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Proceedings of the Inaugural Conference of the Law & (and) Public Policy Program: An Introduction and Summary

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I. PROCEEDINGS OF THE INAUGURAL CONFERENCE
OF THE LAW & PUBLIC POLICY PROGRAM:
AN INTRODUCTION AND SUMMARY

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A. Introduction

"Ohioans Without Health Insurance: *How Big A Problem? Are There Solutions?*", was the INAUGURAL Conference of Cleveland State University's Law & Public Policy Program, an interdisciplinary program of instruction, public service and research sponsored jointly by the Cleveland-Marshall College of Law and the Maxine Goodman Levin College of Urban Affairs. The goal of the Conference was to facilitate an exchange of information and views among representatives of the public and major interests concerned with the growing numbers of persons who either lack health insurance or have inadequate coverage.

Conference speakers represented health care providers (physicians and both private and public hospitals); the not-for-profit sector (foundations and health and social-welfare planning agencies); large and small employers; the health insurance industry; the private bar; elected officials from both state and federal government; and policy analysts. In addition, the question and answer periods that follow each of the Conference's four panels allowed for an unusually candid exchange of views between the speakers and those in attendance.

As its title suggests, this Conference focuses on the health insurance problems of Ohioans and the public and private initiatives that seek solutions to that problem. Despite this focus on Ohio, the Conference proceedings are not overly parochial, but often examine the experience of other states and other societies to gain insights into Ohio's situation. Thus, these proceedings provide the reader with both a general consideration of the health insurance problem and a deeper exploration of one state's efforts to address that problem.

The Conference proceedings as published are essentially a verbatim transcription of the presentations and question/answer sessions with limited editing and the addition of footnotes to assist readers by identifying or explaining certain references and providing citations to information sources. The sole exception is Randall Bovbjerg's Keynote Address, which is the author's expanded version of his Conference presentation. In the Summary of the Proceedings that appears below, the Conference sessions are presented in the order in which they occurred, except that the Keynote Address, which was presented mid-way through the Conference at a luncheon session, now appears at the start of the proceedings.

¹ Associate Professor of Law and Urban Studies, Director, Law & Public Policy Program, Cleveland State University. B.A., University of Pennsylvania, 1967; J.D., University of California, Berkeley, 1977; M.C.P., Massachusetts Institute of Technology, 1979. I would like to thank my Administrative Assistant, Louise Mooney, for her hard work in organizing this Conference and my research assistant, Mark Marshall, for his help in preparing the transcripts of the Conference for publication.

B. Summary of the Proceedings

In his Keynote Address, Randall Bovbjerg, Senior Research Associate at the Urban Institute's Health Policy Center, discusses five salient issues for decision makers to ponder in Ohio and in the nation: (1) What, exactly, is the problem? (2) What are the prospects for the creation of a National Health Insurance program? (3) What roles are likely for national, state, and local governments? (4) How can we design solutions to the health insurance problem and evaluate the trade-offs they pose? (5) What are we willing to pay? His major conclusion is that while there are many technically feasible solutions to the health insurance problem — each with a different emphasis, different structural characteristics, different benefits and different costs — there is presently no social or political consensus on the societal obligations that must underlie any possible solution. In the absence of consensus, he argues, the social, political and economic problems associated with addressing the problem seem intractable, particularly at the federal level. Consequently, any leadership in this area will continue to occur at the state level.

The morning sessions begin with Robert Eckardt's "Opening Remarks: An Overview of the Problem." Mr. Eckardt, Senior Program Officer for Health at the Cleveland Foundation, argues that there are three underlying causes for today's health insurance problem: changing patterns in employment and employee-provided health care coverage; decreasing coverage by governmental programs; and the failure of existing health care controls. These trends, for which he sees little likelihood of change in the short term, have combined to create a very large and growing population of under- and un-insured persons, primarily comprised of the poor and "near-poor," many of whom are the dependents of workers with little or no health insurance coverage. Finally, he contends that this situation is not the result of a failure to put resources into health care, but rather our failure to reach a consensus on how these resources could be more effectively and efficiently used that reflects deeper, unresolved moral and philosophical issues concerning health care.

The morning program continues with two sessions on "Defining the Problem and Searching for Solutions," the first examining the concerns of health care providers and consumers, and the second, insurers and employers. In the first session, Richard Buxbaum, Senior Vice President at the Center for Health Affairs of the Greater Cleveland Hospital Association and Henry Manning, President and Chief Executive Officer of the Cleveland MetroHealth System, present, respectively, the views of private and public hospital administrators; Dr. Daniel W. van Heeckeren, Chief of Pediatric Cardiac Surgery at University Hospitals, Cleveland and past-President of the Academy of Medicine of Cleveland, represents physicians; and Frank Kimber, Associate Director for Health Affairs of the Federation for Community Planning and Director of the Commission on Health Concerns, presents the views of consumers of health care services. The moderator for this panel is Nancy Roth, Executive Director of the Health Systems Agency of North Central Ohio.

In his presentation, Mr. Buxbaum addresses the problem of uncompensated care, noting that private hospitals have traditionally engaged in "cost-shifting" — passing on the cost of such care either to paying patients or insurers — so that those with the ability to pay effectively subsidize those who do not. But several recent trends — the growing number of uninsured patients, the increase in the rate of hospital expenses, and the unwillingness of third-party payers to absorb cost-shifting — are making this increasingly difficult and raise significant concerns for the long-term fiscal soundness of hospitals that attempt to provide free care for those unable to pay. In Mr. Buxbaum's view, there is currently no comprehensive answer to this problem. Furthermore, if hospitals are left to solve the uncompensated care problem on their own, without the assistance of the business sector, health insurance industry and government, hospitals will be forced to initiate cuts in services. To avoid this, Mr. Buxbaum argues, it will be necessary for all parties to work together toward a solution that combines increasing efficiency, through better assessment of the quality of care provided and changing current methods of service delivery, with an equitable approach to funding uncompensated care. Further, such solutions will be best achieved incrementally and at the regional level.

Frank Kimber's presentation combines observations about the consumer side of health care with a description of a local initiative that takes an incremental approach to the problems of Ohio's uninsured. On the consumer side, he stresses that, locally, the uninsured form three discrete groups: the uninsurable, those with pre-existing high risk medical conditions who cannot obtain insurance coverage; the adult population not in the workforce and their dependents; and the working poor and their dependents, who are uninsured, with this last group comprising about seventy percent of the uninsured population. Since the working poor comprise the largest segment of the local uninsured population, this group is the focus of a local demonstration project, sponsored by the Foundation for Community Planning, the Greater Cleveland Hospital Association and the Board of County Commissioners, that is designing a low-cost, no-frills medical insurance package that will be offered to a test group of five hundred low-income workers and their families.

Henry Manning's remarks focus on the increasing financial pressures faced by large urban teaching hospitals that currently are the major providers of health care to the indigent. These hospitals are unusually costly to operate since they not only provide uncompensated medical care for the indigent, but also offer a broad range of social services to disadvantaged patients and, further, must support a large staff of residents to provide the volume of service required by the indigent population. Further, because direct government subsidies and government-financed service reimbursement payments are not sufficient to cover these additional expenses, teaching hospitals find themselves at a disadvantage when they attempt to compete on price with hospitals that bear relatively little of the cost for care of the poor or for training doctors.

The final speaker on this panel, Dr. Daniel van Heeckeren, expresses several concerns of physicians. He notes that rule-based, cost-containment approaches to the insurance problem not only make it more difficult to practice medicine, particularly when the physician must obtain pre-approval for procedures and services that the physician believes are necessary, but can increase a physician's overhead because of the costs associated with meeting an insurance carrier's rules. Dr. van Heeckeren also suggests that physicians receive much of the blame for the rising costs of medical care, while, as a society, we are reluctant to see how our own poor health habits — such as smoking, excessive alcohol consumption and a sedentary lifestyle — are major contributors to the growth of health care costs.

In the second morning session, panel members present the views of insurers and employers. Charles D. Weller, a member of the law firm of Jones, Day, Reavis & Pogue, and Powell Woods, Vice President for Human Resources with Nestle Enterprises, Inc., respectively present the ideas of the Health Policy Coalition and Cleveland Health Quality Choice, twin private sector initiatives sponsored by major Cleveland employers. John Polk, Executive Vice President of the Council of Smaller Enterprises (COSE), the Greater Cleveland Growth Association, describes how his organization has been successful in holding down health insurance costs for thousands of small businesses. Finally, Kenneth Seminatore, a partner in the law firm of Climaco, Climaco, Seminatore, Lefkowitz & Garofoli, which represents Blue Cross/Blue Shield of Ohio, provides a candid personal appraisal of the health insurance problem.

Mr. Weller begins his presentation by noting that the task of providing adequate health care to lower-income Americans has become significantly more difficult in recent years due to both rising health care costs and the strains imposed on the United States economy by the Savings & Loan crisis, a continuing high level of defense expenditures, and the impact of foreign economic competition. As health care costs increase and government subsidies decrease because of these underlying economic strains, the percentage of total worker compensation attributable to health care has risen from an average of three percent in 1965 to an average of fifteen percent in 1987; a 500 percent increase. Given these realities, Mr. Weller argues that we need to adopt new approaches to providing and paying for health care. He then presents the recommendations of the Health Policy Coalition, the first part of a private sector initiative that is seeking to change the existing incentives and structures in health care.

Powell Woods then presents the second part of this private sector initiative, Cleveland Health Quality Choice. The backers of this initiative — the hospitals and Hospital Association, the Academy of Medicine and representatives of the physician community, and the business community — see three basic problems in health care delivery: increasing costs, a resulting lack of adequate coverage, and the variable or indeterminate quality of services delivered in different communities and among different providers. Mr. Woods then explains that Cleveland Health Quality Choice is based on the principle that we need to find a way to reward high quality

and cost-efficiency in health care delivery by making these the criteria for reimbursement. This would create incentives for both quality and efficiency gains in the system that can help produce savings which will, in turn, help to underwrite coverage for the uninsured. Finally, Mr. Woods notes that this is a difficult undertaking due to both the methodological complexities in measuring the quality and efficiency of health care delivery and the difficulty of actually dedicating a portion of any savings to underwriting the problem of the uninsured.

The third speaker, John Polk, describes how COSE, the largest Chamber of Commerce-sponsored small business program in the nation, has succeeded in controlling costs for the 6,700 member companies that participate in its health care programs. Mr. Polk notes a number of things about the COSE program that can be important in addressing the problem of the uninsured. First, the program has proved successful in holding down health care costs: COSE members' health insurance costs have risen only 21.5% in five years, compared with a 106 percent increase in the cost of commercial insurance provided to small businesses. These cost savings are critical, Mr. Polk reports, because thirty percent of COSE's members were unable to obtain health insurance at a reasonable cost prior to joining the program. Second, COSE has learned that most employers want to provide insurance for their employees but find this extremely difficult due to a combination of market conditions and government regulation, including higher sales and administrative costs at the small group level, insurers' cost-shifting from large, individually negotiated accounts to small commercial accounts, and the increased costs required to provide state-mandated forms of coverage. Mr. Polk observes that this experience contrasts sharply with the unfortunate moralistic tone he often finds in the insurance debate: companies that fail to provide insurance are "bad" and should be punished by government's forcing them to make coverage available. After an extended discussion of the management methods COSE uses to hold down insurance costs, he concludes that the problem of the uninsured will not be solved by a single broad initiative but requires an integrated approach which relies on solutions to the reasons underlying the existence of the uninsured.

The panel's final speaker, Kenneth Seminatore, starts his presentation with three personal observations about the current health insurance situation. First, there is no such thing as hospitals' providing uncompensated care for the indigent. Except for a few hospitals that actually have annual negative operating costs, hospitals find someone to compensate them for care they provide to the indigent. Second, unless health care costs are actually reduced there is no solution for the uninsured or anybody else. Third, the federal tax base must be the ultimate source of a solution for those among the uninsured whose needs cannot be addressed otherwise. Based on these observations, he contends that the current situation is the result of two parallel phenomena: price escalation in provider charges and an increasing fragmentation in the insurance marketplace that has destroyed the previous understanding that permitted healthy people to absorb the expenses for the sick without much difficulty.

Finally, he identifies the major factors that contribute to these phenomena: for price escalation, the absence of well-structured competition among physicians and the costs imposed by state-mandated benefits; and for market fragmentation, the end of the old community rating system and its replacement with merit-rated commercial insurance or self-insurance under ERISA.

The first of the afternoon sessions, "Law and Legislation in Ohio," begins with an introduction to current Ohio law on health insurance by the session's moderator, Susan Scheutzow, a member of the law firm of Ulmer & Berne and Lecturer in Law at Cleveland-Marshall College of Law, who is a Past Chair of the Health Law Section of the Cleveland Bar Association. The session then shifts to a discussion of several Ohio legislative proposals by three state lawmakers: Representative Jane Campbell (D-Cleveland), Representative Ray Miller (D-Columbus) and Senator Grace Drake (R-Solon).

In her presentation, Susan Scheutzow asks whether there is a legal right to purchase health insurance, assuming someone has the ability to pay and reveals that, with the exception of HMOs in sound financial condition, the answer is generally no: insurance companies can, with very minor exceptions, decline to sell coverage to anyone they choose to exclude. She then outlines the health insurance continuation and conversion provisions in state law and briefly discusses the extent of Ohio's state-mandated coverages. She completes her talk by noting that neither hospitals nor physicians have a legal obligation to provide non-emergency indigent care — the sole exception being hospitals that have received federal assistance under the Hill-Burton Act — and, while federally tax-exempt hospitals must provide emergency care, they may seek reimbursement for those services.

Jane Campbell addresses the bulk of her remarks to two pending bills that would establish the Ohio Universal Health Insurance Plan, sponsored by Representative Hagan, and the Ohio Comprehensive Health Insurance Plan, sponsored by Representative Guthrie. The Hagan Bill would establish a universal health insurance plan in Ohio that essentially provides publicly funded insurers for private medical care. Funding for the plan comes from a combination of an eight percent payroll tax on employers, a one percent wage tax on employees, a one percent tax on annual interest or dividends that exceed \$1,000, and a ten percent "sin tax" on tobacco and alcoholic beverages. Representative Campbell acknowledges that this legislation is considered too radical for passage at this time, but notes that she agreed to co-sponsor the bill to encourage a thorough consideration of all options by the legislature. She next explains that the Guthrie Bill is a more limited effort, aimed at addressing the problem of those who are uninsurable because of a high-risk medical condition by creating a state-subsidized risk-pool that would guarantee persons who cannot now obtain insurance that they could obtain coverage at a cost that would not exceed one hundred-fifty percent of ordinary individual or group rates. Representative Campbell concludes by stating that she prefers some form of universal health insurance, in large part

because that would eliminate the waste caused by the bureaucracy needed today to service the 1500 different health plans in this country.

The next panelist, Representative Ray Miller, also views the Hagan Bill as a very important addition to the debate on indigent health care but is concerned with finding a more practical approach that can be enacted today. He suggests that in the policy debate on health insurance, we too often lose sight of the individual — the people “behind the data” who need care but are not seeking it because they can’t afford it — and thus fail to have the requisite sense of urgency about this problem. In his view, it is critically important that we go beyond the discussion stage to build a practical coalition that can enact meaningful legislation in the near future.

The final panelist in this session, Senator Grace Drake, comes out strongly against any movement toward universal health care, arguing that it simply has not worked in those countries where it has been tried. As support for her position, she notes the problem of access to certain surgical procedures under the Canadian system, citing the fact that many Canadians, who have been placed on long waiting lists for cardiac surgery, elect to travel to the Cleveland Clinic and pay for their surgery, rather than risk the delays associated with free care under their national plan. She also criticizes the increased taxation burden proposed by the Hagan Bill. In Senator Drake’s view, much of the insurance problem stems from the high costs of health services. Those costs will only be reduced when patients have sufficient information and incentives to allow them to seek out lower cost alternatives and when health care providers no longer face extraneous incentives to increase costs, citing “defensive medicine” — e.g., ordering unneeded tests in anticipation of possible future litigation.

The Conference’s final session, “Alternative Approaches at the Federal and State Level,” features presentations by Professor E. Richard Brown, of the School of Public Health at the University of California at Los Angeles, and Representative Mary Rose Oakar (D-Ohio 20th District), a member of the Pepper Commission, and concludes with remarks by the Conference’s Keynote Speaker, Randall Bovbjerg, of the Urban Institute, acting in the role of Discussant. This session is moderated by Dean Steven R. Smith of the Cleveland-Marshall College of Law.

Professor Brown reviews the experience of some thirty states other than Ohio that have attempted to address the problem of the uninsured. He notes that while these states have used similar types of programs to address the problem, such as direct financing of hospitals and clinics and entitlement programs for the medically indigent that extend the availability of Medicaid beyond federal eligibility standards, such programs have differed dramatically in the specifics of their application. He reports that states which provide entitlement through Medicaid generally tend to provide better access to care than those choosing only to finance hospitals and clinics, but that this is the more expensive option because there is no federal contribution for such expansions of Medicaid. Professor Brown also describes state experiments with such voluntary health insurance programs as high-risk pools for people who have been denied

coverage by private insurers, but finds that the cost of such programs is prohibitive for most individuals unless the state subsidizes premium costs. Other state experiments noted by Professor Brown include programs for catastrophic health care expenses, information programs to make employers aware of insurance sources, tax credit programs for small employers, and a series of foundation-sponsored pilot projects that are designed to provide health insurance through the workplace. Because these experiments are so new, he finds that it is too early to make a definitive assessment of their value; however, he reports that the preliminary evidence is not overly optimistic. Professor Brown concludes his presentation by examining a set of broader questions — including the role of the federal government, the need for political leadership on this issue in the states, and incremental vs. universal approaches to the health insurance problem — and presents his view that the best solution lies in our embracing a universal system of health care financing in the United States.

Congresswoman Mary Rose Oakar begins her presentation by describing her work as a member of the Pepper Commission. After explaining that the goal of the Commission is to present Congress with policies to address both the health insurance and long-term care problems, she states her opinion that the Commission will probably recommend a piece-meal, incremental approach, rather than some form of universal coverage that retains freedom of choice in the selection of health care, which she favors. She also presents her views on the need for a viable long-term care policy that will allow families greater flexibility in choosing how to provide care for sick and elderly family members. Finally, Congresswoman Oakar states that we have a health care crisis in this country that can only be resolved by redirecting our spending and working harder to reach a political consensus on the best solution to the problem.

Randall Bovbjerg, as Discussant for this session, examines what he sees as our two choices for the approach we take to the health insurance problem: a “global” approach through some form of national health care program, or some variety of incremental plans. He notes that global systems achieve their cost savings through budgeting health care, and we need to decide if that’s what we want. In his view, the fact that we spend a greater percentage of our GNP than other countries on health care is not the critical issue. Rather, the critical issue is do we want to spend that much? For example, although we spend a great deal on administration of our health care system because of the paperwork involved with health insurance, that paperwork provides us with valuable information about what procedures have been utilized and their outcomes. Furthermore, we are just beginning to appreciate the value of this information, and thus to see the administrative costs required to produce that data in a more positive light. Bovbjerg then turns to incremental plans, first expressing his view that this is the direction we are most likely to take. He then notes that, so far, few incremental approaches have received the resources necessary to address the health insurance problem because the political willingness to spend at the needed levels

is just not there. This will not change, he says, until we build a consensus on the health care problem that acknowledges that this is a problem for all of us. Finally, we need to redirect our focus from “macro” phenomena, like percentage of GNP, to “micro” terms. For example, the need to affect the incentives that patients and health care providers face when they make one-on-one decisions about health care services because it’s only at that level of specificity that we can really address how we are going to save money and increase access to services.

