 ANNUAL SURVEY (1988).

our services. As you go through the history of medicine, you find doctors have always given free care to those who couldn't pay. And that led to ridiculous scenes where the wealthy would go to the doctor's office dressed in rags so that they would either not have to pay at all or pay a small fee instead of their fair share, their cost-shifted share of care. For, in order for any of us to deliver free care to some segments, some other segment of our patients has to subsidize that.

As a doctor, the DRG's put me on a new fee payment system, but the teaching hospitals get a lump sum payment in a different form to help compensate for their education costs because we have been able to convince our legislators and lawyers that there is some merit to educating more doctors and because the average doctor goes into practice now with an initial debt of \$40 to \$60,000. So that has to be made up somewhere, and if you have to pay them a high salary in residency programs because of their education loan payments, that really becomes difficult. In addition to "OPEN," we have similar programs for children, small amounts, but we are showing a willingness to try to meet the problems by contributing free care. Costs of medical care are escalating. The costs of Medicare, part B, are escalating into the teens, somewhere. But the M.D. component last year only escalated 7.9 percent, which is much less than the rest of the cost components of part B.<sup>20</sup>

Is that great? Certainly not, because the inflation rate is running around four percent, and so the doctor component is still going higher. And I have to defend the profession a little bit. Doctors are being blamed a lot for the increased cost of medical care and the twelve percent of GNP that it's absorbing. But, I don't see doctors standing on street corners selling drugs or cigarettes or promoting the unhealthy life styles of the "couch potato." I see a lot of doctors doing quite the reverse. The American Medical Association is out there promoting their cholesterol program. The American Heart Association has a program for identifying certain foods that contain the lowest levels of harmful substances. Doctors are always out there trying to promote wellness. But there's little incentive that I see outside of medicine. How many companies are there that have a smoke-free environment policy, that have a policy promoting wellness, that give you a bonus if you're well and you exercise and keep your body weight down? There are some isolated examples. For instance, locally the Bonne Bell Co. has a wellness program, but that should be universal and it should be everyone's responsibility. It can't just be the once a year that you go to the doctor's that you say "Well, I really ought to quit smoking."

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<sup>20</sup> See generally MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS, A REPORT FOR THE USE OF THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT (COMMITTEE ON ENERGY AND COMMERCE, U.S. HOUSE OF REPRESENTATIVES) (1988); see also HEALTH CARE FINANCING ADMINISTRATION, MEDICARE AND MEDICAID DATA BOOK, 1988. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (1989); Rowland, Lyons & Edwards, *Medicaid: Health Care for the Poor in the Reagan Era*, 9 ANN. REVIEW OF PUB. HEALTH 427-50 (1988).



As far as cost containment is concerned, unfortunately, I see that the major effort is in rules. Rules that make it more difficult for us to practice medicine. Rules that mean that every time I want to provide a service to a patient, I first have to call a functionary in an insurance office. And they will say "yes we will" or "no we won't agree" to pay for this. It means that they have more people on their payroll to burn their money by denying contractually mandated care. If I hire you at \$40,000 and you don't deny \$50,000 worth of care during the course of the year, you're costing money. If you deny that care, then you're making me money. That kind of cost containment, by the way, creates overhead costs for doctors. If I have to make that call to the insurance company five times, and my secretary gets a busy signal each time, I pay for that. So cost containment is a difficult problem. In closing, I guess I'd like to say that we are fortunate to have people like Henry Manning running Metro or the people who run University Hospital.

#### QUESTIONS AND ANSWERS

Q. For Dr. van Heeckeren. Who is keeping track of the quantity of uncompensated care supplied by physicians?

A. Dr. van Heeckerin: Well, I am not sure that is being done. Fifty percent of physicians now work in salaried positions certainly those finish training programs. They work for HMOs, they work in hospital settings, they work in large clinic settings, and there some data might be available. The people I talk to mainly are the "mom and pop stores," the doctor or doctor in partnership working in a small office. And, for example, in the Medicaid population, many physicians either refuse to see patients or see them without billing because the paper mill is so very complex. And the payment delays and the hoops you have to jump through are too onerous. As you talk to physicians it also depends on where they are located and what kind of practice they have.

Q. Is it largely an unquantifiable problem?

A. Dr. Van Heeckerin: In my own practice it is on the order of fifteen percent. But I see I a lot of small children. I do congenital cardiac surgery, and we look at the needs of the patient more often than at the available funds. If we get paid, fine, and if we don't, fine again, but that is because I can cost-shift. You talk to Don Baumgartner who is an emergency room surgeon at St. Luke's, and he says he might be at close to fifty percent of his billings because in the emergency room setting, you take care of all comers and ask afterwards whether you can be compensated for it. The costs are somewhere in that fifteen to fifty percent range.

Q. For Mr. Manning. You mentioned that there's about a 10 million dollar difference between the cost of care for the uninsured and county subsidy to the hospital. What is the thinking at the county level about this obligation and helping you recover this money?

A. Henry Manning: Well, I believe the history is pretty good on that score. The hospital has been well-supported. These last years, I indicated that there had been no increase in the appropriation since 1981, and that is true; on the other hand, part of what's gone on with this competition is that there has been a lot of re-structuring of payment rates. Metro was in a good position when the Medicare DRG's first came along of having relatively low-cost structures and therefore earning on these payments, and that helped keep the pressure off the County Commissioners. That has changed now, and we're not in that position at all anymore. There's simply no payer out there — Blue Cross, private sector payers, government sectors — none of them are prepared to negotiate much increase, and, therefore, the inflation that is driving us all, that hospitals did have within their power to fix, we don't have that ability any more. That's being driven by vendor payments, the costs that come to us from pharmaceutical companies and so forth. So, there's a big gap between our expense rises and the recovery we are able to obtain now from insurance payers. Therefore, we are back at the door of the County Commissioners now more vigorously seeking increased amounts. I think the Health and Human Service welfare levies that are the source of our appropriations have fared very well over the years. This community has always responded to approve those levies, so until this problem becomes so bad that it goes beyond the ability of the commissioners and the county to appropriate money — as long as we continue to have the other charitable hospitals in town to take their share — I am not too concerned that we will not get at least some increase in assistance from that source as time goes on.

Q. Mr. Manning, we have heard quite a bit on care by hospitals and physicians. What about nursing home care?

A. Henry Manning: Well, I think the supply of nursing home beds in the region is very good. I believe we have 200 or 300 beds in excess of what the state health department believes the population needs. The financing question, of course, is a different matter. This business of requiring people to spend-down their wealth in order to be able to qualify for Medicaid assistance for nursing home care is probably the most serious aspect of that problem. The beds are there, but we need to extend to people who can't afford the cost of nursing homes. It is possible to qualify people for Medicaid, and that system works and works pretty well, as a matter of fact.

Q. What about those who don't have the wealth to spend-down?

A. Henry Manning: Well, then you should be able to get them qualified for Medicaid coverage.

Q. Mr. Kimber, in this new initiative, tell us a little bit about how the hospitals are going to be enlisted in that, especially on the subject of payment and reimbursement.

A. Frank Kimber: Yes, the hospitals will be involved and Dick Buxbaum can describe that involvement. The approach that we're taking in this project is to engage a network of primary care physicians who will see the patients as needed, and make judgments about hospital referrals. Dick can elaborate on that.

A. Richard Buxbaum: But the point about it basically is that the Personal Physician Care which is the HMO that's providing the service has contracts now with ninety-nine percent of the hospitals in the area so that the service will be rendered by the hospital team through the standard contracts, albeit on the basis of a benefit plan that was designed for this purpose. Does that answer your question?

A. No.

Q. Richard Buxbaum: What were you looking for?

Q. What rate of adjustment?

A. Richard Buxbaum: The existing contracts are the ones that will pertain, so that whatever contractual adjustment, discounts, whatever you want to call it, has been worked out to start with between Personal Physician Care and the hospital will pertain in this case as well.

Q. Mr. Kimber, I was wondering if you could explain in a little more detail why you think that national health care governed state by state is not feasible in this century?

A. Frank Kimber: There are a number of factors. First, given the federal budget deficit, I simply don't see any great enthusiasm for a new federal initiative. On the other hand, I think the issue is not going away. Throughout the country, the problem is most real and has the greatest impact at the state level. Therefore, I think that is where the action will be over the next ten years. I think we are seeing states taking the lead already. The initiative of the Robert Wood Johnson Foundation to fund demonstration projects in about fifteen states over the last couple of years is very similar to what the state of Ohio is now doing. These state efforts are being evaluated, and I think you will see states sharing information about how and what can be done in short term. The remaining part of this century will be a period of testing and experimenting in my view.

A. Nancy Roth: Washington state had set-up a program to cover low-income people with a subsidy last year, and there were 9,000 people enrolled after the first year.<sup>21</sup> They were looking for 25,000. One of the problems they found is that the third-party payers, the HMO's in partic-

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<sup>21</sup> See generally Dallek, *State 1989 Initiatives on the Medically Uninsured: A Survey* (1989).

ular, are looking at a population they have little information about, and so they're nervous about entering into contracts with them. Oregon is also doing some work with Medicaid in terms of looking at the relative values of various procedures, and Oregon's program might increase the subsidies to small business for providing insurance.<sup>22</sup> If that does not work out, then they will go to some type of mandated coverage. So there are things happening elsewhere.

**Q.** Mr. Kimber, is the Federation looking at the Oregon system?

**A.** Frank Kimber: Yes, we have. The project that we have here has features that several states are testing, including features of the Oregon plan with regard to a fixed benefit package. We have subsidized premium, using state money to subsidize the monthly premium. We have a premium cost-sharing scheme, involving the employer, employee and a state subsidy, a three-way scheme. We have a sliding fee scale for the employee. We have a managed care arrangement. I think this combination of features makes our project different.

**Q.** Besides this new initiative, is the Federation or any other body that you know of looking at the possibility of an Oregon program for Ohio?

**A.** Richard Buxbaum: Nancy, may I respond? I think it's fair to say that there has been no programmatic initiative in Northeast Ohio. The Association did sponsor a seminar for our executives dealing with the approach Oregon rationing, that's when we had Dr. Golenski, who is the ethicist who, you might say, is the conscience of that program who basically described the approach. But I think that it is important to understand what Golenski himself says, and also Dr. Kitzhaber, the President of the Senate there who's an emergency room physician mainly, that what works in Oregon does not necessarily work elsewhere. Oregon has some peculiar attributes and they weren't at all sure whether that approach would work here and in other large urban centers.

**Q.** Mr. Kimber, have you calculated the affect of the increase in utilization of health care resources if you provide insurance to people who would otherwise be uninsured?

**A.** Frank Kimber: You bring up an important point. In this population, there is little or limited data available on utilization of health services. That is one of the things we want to examine—the use of services with working poor uninsured. We have good data on the public subsidized medical patient population locally and nationwide. We have good data on utilization by commercial patients, but the working poor uninsured, there isn't a lot of data there; except as maybe reflected in hospital uncompensated care data.

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<sup>22</sup> See also Meyer, *Rationing Question Looms with Oregon Plan*, AM. MED. NEWS 1, 9-10 (Aug. 25, 1989).

Q. Mr. Kimber, do you have any way of evaluating the effect of lack of insurance on a person in the lower third and therefore entitled to various programs such as Medicaid? The effects of preventing them from moving to the middle third where they would be without insurance and what effect that is having in holding people back?

A. Henry Manning: I would like to comment on that. I think what you are referring to is people remaining on welfare so they can continue to be eligible for Medicaid.

Q. I suppose that's one aspect.

A. Henry Manning: I think you've cited a real phenomenon. You might be able to move off welfare and get a job, but if it's a job without health care benefits, they're not protected as well as remaining on welfare.

A. Frank Kimber: As noted earlier, our study of 600 welfare mothers showed forty-one percent believed they could find a job that pays enough to live on, but only if they can keep their Medicaid card. Health benefits at the work place are valued by these mothers, especially for their children.

We are working with Cleveland Works, Inc., a non-profit group in town that recruits, trains and places former welfare mothers in jobs. They only place them with employers that offer health benefits. We have a list of those employers that need trained workers but do not offer health benefits. We plan to market the project to that group of employers with the expectation that they will subscribe and offer health benefits—even on a pilot basis.

Q. It is no secret that the problem of uninsurance or underinsurance is more profound in the inner-city than it is in the suburbs. What strategies are you finding that hospitals are employing to limit their exposure to that uninsured care or underinsured care and putting it over onto other options? And what can we do about these kinds of problems?

A. Richard Buxbaum: We are not really seeing any evidence that the hospitals are turning folks away nor are we seeing, as is the case in some other communities, that the private hospitals are dumping the uninsured patients on the public hospitals. Nor are we shying away from a trauma network because we know that in other cities the trauma centers are closing down because they are getting dumped on. So, at this juncture we don't really have the data to show what is happening. There may be some anecdotal cases, but we don't have any hard data to show that that is happening to any significant degree.

Q. Let me just follow-up. I hear statistics about uncompensated care being provided by University Hospitals and it seems way out of proportion to what I know is going on with other suburban hospitals.

A. Richard Buxbaum: I would say the figure of 129.8 was spread rather dramatically among the hospitals in our membership, and while it is true that a disproportionate share is found in the inner-city, there, especially in the bad debt area, we're seeing an increase in hospitals throughout the five county area.

Q. Mr. Kimber, you mentioned that you were designing a very basic package for your pilot program. Are you going to be able to ignore the mandated benefits in Ohio law? There are fifteen mandated benefits that insurers must include in their coverage, whether their customers want them or not and that is one of the things we got into this morning. My question to you is are you going to be able to avoid those mandated benefits in designing your coverage for experimental purposes?

A. Frank Kimber: Personal Care Physicians, Inc. already has a contract with the Ohio Department of Human Services to provide managed care to Medicaid recipients. As an HMO, Person Physician Care, Inc. is required to provide, as a minimum, those mandated benefits for Medicaid in the State of Ohio.

Q. I wanted to ask Mr. Buxbaum, the figures you put out for uncompensated care, most of that was bad debt. Does that include what hospitals often call contractual allowances?

A. Richard Buxbaum: No.

