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Alternative Approaches at the Federal and State Level

E. Richard Brown

Mary Rose Oakar

Randall Bovbjerg

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IX. ALTERNATIVE APPROACHES AT THE FEDERAL AND STATE LEVEL

E. RICHARD BROWN
REPRESENTATIVE MARY ROSE OAKAR
Discussant: RANDALL BOVBJERG

A. DEAN STEVEN SMITH

Thank you. It's a pleasure for me to introduce the speakers for our final session, but let me first note that all of us in this session are, in one way or the other, members of the teaching profession, even though some of us have other jobs for the moment. Our first speaker, E. Richard Brown, received his Ph.D. at the University of California at Berkeley and is an Associate Professor in the School of Public Health at U.C.L.A. He has written extensively on the topic of financing health care for the poor.¹ Following Professor Brown, we will hear from Representative Mary Rose Oakar, currently on leave from the Fine Arts faculty at Cuyahoga Community College, who will speak about the work of the Pepper Commission. We will then take questions for Representative Oakar before continuing our discussion with Randy Bovbjerg. Professor Brown.

B. E. RICHARD BROWN

Thank you Steve. I am really glad to be here, even though I had to leave eighty degree weather and come to a cold winter's day in Cleveland. But it is always nice to be reminded that there really is the change of seasons.

It has been interesting to me to listen to the panels this morning and this afternoon, particularly in that the discussions, and some of the positions being argued, are reminiscent of positions that were articulated in California three years ago. I don't say that with particular pride in how progressive California is, but rather as an indication, perhaps, of where things may continue to go in Ohio.

The reason that the discussions and positions that you heard this morning are no longer being voiced so widely in California is because conditions have continued to deteriorate there rather dramatically. Like the rest of the country, we have a large uninsured population, but the percentage of our uninsured population is larger than the national average as a percentage of the non-elderly population. In the U.S. it's about eighteen

¹ Address by Brown, *Public Medicine in Crisis: Public Hospitals in California*, California Policy Seminar Monography No. 11, Berkley: Institute for Government Studies, University of California (1981); Brown, *Medicare and Medicaid: The Process, Value, and Limits of Health Care Reform*, 4 J. OF PUB. HEALTH POLY 335-66 (1989); Brown, Valdez, Morgenstern, Nourjah & Hafner *Access to Health Insurance in the United States*, 46 MED. CARE REV. 349-85 (1988); Brown, *Public Hospitals on the Brink: Their Problems & Their Options*, 7 J. OF HEALTH POL., POLY & L. 927-44 (1983).

percent or seventeen percent; in California, it's over twenty-one percent. That means more than five million uninsured people.²

1. UNCOMPENSATED CARE BURDENS

Our hospitals are suffering tremendously from uncompensated care burdens, just as hospitals in many parts of the country, including Cleveland and the state of Ohio, are suffering. Uncompensated care, in fact, increased in California between 1981 and 1985 by eighty percent, and if you adjust for inflation the increase was still forty-nine percent in just that four year period.³

We have also seen a continuing deterioration in the position of the insured population due to the rising health care costs facing employers and employees, as well as the state. Rising health care costs are a burden on every payer in the state.

I could continue to describe conditions in California, but my task is to talk about what is going on in other states as well, and I want to do that, perhaps somewhat briefly, in order to get to some of the broader policy questions that have been raised here today. The states are generally faced with two pressing health problems. They are like a vise gripping the states on health care. One is the large uninsured population for which most states are responsible, by tradition and in most states, by law. The second is escalating health care costs, a topic I won't belabor since others have already spoken to those issues today.

In 1985, while thirty-four states and the District of Columbia had some kind of state indigent medical care program, only thirty of the programs were actually operational.⁴ Most involved some administration and/or funding shared between the state and counties; however, six programs, or what passed for programs, were really only the state statutes that delineated county responsibilities, i.e., they simply turned over responsibility to the counties explicitly. The remaining sixteen states had no statutes or programs of any kind and thereby implicitly left this problem to their counties. Thus, twenty-two of the states have left indigent care as a county responsibility, either explicitly or implicitly.

² See generally Chollet, *Uninsured in the United States: The Nonelderly Population without Health Insurance* in EMPLOYEE BENEFIT RESEARCH INSTITUTE (1986); see generally Kasper, Walden & Wilensky, *Who Are the Uninsured?* NATIONAL HEALTH CARE EXPENDITURES STUDY, DATA PREVIEW 1, NATIONAL CENTER FOR HEALTH SERVICES RESEARCH; see generally 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).

³ BROWN, *Access to Health Insurance in the United States*, 46 MED. CARE REV. 349-85 (1989).

⁴ Bovbjerg & Kopit, *Coverage and Care for the Medically Indigent: Public and Private Options*, 19 IND. L. REV. 857 (1986).

2. INDIGENT CARE PROGRAMS

Let's look, however, at those states that do have some kind of indigent care program. They fall into a very wide array of types of programs. One of the broadest types, and the longest standing, has been direct financing of hospitals and clinics, which really goes back many centuries to a tradition rooted in both private charity and public hospitals and clinics. The introduction of Medicaid and Medicare in 1965 reduced, but did not eliminate, the need for public hospitals, and two decades later public hospitals still account for more than a quarter of all community hospitals.⁵ They provide a broad range of services including their traditional role of serving the indigent population. But they also provide trauma care, burn centers, psychiatric care and the like, as well as the training of medical professionals, all to a degree disproportionate to their numbers among all community hospitals.

Public hospitals were struck very hard by rising health care costs which they, of course, have to meet in order to provide medical care at the existing community standard and by declining tax revenues due in large part to the tax revolt which swept the country in the late 1970s and early 1980s.⁶ Nevertheless, even today public hospitals provide about forty percent of all uncompensated care in the United States, which is about twice the share of all hospital beds and all hospital charges that they represent.⁷ And that is true also in California.

In addition to the direct provision of health services through public hospitals and clinics, a number of states also have entitlement programs for the medically indigent. These are basically for the low-income uninsured who are not eligible for the state's Medicaid program but who do meet eligibility standards for its indigent medical care program. Many states do include these indigent groups in the Medicaid program, but the indigent medical care portion is funded only by state dollars. There is no federal contribution. For example, when a state adds medically indigent adults to its Medicaid program, it has to pay the full costs of those people; the federal government provides no contribution as it does for federally subsidized public assistance eligibles.⁸

How well do these programs work? Well, for one thing, these programs are as varied as the individual states. They differ dramatically. There are no guidelines for this, and so any state can do anything it wants to

⁵ Brown, *Public Hospitals on the Brink: Their Problems and Their Options*, 7 J. HEALTH POL. POLY L. 927-44 (1983).

⁶ Brown *Access to Health Insurance in the United States*, 46 MED. CARE REV., 349-85 (1989).

⁷ See generally Sulvetta & Swartz, *THE UNINSURED AND UNCOMPENSATED CARE: A CHARTBOOK* (1986); see generally Sloan, Valvona & Mullner, *Identifying the Issues: A Statistical Profile in SLOAN, BLUMSTEIN, & PERRIN UNCOMPENSATED HOSPITAL CARE: RIGHTS & RESPONSIBILITIES* 16-53 (1985).

⁸ Dallek, *State 1989 Initiatives on the Medically Uninsured: A Survey*, N-4421-Dol RAND CORP. (1989).

in its indigent care service. But those that provide entitlement through Medicaid generally tend to provide better access to care than those that do it just through public hospitals and clinics. And the reason is that there is a wider source of care available to that population, basically, the same source of care that is available to the Medicaid population in that state. And, as I will show in a moment, while that imposes numerous limitations on access, these people are still much better off compared to those without any coverage or entitlement whatsoever. However, it is expensive for the states because of the lack of any federal contributions.

3. MEDICAID: LOGICAL ALTERNATIVE OR PROBLEMATIC OPTION?

The other program that, of course, represents the universal solution to part of the indigent care problem is federally-funded Medicaid. It is a logical solution since so many of the uninsured are poor, but many states have very low eligibility levels. In 1986, twenty states had Medicaid eligibility standards for their AFDC population that were less than fifty percent of the poverty level, with some down around twenty percent of the poverty level, and that was after two years of federal expansion of Medicaid eligibility.⁹

Access for Medicaid patients is poor compared to access for people with private health insurance. Generally, across the country, Medicaid programs pay about half of physicians' usual and customary fees. In California, it is slightly under half, around forty-seven percent,¹⁰ and physicians prefer to serve privately insured patients, and that is what they tend to do. About six percent of all physicians serve about half of all Medicaid patients.¹¹

With all its faults, however, including low income eligibility standards in many states and poor access in almost every state, Medicaid has made significant improvements in access to care for the low income population. No matter how you study Medicaid, whether through historic data or through surveys which compare the use of services by the Medicaid-eligible poor to those without any health insurance, you find the same kinds of results.

With the passage of the Omnibus Budget Reconciliation Acts (OBRA) of 1986 and 1987,¹² Congress broke with the past by severing the historic

⁹ See Rowland, Lyons & Edwards, *Medicaid: Healthcare for the Poor in the Reagan Era*, 9 ANN. REV. OF PUB. HEALTH 427-50 (1988).

¹⁰ See also U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH CARE FINANCING ADMINISTRATION MEDICARE AND MEDICAID DATA BOOK, 1988 (1989); see generally U.S. HOUSE OF REPRESENTATIVES (1988). A REPORT FOR THE USE OF THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT, COMM. ON ENERGY AND COMMERCE; MEDICAID: SOURCE BOOK: BACKGROUND DATA AND ANALYSIS, CONGRESSIONAL RESEARCH SERVICE, 100th Cong., 2nd Sess.

¹¹ See generally Mitchell, *Medicaid Participation by Medical and Surgical Specialists*, 21 MEDICAL CARE 929-38 (1983); see generally Davidson, *Physician Participation on Medicaid: Background and Issues*, 6 J. OF HEALTH POL., POLY & L. 703-17 (1982);

¹² Omnibus Reconciliation Acts (OBRA) (1986-87).

link between Medicaid and the public assistance or welfare programs sponsored by the federal government and the states, permitting states to expand Medicaid to poor children and pregnant women who would not be eligible for AFDC up to the poverty line and well above it, up to one hundred and eighty-five percent above the poverty line. By July 1989, forty-four states and the District of Columbia provided Medicaid coverage for pregnant women and infants in families with moderate incomes.

But the states are reluctant to expand Medicaid because Medicaid is expensive for the states, despite bringing in federal dollars on a matching basis that's at least a fifty-fifty match—and in some of the poorer states it is as much as a three to one match. If all states set income eligibility for Medicaid at the federal poverty level, it would cost an additional nine billion dollars a year throughout the country just to include the presently uninsured population that is below poverty.¹³ The states and local governments would pay about four billion of that nine billion dollars. If, in addition, we moderately improve the Medicaid benefit package so that all states had a uniform level of benefits, and if we improve payments to providers so that more physicians and hospitals would accept Medicaid payments and, therefore, participate in the program and serve Medicaid patients, it would cost at least an additional twenty billion dollars at minimum, and that would be a sixty-four percent increase over 1988 spending on Medicaid.

But, it is also a problematic kind of solution because the low-income population would remain in a separate, politically isolated, and, therefore, vulnerable program. These low-income persons would be more vulnerable to budget cuts than if they were in a program with a cross section of the population. And, as we have learned from Medicaid, as well as from education, separate is not equal.

4. HIGH RISK POOLS: ALTERNATIVE APPROACHES

States have been turning to other approaches as well, partly because of the tremendous burden on their own fiscal resources from public hospitals and clinics, indigent medical care programs, and Medicaid costs; and, of course, what they have been turning to is voluntary health insurance programs. We have heard about risk-pools for the medically uninsurable. These are programs generally not just for people who have a hard time getting health insurance, but usually for people who have been denied coverage by private health insurers.¹⁴ These programs have political appeal because even the most callous observers like myself have

¹³ See generally, Thorpe, Siegal & Daily, *Including the Poor: The Fiscal Impact of Medicaid Expansion*, 261 J.A.M.A. 1003-07 (1989).

¹⁴ See generally Bovbjerg & Koller, *State Health Insurance Pools: Current Performance*, 23 INQUIRY 402-18 (1986); see generally GENERAL ACCOUNTING OFFICE, HEALTH INSURANCE: RISK POOLS FOR THE MEDICALLY UNINSURABLE, BRIEFING REPORT TO THE COMM. ON LABOR AND HUMAN RESOURCES, U.S. SENATE (1988) [hereinafter ACCOUNTING OFFICE, HEALTH INSURANCE: RISK POOLS FOR THE MEDICALLY UNINSURABLE].

to feel some sympathy for the population who are in need of that kind of coverage. The woman who is recovering from breast cancer, the child with muscular dystrophy, these are people who cannot get coverage on an individual basis in most states, and these kinds of risk-pools are designed for them.

But, as we have heard, these programs have some problems. Nineteen states require insurers to set up these kinds of risk pools to provide insurance, but the premiums run between 125 percent and 400 percent of standard risk individual policy premiums.¹⁵ Well, that is a lot of money for anybody. If we are talking about premiums that are, let's say 200 percent of the normal individual rates, we are talking about a minimum of \$2,400 a year per person that is out-of-pocket, i.e., these are people whose employers are not paying for their insurance coverage; they are paying for it themselves. And when you realize that this population has a disproportionately large number of low-income people, even among those who are working, you can imagine that not many people will be able to afford coverage, and indeed that is the case.

Two states, Wisconsin and Maine, subsidize premium costs for low-income enrollees, and California will soon join them under a law enacted just this year, bringing premiums down to 125 percent of standard risk premiums. But the high premium costs, high deductibles and other cost-sharing provisions have limited these programs to a very small eligible population, generally less than three percent of the estimated number of people in need of these programs.¹⁶ In California, we estimate that of the more than five million people who are not insured, about 245,000 are uninsured because they have preexisting conditions and have been denied health insurance. Out of that 245,000, the state has estimated that about 15,000 people would be able to enroll in the risk pool subsidized down to 125 percent of standard premiums. Not only is there limited enrollment, but the subsidy required to bring down those costs represents a very high cost to the state per person covered.

Another feature of these risk pools that I think accounts for their political popularity among legislators and governors is that they create an illusion of doing something about the broader uninsured problem. For example, in California the legislative sponsor of a risk-pool bill that passed both houses of the legislature, although it was restricted to people who are "medically uninsurable," held a press conference when it passed and announced that his bill had solved the problem of California's five million uninsured people, even though he knew from the studies done by the state legislature's own research arm that was quite untrue.

¹⁵ See also Tresnowski *Use of State Risk-Pools in Protecting the Uninsured*, 260 J.A.M.A. 1003 (1989); see also Laudicina, *State Health Risk Pools: Insuring the 'Uninsurable'*, 7 HEALTH AFF. 97 (1988); see generally *Protecting the Uninsured, Use of State Risk Pools: AMA Council on Medical Service*, 52 CONN. MED. 495 (1988).

¹⁶ See generally ACCOUNTING OFFICE, HEALTH INSURANCE: RISK POOLS FOR THE MEDICALLY UNINSURABLE, *supra* note 14.

5. CATASTROPHIC EXPENSE PROGRAMS

Another strategy adopted by states is to create programs for catastrophic expenses. These are really programs for people with health insurance that enable them to protect their income and allow access to medical care when they incur enormous medical expenses. Only two states, Rhode Island and New Jersey, still have catastrophic health insurance programs, and New Jersey's is limited to families with catastrophic costs due to disabled children.¹⁷ Alaska, Maine and Minnesota dropped their catastrophic coverage in the 1980s because, like high-risk pools, catastrophic programs help only a small number of people at a very high cost per person—always higher than estimated.

6. INFORMATION DISSEMINATION

Another tactic is information dissemination. For many small employers who would like to be able to get health insurance but don't have the resources to shop around, as Senator Drake suggested might be done for health care, finding affordable insurance can be a difficult and time-consuming task. So, some types of information programs may be useful to inform an employer about a potential source that he or she did not know of. In 1989, New Jersey, Vermont and North Carolina initiated programs to provide information to businesses on health insurance products available to their employees.¹⁸

7. PILOT PROJECTS

Still other programs are being tried as part of a series of pilot projects operating in at least eleven states.¹⁹ Many of these are part of the Robert Wood Johnson Foundation's Insurance Demonstration Programs. Except for programs in Washington state and New York, most of these pilot projects are designed to provide health insurance through the work-place. The Washington and New York pilots target individuals and families with incomes below the poverty line and subsidize the purchase of insurance by those people. Some pilots actually negotiate reduced-cost insurance packages that are marketed to eligible employers.

Two states, Oregon and California, have enacted tax credit programs to encourage small employers, who have not been providing health insurance, to do so.²⁰ Oregon, in 1987, enacted such a program for small

¹⁷ Rhode Island - Catastrophic Health Insurance Plan Act (CHIP): R.I. GEN LAWS § 42-62-1 (1974); New Jersey - Catastrophic Illness in Children Relief Fund: N.J. STAT. ANN § 26 (1988). See generally, VAN ELLET, STATE COMPREHENSIVE AND CATASTROPHIC HEALTH INSURANCE PROGRAMS: AN OVERVIEW, INTERGOVERNMENTAL HEALTH POLICY DIGEST (1989).

¹⁸ Dallek, *supra* note 8.

¹⁹ ALPHA CENTER, HEALTH CARE FOR THE UNINSURED: PROGRAM UPDATES (March, July 1988) (April, June, October, 1989).

²⁰ See generally Dallek, *supra* note 8.

employers with twenty-five or fewer employees in which employers who purchased a state-certified plan, premiums of which cannot exceed fifty-three dollars a month per employee, will receive a tax credit of fifty percent of monthly premiums or twenty-five dollars a month per eligible employee, whichever is less. They began enrolling firms in May of this year, but so far enrollment figures have not been promising.²¹ California's program is not scheduled to begin until 1992.

8. HOW SUCCESSFUL ARE THE ALTERNATIVES?

How well do these programs work? Well, the state initiatives and pilot projects are untested. They are really in the very early stages of implementation. Preliminary evidence, however, is not overly optimistic. It seems unlikely that state educational approaches by themselves will have a major impact. Some small employers do have difficulty finding insurance products to buy, but their problem lies mainly with their inability to afford insurance, not the lack of information. The most common reason given by small employers, those with under one hundred employees, for not offering coverage is insufficient profits followed by the high costs of insurance.²² Subsidies to small employers seem necessary if states hope to improve voluntary coverage by them. Employer participation in voluntary programs, however, is likely to depend on the employer's profit margin, the cost of available health insurance plans, the market for the firm's own products and services (i.e., would adding the costs of health insurance to the products and services that the firm sells make it less competitive?) and the labor market in which the firm competes (i.e., would it be less likely to be able to recruit and retain employees if it doesn't provide health insurance?).²³

By the way, COSE, Cleveland's own voluntary program, is virtually unique in the country and I think it's possibly due to the very forceful leadership of John Polk. I think most of the people who have dealt with John probably would not like to be on the other end of negotiations with him. He is not only very logical, but he is extremely forceful.

In fact, there are numerous problems with these kinds of voluntary programs. Granted that they are new and more time is perhaps needed to see how well they will work. But the logic of the situation suggests that much more will be needed than just these programs to extend the availability of insurance.

²¹ *Id.*

²² See SMALL BUSINESS ADMINISTRATION THE STATE OF SMALL BUSINESS: A REPORT TO THE PRESIDENT, U.S. Government Printing Office (1987). See also Kramon, *Small Business is Overwhelmed by Health Costs*, New York Times, Oct. 1, 1989, at 1, col. 1.

²³ See Gabel, DiCarlo, Fink & de Lissovoy, *Employer-Sponsored Health Insurance in America: Preliminary Results from the 1988 Survey*, HEALTH INS. A. OF AM. (1989); see also Wilensky, *Public, Private Sector Options to Cover Uninsured Workers*, 4 BUS. HEALTH 42 (1987).

9. EMPLOYER MANDATES AND ERISA

We have heard also about employer mandates. This is the approach in which states would force employers to provide insurance coverage.²⁴ But only the state of Hawaii now has a broad general mandate which simply requires employers to provide insurance to their employees,²⁵ although the Kennedy-Waxman Bill,²⁶ in Congress would do a similar thing nationally. Further, the Employee Retirement Income Security Act (ERISA)²⁷ stands in the way of states imposing employer mandates, and the word from the Congress that I have—perhaps we will hear differently today from Representative Oakar—is that Congress will not open the ERISA “can of worms” to consider giving additional congressional exemptions to more states.

In response to this problem with ERISA, many states have begun looking at the so-called “play or pay” option in which the state says to employers: either you provide health insurance to your employees or you pay a tax. The states are hoping, of course, that “play or pay” gets around the ERISA prohibition. Massachusetts is the only state to have enacted such a program, and it's too early to tell how well that will really work. There are some positive signs, but it really has not even been implemented yet in terms of the “play or pay” option. The program is underfunded by the state, which has met with serious fiscal problems.²⁸ How well “play or pay” will work is open to question, as are mandates. The Congressional Budget Office estimates that if the Kennedy-Waxman Bill were implemented, it would increase the payroll costs of the lowest wage paying employers by twenty percent. But we need to see how well their programs can work.

10. THE BROADER PERSPECTIVE

Let me get on to a set of broader questions, if I may take a few more minutes to do so. State efforts are important in the absence of any kind

²⁴ See Jenson & Gabel, *The Erosion of Purchased Health Insurance*, 25 INQUIRY 328-43 (1988).

²⁵ Hawaii Prepaid Health Care Act of 1974, HAW. REV. STAT. § 393-1-51 (1974); see generally, Friedman, *Hawaiian Health Care: A Look at the Mainland's Future?* 4 HEALTH BUS. 10, 17-27 (1989); see generally address by Lewin at a Conference on Managing Employer Health Care Costs in the 1990s: No Easy Answers (Los Angeles, May 12, 1989).

²⁶ See Langan, *Health Coverage for the Uninsured: The Kennedy Proposal Focuses on Employers*, 13 EMPLOYEE REL. L. J. 707 (1988).

²⁷ Employee Retirement Income Security Act (ERISA) 29 U.S.C.A. § 1001 (West 1974). See also Fox & Schaffer, *Health Policy and ERISA: Interest Groups and Semipreemption*, 14 J. HEALTH, POL., POLY & L. 239-59 (1989); see also Demkovich, *ERISA and the States*, 9 FOCUS ON INTERGOVERNMENTAL HEALTH POLY PROJECTS (1986).

²⁸ 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).

of serious federal leadership on these issues, but there are constraints on what the states can do. ERISA is clearly one in terms of mandating employers. The costs of providing health care and health insurance coverage, or Medicaid coverage, is another burden on the states' own fiscal problems which are quite serious. There also is the political process itself, in which state health care politics, as well as the Congress, are dominated by health care industry interest groups. And, quite frankly, I think we heard from them this morning, each speaking for their own interest, which is, of course, what you would expect them to do. As someone said, you cannot fault a wolf for acting like a wolf; you cannot fault any of us for acting on behalf of our own interests. But I think at some point the political leadership in the state, whether it's in the legislature or the governor's mansion, or in the Congress, has to get beyond simply responding to each interest group's own individual interests.

11. THE PIECE MEAL APPROACH: FUNDAMENTALLY UNSUCCESSFUL

I think that there are problems with approaching the solution to this problem on a piece-meal or incremental basis. No element in our health care financial system is in isolation from the others. Each one has consequences and, if we change one element of it, it has ramifications that we had better pay attention to before we make the change. For example, should we try to expand access without controlling all health care costs? Many people argue, "Look, let's worry about the other later; let's deal with this now; this is something that we can manage." The problem with that is that when you create a program essentially for the lower income uninsured population, it is a program that remains politically isolated. In order to keep down total program costs, you have to do one of three things. You have either to restrict eligibility, thereby making it available to less than the entire uninsured population you want to target; you have to reduce fees paid to providers, which means reducing their participation and thereby lowering access; and/or you have otherwise to decrease and restrict utilization compared to other programs, again turning off providers and restricting utilization and access by the target group. Furthermore, we end up increasingly segmenting what is already a tremendously segmented insurance market. For example, while it is very expensive to insure just the high-risk population as one group, it is not very expensive to insure them, per person, as a part of an enormous risk-group. Basically, if everyone is in one large risk-pool together, then the average cost of insuring those high-risk people for their very large expenses is something that would be negligible to almost all of us. And finally, just doing that, and putting more money into the health care system, only fuels health care inflation for all payers, not just for the payers of this new target population.

Suppose, on the other hand, that we control health care costs without providing universal coverage. Maybe that is a better alternative, deal with that first. Well, in a sense that is what has been happening for the

last five or seven years in the United States—and we have seen it very brutally in California—with PPOs, HMO contracting and the Medicaid program contracting with hospitals.²⁹ What we have seen is that hospitals have responded to increasing costs by reducing indigent care, finding ways to shut-out uninsured poor patients because they have no place left to cost-shift.³⁰ So, if you are going to shut off the options for cost shifting, then you have to provide coverage to those people. Hospitals in Los Angeles and other places in California are closing their emergency rooms and their trauma centers because those are the routes through which most of their uninsured patients come into the hospital, running up bills in the millions of dollars a year.³¹

12. UNIVERSAL FINANCING FOR A FEDERAL HEALTH CARE SYSTEM

So where does that leave us? In my view, it leaves us with having to embrace a universal financing system for the United States. I think that system has enormous advantages and let me tell you a few. First, a universal program does create an enormous risk-pool so that the cost per person is really very low, even for the high-risk population. Secondly, it eliminates cost-shifting because everybody is covered, so that providers no longer have to provide free care and find a way to pay for it by charging it against somebody else's bill. Third, it allows us to control health care costs much more effectively, and that is the lesson of all other industrial countries in the world. There is not one other industrialized country that spends more than nine percent of its gross national product on health care. We spend over eleven percent and ours continues to go up, whereas theirs have remained flat for a number of years.³² We spend thirty-eight percent more dollars per person in this country than Canada does and sixty-six percent more than Sweden, and they cover their entire populations and, despite Senator Drake's comments, they have very high levels of satisfaction among their populations with their health care systems.³³

Fourth, a universal financing system would enable us to control and reduce administrative costs. About half of the difference between what we spend per capita in the United States and what Canada spends per capita, and remember there is a thirty-eight percent gap there, is ac-

²⁹ See *Symposium on Medical Cost Containment*, 3 NOTRE DAME J. L. ETHICS AND PUB. POL'Y 161 (1988); see also Samuelson, *Pampering the Elderly*, Wash. Post Oct. 24, 1990 at A19, col. 2; see also *Cost Containment of Hospital and Health Care Costs—The Regulated Marketplace*, 13 FLA. ST. U.L. REV. 795 (1985);

³⁰ See Marsh, *Health Care Cost Containment and the Duty to Treat*, 6 J. LEGAL MED. 157 (1985); see also Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719 (1987).

³¹ See Spiegel, *Hospital: A Crisis in Critical Care*, Los Angeles Times, Sept. 3, 1989 at I-1, col. 3; see also Brown, *Public Hospitals on the Brink: Their Problems and Their Options*, 7 J. HEALTH POL. POL'Y & L., 927-44 (1983).

³² U. S. *Statistical Abstract 1990* Table No. 690, at 425, Table No. 1446 at 840.

³³ *Id.* See also Blendon & Taylor, *Views on Health Care: Public Opinion in Three Nations*, 8 HEALTH AFFAIRS 149-57 (1989).

counted for by higher administrative costs in the United States compared to Canada's system of paying for medical care.³⁴ That is a big savings that we could take advantage of. And finally, we may not have to raise taxes very much in order to extend coverage to the entire population if we use a universal financing system because many people might argue that we already pay enough for health care as is. Since we spend approximately forty percent more than the second most expensive country in the world, one could well argue that for \$600 billion a year, we can indeed take care of our entire population, perhaps by eliminating duplication of services and excess capacity in hospitals, doing it in a rational way, by controlling and reducing our administrative costs, and by allocating our health care dollars effectively. Thank you.

C. DEAN SMITH

Thanks very much Rick. One of the joys that we have in Cleveland is that we can look to one of the experts in the country on health and long term care. Congresswoman Mary Rose Oakar is someone who cares about a wide range of things affecting the quality of life, from health care to libraries. She serves on the Select Committee on Aging and the Subcommittee on Health and Long Term Care. I mentioned that she is a fine arts professor. We consider her an honorary law professor in addition, which means she may use this building when ever she wants but doesn't have to attend the faculty meetings. Welcome.

D. CONGRESSWOMAN MARY ROSE OAKAR

Thank you very much, Dean Smith. I will tell my brother Jimmy, who is an attorney, that you said that. I appreciate it. It is a pleasure to be here, and I am not going to take quite as much time as our distinguished visitor from California because you can get at me at any time.

1. THE PEPPER COMMISSION

The Dean noted that I am a member of the Pepper Commission.³⁵ There are fifteen of us on the Commission, twelve members of Congress who were appointed by the leadership of the House and Senate and three from

³⁴ See Evans, *Controlling Health Care Expenditures—The Canadian Reality*, 320 NEW ENG. J. MED. 571 (1989); see also *Canada's Health Care System Faces its Problems*, 322 NEW ENG. J. MED. 562 (1990); see also *How Canada's Health System Works*, 7 BUS. & HEALTH, 28 (1989); see also *Canadian Way: Universal, but not Immediate Access (Canada's Universal Health Insurance Program)* 19 MOD. HEALTHCARE 28 (June 9, 1989).

³⁵ *Medigap Insurance: Expected 1990 Premiums After Repeal of the Medicare Catastrophic Coverage Act, Testimony Before the Senate Special Comm. on Aging, Cong., Sess.* (1990) (statement of Janet Schildes, Director of Health Financing & Policy Issues).

the private sector who were appointed by the President of the United States, including a representative from the AMA, and a representative from the insurance industry. We don't have many consumer representatives on this Commission but, nonetheless, I believe the members of Congress are supposed to fill that role.

I want to tell you a little bit about what I think are our real problems, and how we're addressing them on the Pepper Commission. But first, let me say that we have an awful lot of problems with the recent repeal of the Catastrophic Care Bill.³⁶ I worked six years to get mammogram coverage somewhere in some kind of plan, because our office could show that it would save money, which is always the bottom line when you talk about these issues; and, of course, it would save an awful lot of lives. So, can you imagine how you feel when this legislation finally was part of a bill, the Catastrophic Care Bill, the only preventive care portion of that Bill, and it was repealed before it was even accessible to the public?

2. LACK OF A LONG TERM CARE STRATEGY

In addition to repealing that Bill, another problem is that we have no long term care strategy in this country and really no comprehensive national health policy. We simply don't think comprehensively in this country. And so, the charge of the Pepper Commission, which the late Senator Claude Pepper initiated, is to conduct a study on what we do about the thirty-seven million Americans who have no health insurance³⁷ and the thirty-six million Americans who have health insurance but for whom it is painfully inadequate.³⁸ Then add on about twenty million older Americans who have Medicare which only covers forty-five percent of their needs.³⁹ The Commission also is studying long-term care strategies in terms of what we do about the problems that families face when there are seventy year old children taking care of ninety year old parents because the good news is that everybody is living a lot longer. The fastest growing group in our population is people over eighty-five.⁴⁰ What do you

³⁶ Catastrophic Care Act of 1988 (P.L. 100-360).

³⁷ See generally Kasper, Walden & Wilensky, *Who are the Uninsured?*, NATIONAL HEALTH CARE EXPENDITURES STUDY, DATA PREVIEW 1. NATIONAL CENTER FOR HEALTH SERVICES RESEARCH; 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 [hereinafter *A Profile of Uninsured Americans*].

³⁸ See generally Woodward, *Private Health Insurance and the Underinsured*, 4 HEALTHSPAN 3 (1987).

³⁹ See also Warren, *Serving the Health Needs of Aging Americans: Market Opportunities and Legal Permissiveness*, 17 CUMB. L. REV. 469 (1986-87); see generally, U. S. DEPT. OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION, *MEDICARE AND MEDICAID DATA BOOK*, 1988 (1989).

⁴⁰ U. S. *Statistical Abstract 1990* Table No. 41, at 37; see generally Friedman, *Helping the Uninsured Employed*, 27 MED. WORLD NEWS 41 (May 12, 1986); see generally Monheit, *The Employed Uninsured and the Role of Public Policy*, 22 INQUIRY 348 (1985);

do about the families who have children with chronic problems and need some help to be health providers and home givers and who also need other elements such as resident care?

3. WORKING TOGETHER TOWARD A SOLUTION

I know that the great thing about this group, for the benefit of guests who may not know the people in the audience personally (and I have the pleasure of knowing many of you personally) is that you have attorneys in the audience, you have health care providers in the audience, you have doctors, you have community activists, you have community leaders, you have some people who are on the cutting-edge of all these issues. And we are especially proud here in Cleveland of the small business community having a significant affect by creating the kind of insurance plan that provides coverage at reasonable rates for 50,000 people who work for small businesses in this community. So, we have this cross section of people who could definitely have an impact on legislative decisions if we could only work as a team.

It is absolutely frustrating for me to talk about the repeal of the Catastrophic Care Bill; it seems that all we end up doing in Congress is fighting about things. We have an Omnibus Drug Bill that we will be working on, and sixty-four percent of the Bill is for construction of new prisons. And there is nothing in the Bill as it stands on alcoholism treatment, very little on education, and very little on drug treatment, etc. So, when you see what is out there, I have to say that I agree with you totally that we can no longer deal with this issue piece-meal. We have eighty different programs in the federal government that deal with long term care and none of them cover long term care comprehensively.

4. RECOMMENDING A PLAN TO DEAL WITH THE UNINSURED

What is the purpose of the Pepper Commission? We're charged to discuss and recommend a plan to deal with the uninsured. I fully support Medicaid, and I am sorry that the states can't do more for those people who fall between the cracks, the near-poor individuals who need more types of coverage. But the fact is, of the thirty-seven million Americans who have no health insurance, eighty-eight percent of them work but do not have access to insurance for one reason or another. Their jobs either do not include it as a benefit, or perhaps they have a chronic health problem and cannot be covered. For example, when the Pepper Commission held hearings in Cleveland, we heard from a woman who was making \$70,000 a year. Of course, you say that she's lucky to make that kind of money, but she has a chronic health problem and can't get insurance because she owns her own company and cannot plug into the COSE Plan. So, in addition to the whole spectrum of people who have no insurance at all, we also have many Americans who have health insurance that is simply not adequate.

5. WHO NEEDS HEALTH INSURANCE THE MOST?

Who are the people who need health insurance the most? I find it interesting that it is the eighteen to twenty-four year olds that form the largest group that is not insured.⁴¹ People will tell you that it is because they elect not to have health insurance. They think they are healthy. The truth is, many of them are in jobs that do not provide any type of health insurance.⁴² We have a situation, as you probably already know, where one-third of the uninsured are children under the age of eighteen.⁴³ Because of that, one of the reasons why you have so many female head of households who are on welfare, wanting to remain on welfare where they receive Medicaid, is because we still have not provided a flexible method of transition from welfare to employment that allows them to retain their medical benefits. Now, I don't understand how anyone could want a good mother to imperil the health of her children by going out and getting a minimum wage job with no health insurance.⁴⁴

6. THE HEALTH CARE CRISIS

So, we have a crisis in this country, a true crisis, and the question is: what do we do? Twelve percent of our GNP is spent on health care, while other industrial nations spend only about seven to nine percent of their GNP on health care. But despite that level of spending, the fact remains that many people today do not have any kind of access to health insurance. So what do we do? Well, I think we need a comprehensive bill to put on the table. We are meeting this Friday, and I know what people are going to recommend to our Commission. They are going to recommend piecemeal approaches, do a little fine-tuning on long term care. They are going to propose, perhaps, doing a little more on Medicare, doing a little more on Medicaid. But they are not going to face reality and say we need a comprehensive strategy. Whether it's a private/public partnership, or it's fully funded in a public way, we need to have every American with full insurance, and we need to have a long term care strategy.

7. WHAT ARE THE SOLUTIONS?

Our Commission has studied various strategies throughout the world. We have studied the Canadians, we have heard people from Great Britain

⁴¹ *U. S. Statistical Abstract 1990* Table No. 152; see generally *A Profile of Uninsured Americans*, *supra* note 37. See Chollet, *supra* note 2.

⁴² See generally Friedman, *Helping the Uninsured Employed*, 27 *MED. WORLD NEWS* 41 (May 12, 1986); see generally Monheit, *The Employed Uninsured and the Role of Public Policy*, 22 *INQUIRY* 348 (1985).

⁴³ *U. S. Statistical Abstract 1990* Table No. 152, at 100.

⁴⁴ See generally, HILL, *MEDICAID ELIGIBILITY AND COVERAGE FOR PREGNANT WOMEN, CHILDREN AND FAMILIES*, NATIONAL GOVERNOR'S ASSOCIATION (1989); see generally Kasper, *Health Status and Utilization: Differences by Medicaid Coverage and Income*, 7 *HEALTH CARE FIN. REV.* 1 (1986).

and France, we have had people from Italy in, we have heard people from the private sector and public sector, the states, etc. I think we, as Americans, can no longer regard ourselves as truly civilized with this crisis going on. Now we are seeing an increase in abuse within families in this country: elder abuse, spousal abuse problems, child abuse problems. I am convinced that one of the reasons for this is that we do not have a long term care policy that assists families who have problematic family members, who need readily accessible services and in-home health services. I am also convinced that you can not put the burden of the entire cost on business or any one sector in society.

And so, what I am looking at in the bill that I am in the process of preparing, is to provide some form of universal coverage that provides reasonable freedom of choice in the selection of a team of health professionals. Such a program of universal coverage will not be biased against those individuals who want to have an additional private health insurance policy, but will provide a basis of standard coverage that can be folded into that supplementary private insurance as they do in Canada.

I am not enamored with everything about the Canadian plan. Many Canadians come to Greater Cleveland for health care because they're placed on a waiting list in Canada.⁴⁵ For example, I just had an experience involving a Canadian woman who found a lump in her breast, and she was put on a waiting list and told she would have to wait about a year for surgery. She waited, but after the year passed, and she was still on the list, she came to Cleveland and learned that her breast cancer had traveled. Unfortunately, they didn't get it soon enough. So everything is not perfect with the plans of our neighbor and the European countries. But, at least they provide an accessible standard of health coverage for every single citizen, and, in most of the provinces in Canada, they also provide long term comprehensive care. We heard testimony from a man whose mother, here in Cleveland, and mother-in-law in Canada both suffer from Alzheimer's Disease. And the difference between the kinds of services that were available there, as opposed to here, was unbelievable. You have to say that Canada does a better job in terms of long-term care.⁴⁶

8. THE BOTTOM LINE

People in Congress always like to get to the bottom line. They'll say the reason we have to cut Medicare by ten billion dollars is that we can't afford to deal comprehensively with the problem. We have a huge budget deficit. But I think we are in terrifically exciting times, and that is the challenge that I would give to every single person in this audience. We have discussions on arms control going on; we have people throughout the world seeking democracy; and all of this lowers the need for military spending in our budget. I vote for a quality defense, I really do, but the truth of it is that we spend over fifty percent of your tax dollars on military

⁴⁵ See Evans, *supra* note 34.

⁴⁶ See generally Petite, *U.S. and Canadian Systems Compared*, 20 MOD. HEALTHCARE 562 (1990); see generally Iglehart, *Canada's Health Care System Faces Its Problems*, 1 NEW ENG. J. MED. 322 (Feb. 22, 1990).

items in the budget. Because, if you exclude the Social Security trust fund, which we should do, military spending is almost half of the budget. Also, some of us feel there ought to be an element of burden-sharing with our allies because we pay the lion's share for NATO security. West Germany has free education and free health programs for every single person, and we are really picking up the tab in many ways for their military expenses through NATO.

We also spend tremendous amounts of our tax dollars on the security of Asia, including Japan. While I think we should be out there and have a presence in the Philippines and other places throughout the world, the fact is that with this reduction in tensions as the Cold War ends, I think we should redirect our spending to reduce the deficit, and I also hope we can take a look at what government's responsibility is in providing an anchor of health care and other related services for every American.

That is the charge of the Pepper Commission. That is what we are going to be debating this Friday in terms of the varieties of options that our staffs will be putting on the board. We will be looking at all of them. I hope that the Commission report, which comes out in March, will say that as Americans, we feel that everyone should have access to health care. If we cannot now say that and mean it, then shame on us because we are in a crisis, ladies and gentlemen; and all you have to do is take a look at the hospitals and see how many people they are laying-off because of a lack of funds. It is not always the hospital's fault because we in Congress have reduced many of their benefits programs for the indigent and the elderly.⁴⁷

So, I really call upon you to not be confrontational in terms of your points of view but, as Americans, unite in a solution. I guess I am an optimist, because, even though we have people on all different sides on this Commission, I really feel we should be able to develop a consensus and come to a final conclusion about this crisis. I won't go into all the charts and plans because you might want to ask questions, and I will be delighted to hear from you. That is my position on this issue as a policymaker in the United States Congress. So I would be glad to hear from all of you. Thank you.

E. DEAN SMITH

We are going to have a slight change from the announced schedule because Mary Rose Oakar must leave very shortly. So we are going to pause for a few questions before she leaves and then Randy Bovbjerg will provide a response.

Q. Does your position represent the majority opinion of the Pepper Commission or are you in the minority?

⁴⁷ See Rowland, Lyons & Edwards, *Medicaid: Health Care For The Poor in the Reagan Era*, 9 ANN. REV. OF PUB. HEALTH 427 (1988).

A. Mary Rose Oakar: I think, in terms of the bill on which I am now working and that I will ultimately introduce, that not everyone will agree with me; but I still think it has to be put on the table. I think there is agreement with the philosophy that everybody ought to have health care, but we can't bite the bullet and figure out how to do that. We should be ashamed of ourselves in the Congress and Administration if we don't figure out a solution, especially when this Commission has been spending months trying to arrive at a positive conclusion. We should divorce what happened with the catastrophic health insurance issue from what will happen in the future. I say this because I think one of the big problems with that bill was means-testing. I think that it is absolutely awful to employ a means-test in any medical care program—I truly do. What happens is that you pit “near” poor people against the poor. There are very few wealthy older people. Most older people are at or near the poverty level: an average woman lives on \$400 a month; the average man does not live too much better. He lives on \$500 a month, and fewer than thirty percent of them have access to another source of income.⁴⁶ They fall through the cracks in terms of SSI and other related programs, and what you have is a situation in which you have a sort of “near” poor lower income group fighting the down and outers. That is crazy, and that is a manipulative kind of thing that the administration and members of Congress sometimes do. But the real problem transcends what your income level is—whether it's poverty or near poverty level or moderate or middle income—and despite the repeal of the Catastrophic Care Bill, I think we have to put that aside and go on to the future, keep going because we have to do something about the crisis.

Q. How do you feel about a central insurance source, a total federal program? I also heard you talking about an insurance partnership. Which way do you think they are leaning?

A. Mary Rose Oakar: I think that we should agree that there would be freedom of choice because I think many people would say they don't want to have socialized medicine. They don't want to be told what doctor and what hospital to use. I think that is fair to put that on the table. After all, today, people do pay something towards their Medicare coverage. I personally feel that if we take all the government programs that relate to health care and combine them all into a universal plan, the savings from the elimination of duplicative bureaucracies would itself put a big chunk of money on the table. And then you could have some additional revenue that could be generated out of maybe a sin tax of some kind. I mean why not increase the tax on tobacco and alcohol? I don't think people would mind paying another three or four cents for a pack of cigarettes or a few pennies on a glass of beer or wine. Then you combine that with maybe people paying something for insurance. The average senior in my district has two or three policies. They pay a lot for their

⁴⁶ U.S. STATISTICAL ABSTRACT 1990 Table No. 734 at 454.

health insurance. They have Medicare and then they get Medigap, and they try to get some cancer insurance. They are paying an awful lot for their policies, so I think people, those who could afford it, would be willing to pay something toward a policy. We may even get the private insurers involved to provide that. I think it is really possible to work out a deal where everybody kind of says: "I hate the plan, but I am still in there because it's better than what we have." And that is where my thinking is because you have got to compromise with some kind of universal accessibility. I think that is what my bill is going to try to do, and we can then work on some fine tuning in the Commission.

Q. Rick Brown suggested that with a universal health care plan we could really just shift some of the record-keeping money and some of the other administrative resources of the eleven and one half percent of GNP now spent, and that would create an efficiency that would provide some additional funds for medical care. But it also hints that some people receiving medical care now should not be receiving some services. Are there some services that people should not be receiving?

A. Mary Rose Oakar: I don't know of any service people receive today in health care that they should not be receiving. The problem is that we have been taking the decision away from you doctors and hospitals, and you know we have been doing that. We have been taking lots of services and avenues of access away from you. So I guess off of the top of my head I would say no, but the government does have a database that, somehow, in terms of efficiency could provide the mechanism for universality that makes that type of cost cheaper. I don't know if that is exactly the same thing, but I do think there is potential here, involving the private sector also somehow because we need everybody working together; and I think it is possible. We're just going to have to wrestle with that issue and see what happens. But I certainly agree with our distinguished guests that we ought not to do this piece-meal. If we take Medicare as an example or expand Medicaid as the example of what we want to do and fine-tune that, that is a cop-out. Because these models, in my judgment, are inadequate to begin with. So, all we are doing is adding another piece-meal approach to the problem. We ought to think of health care as a national security issue.

F. DEAN SMITH

Thank you Congresswoman. You already know Randy Bovbjerg, so without further ado, Randy, a few remarks in response.

G. RANDALL R. BOVBJERG

This is the time of day when we all begin to appreciate the value of fixed schedules: there're only fifteen minutes until the reception. Amazing how a fixed budget focuses the mind, isn't it?

1. THE ISSUE OF HIGH RISK POOLS

The Brown paper is a very good summary of the current system as piecemeal, patchwork, or fill-in, whatever you want to call it. I pretty much agree with almost everything he says about inadequacy, in the sense that so many people are still left uncovered. I would like to take issue with one thing he said because it presents a real issue in thinking about going to a global approach. That was the remark that high-risk pools—which have distinct limits as a strategy, are expensive because when you isolate these people they cost a lot per head, but if you put them in a broader pool, they would be cheaper. That is simply not true. In a broader pool, high risk people cost just as much, and perhaps more, because if you put them in a better plan and give them better access, it will cost more. What happens, of course, is that the broader pool provides a larger source of funding, so everyone else's premium is only a little bit higher, but the costs imposed on the pool, i.e., the marginal cost of a high-risk individual, is exactly the same or higher than when those people are in a narrower pool.

My own suspicion about many of the uninsured, however, is that usually they do *not* cost more per head. In general and on the average, they may be in better health than people who have insurance; not having so many health needs is a good reason for foregoing coverage. That is only a suspicion, and it remains to be seen if I am correct.

Representative Oakar performed a very useful service, especially by mentioning the long-term care issue, and I wish she could have talked more about that. It is an extremely important issue, with different dynamics from the medical model we are used to dealing with on the acute side. Certainly, private insurance is a generation or more behind, although it is attempting to catch up.

2. THE ELDERLY AND LONG TERM CARE

Again, I have one disagreement. My understanding about the average fiscal status of the elderly is that they are slightly better-off than the general population, with a higher per capita money income after taxes and lower percentage below the poverty line. And in terms of assets, their net worth is higher, especially because many more of them own their home. They are better off than the rest of the population, except for some elderly living on social security alone. But, be that as it may, I think it is very helpful to focus on long term care because if you need much of it you are going to be impoverished. There is no question about that: many who go in, don't come out. Fortunately, over half the people who go into nursing homes do come out.⁴⁹

⁴⁹ U.S. STATISTICAL ABSTRACT 1990 Table No. 178 at 113.

3. TWO APPROACHES TO HEALTH CARE

Let me talk very quickly about two types of approaches to health insurance. We have focused differently at different points during the day. First are global plans or national health insurance or some broad approach. Second are incremental plans, although in this last session we didn't say anything good at all about patchwork approaches.

4. COST CONTAINMENT DOES NOT EQUATE TO HEALTH CARE ACCESSIBILITY

To start off, cost-containment or controlling spending or whatever you want to call it, getting value for money, is not the same thing as getting health insurance to people. They are not necessarily connected. On the face of it, giving people more coverage is not going to make it cheaper; let's start out with that. There is no such thing in any coverage anywhere, in Canada, Germany, or any place, where you give people free access to care, and they use less of it. That is a crock. In Great Britain at the end of World War II, they argued that it would be cheaper to have national health insurance than not to have it. Why was that? Because before national health insurance people had unmet needs. It is clearly true that uninsured people will skip much health care. But if you cover more people, you are going to raise utilization, raise demand, and put upward pressure on price. Yet in Great Britain they thought that the price would go down. You would meet the unmet needs and then, when people had their unmet health needs met, you'd be done with it.

Well, I have news for you. At one time people thought there was such a thing as limited medical need, and there is in a certain sense, but need is not a limiting concept as once thought. Rather, it is an expansive concept.⁵⁰ As Walter McClure, the architect of the Buy-right system,⁵¹ said at one point, the health care system is a little bit like a vacuum cleaner: once turned on, it can suck up everything in sight. It is not self-limiting; there is almost no limit to what we can spend and still do some good, some small amount of good.

Because that point about unmet needs can be exaggerated, I will exaggerate in the other direction to make a point going the other way. When you think about living in Germany, it is very attractive as regards health care. And why is it attractive? Because their safety net really is a safety net. It does not have all these holes in it. Thus, if you lose your job or you want to start a small firm or anything like that, you can do it without worrying about paying for health care. That is one worry in life people

⁵⁰ See generally Goodman, NATIONAL HEALTHCARE IN BRITAIN: LESSONS FOR THE U.S.A. (1980); see generally A. CUYLER, NEED AND NATIONAL HEALTH SERVICE: ECONOMIC AND SOCIAL CHOICE (1976).

⁵¹ See, e.g., McClure, *Buying Right: The Consequences of Glut*, 2 BUS. & HEALTH 43 (Sept. 1985).

don't have which is very attractive, and people should be willing to pay something for that.

5. UNIVERSAL ACCESS AND QUALITY OF CARE

Now, be careful when you hear any of us intellectuals talk about how great universal access is and how "we" need to rationalize the system to save money on administrative costs that those supposed dummies at Blue Cross are always over spending. Remember that what we usually have in mind is that this new system will be guided by a class of planners, and guess who is going to be in line for those \$70,000 a year planning jobs, of course with full fringe benefits. Similarly, when doctors talk about quality of care, they are talking about something that is very important, and yet, at the same time, as a colleague of mine says, when they mention quality of care, hold on to your wallet. So when the intellectuals mention rationalizing the system through planning—get ready—guess whose interest the system is going to serve? It is certainly not going to be the man on the street who is going to be well-represented among planners. That is not to say that an elite cannot do planning; it is to say that I think you should be careful about it. It is also to suggest that global systems should feature considerable decentralization and choice.

6. COMPARING THE UNITED STATES TO OTHER NATIONS

I am also quite tired of hearing all these comparisons of GNP percentages devoted to health spending. There is no dispute about any of that: we spend more. The question is, do we want to spend more, and if not, what are we going to do about it? Canada spends less, Great Britain spends less, so you might want to live in Canada or Great Britain or, more realistically, you can try to move one of those systems here. But can you do that? Bob Evans,⁵² who is perhaps the leading Canadian health economist, agrees Canada is a lot better. That is the good news. The bad news is we cannot have it in the United States.

If we move the Canadian system here, or any other system, we are still going to have the Americans running it and using it. And we can look at all the restraints they have, asking whether we the people would put up with it. Remember, we are the nation that brought the fuzz-buster to the world. Americans do not like to stand in line; Americans do not like to follow rules; Americans will bend the rules or cheat. If you think that the Canadian system, exactly as it is, will work here, think again. It just does not seem completely transplantable. This does not mean that a lot of the incentives might not be useful. Certainly, the concept of a safety net is extremely appealing. So, in many ways, is the concept of regional control over system spending.

⁵² See generally R. EVANS, *STRAINED MERCY: THE ECONOMICS OF CANADIAN HEALTH CARE* (1984).

7. GLOBAL SYSTEMS

Global systems and their design can be approached in different ways. This afternoon has mainly addressed health planning-style global approaches, and it is certainly the case that global regulation, and particularly global budgeting, could work, in the sense that if you set a budget and you tell someone to live with it, they probably will. Not necessarily, though. Remember we have something like global budgeting for the Pentagon. Liberals often favor global budgeting for the doctors, and yet they'd say that a not dissimilar system for the defense contractors in the Pentagon does not work so well. Global budgeting is not magic; it is the set of incentives that really matters.

8. "BLACK-BOX" DECISION MAKING

Remember, too, that global budgets foster "black box" decision-making. The way these other countries work it, for the most part, is to put the doctors and the hospitals in charge, give them a budget, and then don't ask too many questions. Trust them to use professional judgment. This makes for good economizing incentives and good provider relations, but you don't really know what is going on. One feature of current U.S. health care and health insurance is a tremendous paper trail, hopefully a computerized paper trail, that lets you look at what actually happens in medical services.

One of the very great needs of the next generation of health policy is understanding what works, what does not work, what people like, and what people don't like. We have got to know what is happening out there. Suppose you've given a hospital an annual budget, like the V.A., and you want to find out at the end of the year what actually happened, and whether X, Y or Z is more effective. Without a paper trail, you have to mount a special study. But if you are willing to put a little bit more money in on top of the administrative costs of processing the bills, you then have a data system in place. People haven't started to appreciate that.

9. THE BUREAUCRATIC MAZE - SOME SURPRISING BENEFITS

Unusually, the federal government might be in the lead on this. One very good thing about their bureaucratic maze is that it produces data for tracking what people have done and what the outcomes were: what other services they got afterwards, whether they are dead or not, whether they go back into the hospital. One good thing about that system is that, unlike a study where you ask people to volunteer, you get full participation because doctors and their patients like to see their medical bills paid. So, when they receive or perform a service they submit for it, and then you can know exactly what has happened. If you try to get that data from a study, let me speak from experience, you can go out and ask, "How many X, Y, or Z did you do?" You may get an answer, and you may not get an answer; you may be correct, and you may not be correct. The other

benefit of the paper trail is the validity of results. If they did not do the procedure, and they submit for it, they run the likelihood of going to jail. That tends to penalize over-reporting. If you did do the procedure and don't report, you won't get paid. That penalizes under-reporting. So it is a pretty good data system, although it is quite costly to run that way.

10. INCREMENTAL PLANS

I'll speak very briefly on incremental plans because that is the way we are headed. The big problem is that we are not willing to pay for the full package many of us would like. When you look at all these incremental things, they are all unfunded relative to the "need." Look at Medicaid. Here we are talking about states. Because of the federal matching payment, they're spending "50 cent dollars" or even "25 cent dollars." Even so, no one is at the maximum use of those federal matching dollars. Where states have got a fairly comprehensive program, they choose not to pay doctors enough to get high participation. Where they are generous, they tend to be stingy on eligibility. Even when heavily subsidized, states don't want to spend as much as they could to help the unfortunate.

11. THE "GUILT TRIP" - AN UNSUCCESSFUL APPROACH

The political willingness to spend is simply not there. If you want more coverage, what are you going to do about that political attitude? Well, what most of us do is to try to put a "guilt trip" on them. We ask, "Don't you feel terrible to live in this great country of ours and see others denied care because you don't pay for this?" So far, that approach is not working. What might work on the incremental basis is to develop the sense that everyone is in health services together. We shouldn't try to make people feel guilty about not helping someone because that's not a real, winning strategy. It's more valuable, I think, to play on Americans' native decency and sense of altruism. It also would not hurt to note that anyone can lose their job and health coverage or be hit with massive bills. Look, we can all make our lives better; this can help all of us.

Get more help directly to the uninsured people, and from themselves as well. Charging premiums is something that has not been mentioned much today, but there is individual responsibility. What do you say about people who choose not to have health care insurance? What do you say about the three million kids in this country, one of whose parents could obtain group insurance, but who is simply choosing not to pay the premiums? They have a group rate available to them; they don't have any search costs. All the things you can think about that would make things easier and better, all the types of things that COSE does, all that is there. And here are people who don't pay; they simply think it costs too much. Many, but not all, are poor; and even the "near" poor could contribute something. Many in similar circumstances do get coverage. We could socialize the full cost, perhaps making that decision from inside the Beltway or better perhaps, in Columbus. But you have to ask, "Why it is that some people are not paying anything now?" And, "Should even the poor or 'near' poor get a completely free ride?"

12. THE SPECIFICS - GOING FROM "MACRO" TO "MICRO"

Now when it comes to saving more money under any of these plans, lets get specific. We all like to talk "macro" because it is fun, especially fun if we can go to speak in London at a "big think" conference. What really drives health care spending, however, is not "macro" developments. We can talk in "macro" terms of the percentage of people uninsured in proportion to GNP, but where the rubber really meets the road, developments are very "micro" phenomena. It comes down to clinical, one-on-one situations, with people who need health care, who want health care, and a doctor or some other providers who try to help them. And unless and until you affect those incentives, you are not going to change things. Most of the change in getting broader coverage is going to affect those incentives in a way that will lead to increased utilization and, because of the dropping of price resistance, to higher fees or salaries. So, we should be very specific about how we are going to save more money by giving more care.

I think at the end there is really no substitute for well motivated, informed judgment. This is true equally for in a well-run global system that is more socialized or for a well-run managed-competition system. Either one needs somebody in charge, someone well motivated who has the information and the means to do something. We need more people like John Polk on the insurance side; we need more intelligent managers who are not just following the rulebook on the medical side. I will save my last anecdote because I have used up my ten minutes. Thank you.

H. DEAN SMITH

Thanks, Randy. I would like to give Rick Brown a chance to respond to the same question. Do you think that some people who are receiving health care now should not receive some of the care that they are receiving, or do you really think that we can provide the same level of care more efficiently?

A. Richard Brown: No, I don't think that all the money that we need to provide care to the whole population can be garnered from greater efficiency. What I am saying is that we can save a substantial amount, which could be applied and thereby reduce the need to raise additional funds. And I think that is something that can clearly be done. We also need to determine which procedures are ineffective or actually cause harm. When we learn more from the kinds of studies Randy was talking about, which are now going to be expanded through funding from the federal government, we will be able to learn more to help guide us. Those are the kinds of micro decisions that I really agree with; however, I would like to take exception to a couple of things that Randy said.

One of them is on the issue of macro versus micro levels at which we look at these things. As in any marketplace, it's those transactional decisions that make a difference in the aggregate, but we can influence

each of those decisions, both through providing information from good studies about what is effective and what's not, and also through the incentives that we provide. We do that now. In fact, about six years ago we reversed the incentives for hospitals. Beginning in the next few years, that is going to be happening for physicians under Medicare.

Also, on the issue of foreign comparisons, I, for one, do not advocate the Canadian system being transplanted to the United States. I agree with Randy. I don't think it would work the way it does there when it is transplanted here. My argument about looking at other countries is that what we learn from them can inform our own decision-making about what we want to do with our system here. I think the notion of trying to save money through administrative savings is an important lesson, even if we are not going to do it the same way that they do.

I think that universal coverage does not provide cost containment. I don't think I said that. My argument about the issue of universal coverage is that it allows us to contain costs in a way that is impossible when we have 1500 different health plans and 175,000 different self-insured employers, all paying doctors and hospitals according to their own methods. I think that is an important area in which we can begin to save costs and use our money more rationally.

I also want to make a minor correction to one statement about the issue of high-risk people being added to a very large risk-pool. It is not that their high costs per person are necessarily reduced by that process, but rather that the average costs of having the higher risk people included in the pool is almost negligible to the average person in the population because it is a very large pool, and we are talking about small numbers of high-risk people. The point is that the better solution is to create larger and larger risk pools, going back to community rating which is where health insurance in this country started some forty years ago, and moving away from the increasing segmentation that comes with narrower and narrower experience ratings.