Law and Legislation in Ohio

Jane Campbell
Ohio House of Representatives

Ray Miller
Ohio House of Representatives

Grace Drake
Ohio Senate

Susan Sheutzow

Follow this and additional works at: https://engagedscholarship.csuohio.edu/jlh
Part of the Health Law and Policy Commons, and the Insurance Law Commons

How does access to this work benefit you? Let us know!

Recommended Citation
Jane Campbell, Ray Miller, & Grace Drake, Law and Legislation in Ohio, Symposium: Ohioans without Health Insurance: How Big a Problem - Are there Solutions, 4 J.L. & Health 207 (1989-1990)
A. SUSAN SCHEUTZOW

It's a pleasure to be here today. My task is to set forth the current Ohio law for the uninsured, underinsured and for those people seeking health insurance in Ohio. But first, I'd like to take a moment to introduce our speakers because it is truly a pleasure for me to be able to moderate this panel. The legislators that we have here today are among the very best in the state.

I have had the privilege of knowing Jane Campbell for years, long before she went on to the legislature in 1984. She has truly had a remarkable and distinguished career. She currently chairs the Children and Youth Committee and sits on the House Finance and Ways and Means Committees, two of the most powerful committees in the House.

Our second speaker, Senator Grace Drake, from Solon, has been in the Senate since 1984 and is a wonderful committed legislator. I had the privilege of having dinner with her a few weeks ago and was struck by her insight into some of these issues of health care for the uninsured and the underinsured.

I have also had the privilege of knowing Ray Miller, our third speaker, since before he was in the legislature; and he's one of the few people I know who once actually worked in the White House. I'll say more about him when he arrives.

1. HEALTH CARE COVERAGE IN OHIO

My task, as I said, is to set forth current Ohio health insurance law regarding the uninsured and underinsured. In preparing these materials, I continually had the image of the maze in the movie, "The Shining." That poor young boy kept running through this maze with a crazed Jack Nicholson at his heels, and everywhere he turned there was no way out. In looking at the current law in Ohio, what we have is a phenomenal maze, with little passages here and there that, perhaps, provide a little relief to somebody who fits into that particular cubby hole. But when it's all said and done, there is very little legal recourse to someone who does not have insurance and wishes to purchase it, or someone who can't purchase insurance but needs health services nonetheless.

There are basically three types of health care coverage in Ohio: 1) traditional indemnity insurance, which now includes the Blue Cross plans and other insurance plans; 2) HMOs, and 3) self-insurance plans. Self-insurance is largely unregulated because it is pre-empted1 by the federal

---

ERISA law, and so I will not be discussing that topic. Nor will I discuss Medicare, Medicaid and the federal programs because that's beyond the scope of this session. Obviously, those people who are eligible for federal programs and Medicare or Medicaid do receive some type of health coverage. While it is not always adequate, particularly in the case of Medicaid, it is reasonable coverage and so we're going to exclude that from this talk.

2. NO LEGAL RIGHT TO PURCHASE INSURANCE IN OHIO

What I'll focus on are the rights to purchase insurance, assuming that someone has the ability to pay for insurance. These are not the working poor, but average working people who, for some reason or another, don't have health care insurance.

The underlying premise in Ohio today is that there is simply no legal right for anybody to purchase health insurance. The insurance companies, with very minor exceptions, can refuse to sell coverage to anybody that they feel like excluding.

In the traditional indemnity insurance plans there are basically two types of coverage: group plans and individual plans. Group coverage is sold to an employer and the employer bargains with the insurer regarding who will be covered. If you have a large enough group, generally everyone in the group is covered. If there is a small group, however, the insurance company can, and does, say that they will cover the group only if the employer agrees to exclude one or more individuals who usually are people with a high-risk medical condition. I am told stories of individuals who wish to change jobs, but because they have a child who has some expensive medical condition, they are afraid to make such a change. They don't think that they will be covered under the new employer's plan, particularly if that employer has a small employee base.

Now, we heard this morning about the success of the COSE plan, but if an employee is working for a company that does not use COSE, the coverage may well not be there. So, as I said, there is no real right to purchase health insurance. The insurance company may exclude whomever they wish, with two limited exceptions. First, dependent children, including adopted children, must be covered from the moment of birth. Second, under Ohio's new AIDS bill, an insurance company may not exclude anyone on the basis of sexual preference, or because the insurance company believes the person would be at high risk for AIDS. The insurance company can, however, exclude someone who is confirmed HIV positive at the time of application. So while an insurance company may refuse coverage to anybody who is known to have AIDS, it cannot exclude somebody based on extraneous factors that would put them at high risk of contracting the disease.

The picture is much different in the state of Ohio with an HMO. If an HMO is in good financial condition it must offer an open enrollment period and may not refuse coverage to persons in a group based on health status. If the HMO is not in particularly good financial condition, the Department
of Insurance may waive the open enrollment period and may permit the company to have underwriting instructions. So, whether or not an HMO will have an open enrollment period every year is really open to question depending on the HMO's financial condition.

Self-insurance plans may generally exclude whomever they wish. Such plans generally aren't regulated as to enrollment. Despite this, the reason why a large employer would self-insure is to cover all its employees. I have not seen many circumstances in which people are excluded from large employer self-insurance plans.

I'm not going to go through all the health insurance continuation and conversion provisions; I have those outlined in your materials. I would just like to note that once someone gets into an insurance plan, if he/she later becomes non-eligible for that plan, whether by divorce from the insured, or because a dependent child reaches a certain age, or the insured loses his or her job, the various conversion and continuation rights allow them to continue group coverage for up to three years.

State law provides that an insurance company cannot cancel a policy. If you go to the Ohio Revised Code you will find that provision, but the interesting fact is that there is nothing mentioned in the statute as to non-renewal of a policy. So, what an insurance company can do, once you have the policy, is to keep you on for the year and then fail to renew the policy. The only exception is that an insurance company may not fail to renew your policy due to health status if you have a policy that was converted from a group policy to an individual policy. So, in advising people as to whether or not, if they have to seek insurance on their own, they should seek a "straight" individual policy or try to exercise their conversion rights, it's important to know that an exercise of their conversion rights brings them some additional benefits. An HMO, however, cannot fail to renew a policy based on health status, so, once somebody is in an HMO, they may not be excluded because they developed an expensive medical condition.

3. LEGALLY MANDATED COVERAGE

The next topic I want to discuss is legally mandated coverage. By now, you're seeing that HMOs are treated much differently than insurance companies under the law. HMOs generally cannot exclude conditions because they are expensive conditions, nor can they exclude people on the basis of pre-existing conditions. Insurance companies, however, can

---

put in fairly stringent pre-existing condition limitations, and they also can limit coverage for just about any condition they choose.9

You’ve heard quite a lot this morning about mandated coverages. Those are listed on pages six and seven of your materials. But basically there is mandated coverage for someone who develops AIDS, although not for someone who knew that he had AIDS at the time of the application and didn’t state that,10 and other mandated coverages include dependent children,11 outpatient kidney dialysis,12 and outpatient services for treatment of mental disorders or alcoholism.13 Finally, because federal law prohibits an employer from discriminating on the basis of pregnancy, a group plan has to provide pregnancy benefits. That’s really the entirety of Ohio’s mandated benefits at this time, although, as you heard this morning, the legislature is considering other benefits, such as infertility treatment.

So, to summarize what insurance is available: unless you can get into an HMO during an open enrollment period, there basically are no absolute rights to purchase insurance in Ohio, and if someone is in an insurance plan, unless they are protected by the size of the group and through the negotiation of their employer, there is little protection for their right to maintain their insurance.

4. NON-EMERGENCY CARE PROVISIONS

What is left in the state of Ohio for people who have not been able to purchase insurance or that wide, wide group of people who are above the income level for Medicaid and yet do not have the resources available to purchase insurance or be able to find it? Again, I am sorry to say there’s not much in the law. There simply is no requirement for anyone to provide care in a non-emergency situation, no right for a person to get medical care in the state of Ohio. No hospital, public or private, must provide indigent care.14 Most public hospitals do because part of the purpose for which they were created is to provide indigent care, but there is no legal mandate requiring it. And there is no mandate requiring private hospitals to provide that care even if that hospital is tax-exempt.

Thus, for non-emergency services, the only absolute remedy for someone who is seeking hospital care is to go to a hospital that has a Hill-Burton obligation.15 Most of you are probably aware that hospitals which

---

received federal construction funds back in the 50s and 60s have an ongoing obligation to provide a reasonable amount of uncompensated care. The amount is actually the lesser of three percent of the facility's annual operating cost, or ten percent of the amount that they borrowed or received by grant from the federal government. Each hospital that has a Hill-Burton obligation sets up an allocation plan specifying how it is going to make those funds available, and those funds are available only to people earning no more than two times the poverty level, which clearly makes them available for the working poor. To obtain free care from a hospital with a Hill-Burton obligation, people can call the hospital and find out whether it has a non-emergency obligation.

As to physician services, there is just no obligation at all for access to physician services for those who aren't able to pay. In preparing for this Conference, I was struck by the fact that written into the AMA Principles of Ethics is a statement that, except in emergencies, no physician needs to provide care in any circumstance other than when he or she chooses to do so. So the AMA is very clear that physicians do not have an obligation to provide any type of care in non-emergency situations.

5. EMERGENCY CARE PROVISIONS

The emergency care situation is a little different. As was mentioned at our luncheon, COBRA provides very clearly that no hospital may transfer a patient who needs emergency care or is in active labor; under those conditions services must be made available. Something that is often left unsaid, however, is that while services have to be made available in that situation, that does not negate the obligation to pay for those services if one can in fact do so. Thus, individuals who have assets, for example a home, and need expensive emergency services, may not seek them because their assets could be attached to pay for that care.

All hospitals receiving a federal tax-exemption also need to provide an open emergency room, and the Joint Commission on Accreditation of Health Care Organization's standards provide that persons in emergencies must receive care. Again, none of those regulations require that care must be provided for free.

In summary, the picture is bleak: Those people at the very low end of the income scale can receive some benefits through federal programs.

---

16 The American Medical Association's Principles of Medical Ethics, VI provides: "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services." Principles of Medical Ethics, CURRENT OPINIONS, COUNCIL ON ETHICAL & JUDICIAL OPINIONS, AMERICAN MEDICAL ASSOCIATION, (1989). See generally OHIO REV. CODE ANN. § 4731.22 (Pages 1989).


Those persons with some ability to pay may be able to join an HMO or purchase insurance, unless they are excluded because of a medical condition. But that middle group, the working poor or those unable to get into an HMO, are really left to seek free care or pay for the care themselves. While emergency care must be made available, the law doesn't provide for primary care, neither does it provide for emergency care to be provided for free or on some low-cost basis.

At this point, I'd like to turn the session over to Jane Campbell, who is going to comment on several proposals in the Ohio legislature: HB 425, the Ohio Universal Health Insurance Plan; HB 188, the Ohio Comprehensive Health Insurance Plan; and HB 24, Ray Miller's demonstration projects legislation.

B. JANE CAMPBELL

Thank you Susan, good afternoon. My charge is to talk to you about the Universal Health Insurance Bill that Representative Hagan has sponsored in the Ohio House and Representative Guthrie's Bill to insure the uninsurable. Let me try to put this into context for you.

1. THE LEGISLATOR'S ROLE

I understand you spent your morning with various people telling you that legislators are uninformed and generally dangerous to the health care system. Let me acknowledge to you that there may be some truth in that, although there is a considerable difference of opinion on the matter. And furthermore, what people fail to see when they look at the state's involvement in health care is that we are, in fact, a very large purchaser of health care through the Medicaid system. Indeed, Medicaid is the single portion of the state budget that is consistently out-of-control. We sit down every two years; we try to balance the budget; we try to figure out what we are going to do. Invariably, what brings us back to the table a year later, in the middle of the biennial budget, is the Medicaid problem. Why? Because Medicaid costs have outstripped the allocations that we provided. So, we have an investment in looking at the health care system from that perspective. The other thing is that we're a major purchaser of health care for the employees of the state of Ohio and, therefore, can look at it in some way as any large employer purchasing health care.

So, it's not that we're really so limited in our understanding of the health care system. It just may be that we disagree among ourselves on how it ought to be handled, and what you have when there are disagreements is legislative compromise. Legislative compromise fundamentally means that everybody gets a little bit of what they want and a little bit of what they don't want—i.e., what someone else wants—and that, in my opinion, is why you end up in the maze that Sue alluded to. Anyone can say: "If I were in charge here, this is how we could work it." You can always think up a very logical and manageable plan, but that's not what
you get from the legislature. What you get is my logical plan, and Grace's logical plan, and Madeline's logical plan, and Ray's logical plan. Then, we have to negotiate our differences; and that's why we end up with legislation that has some fair amount of confusion.

But I think what's happened now is that the health care problem has reached a level at which the legislature is going to be much more directly involved. At any given point, the legislature theoretically could be involved in almost any aspect of our collective lives, and the areas that we tend to work on are areas where there is significant public dissatisfaction with the way things are and a strong commitment to change.

2. TAKING A LOOK AT THE CANADIAN HEALTH CARE SYSTEM

Now, that doesn't mean there's consensus on what the change should be; it means that there's a commitment to address the issue. I think that's where we are with health care. I'm sure that we have had someone cite to you the Harris poll that shows the high level of dissatisfaction with our current health care system and shows that there is some interest at looking toward a program modeled on the Canadian health care system. We're now spending 11.5 percent of our gross national product on health care,\textsuperscript{19} while in Canada they spend only nine percent of their gross national product on health care.\textsuperscript{20} Yet, we still have 35-40 million Americans who have no health coverage,\textsuperscript{21} our life expectancy is no better than any industrial country,\textsuperscript{22} and our infant mortality rate is worse—when you look at the infant mortality rate among the minority population in the city of Cleveland, our figures are worse than some of Third World countries.

What has brought Lee Iaccoca to the table to start talking differently about the value of some public involvement in health insurance is that Chrysler now spends seven hundred dollars for employee health benefits for every car produced in the United States as compared to two hundred and thirty-three dollars per car for those built in Canada. Basically, what Iaccoca argues is that instead of having the cost of health insurance covered through taxes, as is done by our foreign competitors such as Japan, Germany, and Korea, Chrysler is forced to absorb its health insurance costs as a business expense that raises the cost of its products, so that when dealing in the global marketplace, that seven hundred dollars for employee health insurance that is added to the cost of Chrysler's American-built cars puts them at a competitive disadvantage.

Another problem caused by having so many people uninsured is that in many instances we end up with having to deliver very expensive care.

\textsuperscript{19}Statistical Abstract of the United States 839, Table 1444 (1990).
\textsuperscript{20}Id.
\textsuperscript{21}Id. at 100, Table 152.
\textsuperscript{22}Id. at 72, Table 103; see also E. Jamison, World Population Profile, U.S. Bureau of the Census (1989).
very late in an illness when the individual is at a crisis point. Look at some types of health care where there are simple and inexpensive procedures, like prenatal care where the average cost is about eight hundred dollars for a woman's entire pregnancy. But just one day in a neonatal intensive care unit is going to cost at least one thousand dollars. This, of course, is what we argued when we created the Prenatal Investment Program, which Aggie Hoskins has been the mother of over these many years, and why we have now expanded our Medicaid program in the state of Ohio to cover prenatal services. Again, this is part of the patchwork, but nevertheless, it's an important step.

3. CREATING AN OHIO HEALTH CARE TRUST FUND

What Bob Hagan’s Bill proposes to do is establish a universal health insurance plan in Ohio. This is a comprehensive proposal that essentially provides publicly funded insurers for private medical care in the state of Ohio. All Ohioans would be covered under this public insurance program, but we would continue to have the choice of what doctor we use.

It would be operated by the creation of an Ohio Health Care Trust Fund that would be supported with an eight percent payroll tax on employers; a one percent wage tax on employees; a two percent tax on Ohioans receiving one thousand dollars or more in annual interest or in dividends; and a ten percent tax on cigarettes, cigars and alcoholic beverages because of the particular contribution that those substances make to our health care needs. The plan would be administered by a nineteen-member board of governors composed of ten consumer representatives and five representatives of health care providers, all of whom would be appointed by the governor and the heads of four state agencies. Finally, the Bill creates a Health Professional’s Education and Training Fund consisting of all money received from the federal government for training health professionals.23

There have been a lot of concerns expressed about the Bill because it is a dramatic step. There is no question that if we were to enact this Bill exactly as written the day after tomorrow people would probably "freak out". Nevertheless, let me tell you that Representative Hagan has made a thoughtful analysis of what might be done in the state of Ohio. He first looked at what happened in Canada—and the background in Canada is that several provinces enacted universal health care insurance plans which led to the enactment of the national health insurance program—and so, in his plan, we are trying to do that same kind of thing in Ohio. There are several of us who agreed to co-sponsor the Bill because we think it's very important that we consider this option. In fact, if we're going to solve the problem of providing adequate health care for all Ohioans, we need to look at all of the options, and we did not want simply to dismiss out-of-hand the concept of universal health care coverage.

23 Ohio House Insurance Committee, Ohio Universal Health Insurance Plan, HB 425 (introduced April 12, 1989) (legislation is pending).
There needs to be continuing discussion about this issue, and I think that people are not served well by simply saying: "Well, we're not going to do that." We are all, in many ways, being affected by the number of people who are uninsured because, one way or another, they do eventually seek access to health care and become involved with public resources and public funds. And so, I think that it's an important challenge for those who say "we're just not going to do universal health care" to offer some alternative to deal with the problem of providing health services to all Ohio citizens.

4. PROBLEMS OF THOSE IN HIGH-RISK HEALTH CARE CATEGORIES

Of course, the insurance crisis extends beyond those who cannot afford health insurance to include those people who cannot get health insurance because they have a condition that puts them in a high-risk category and, thus, makes them uninsurable under our traditional health insurance mechanisms. Groups that have been particularly concerned and vocal on this issue before the legislature are the Diabetes Association, the Kidney Foundation, and representatives from various other organizations concerned with a particular disease, and I can share with you that this has been a matter of discussion for the entire five years I've been in the legislature.

About three months ago, this last problem came home for me. I have a brother who is thirty-three years old, and he fell and hurt his knee playing frisbee in Central Park, New York, and subsequently needed to have his knee rebuilt. So, he went into the hospital to have his knee rebuilt, and when the bills were submitted to the insurance company, they retroactively denied his insurance because they found he had high blood pressure—and for a thirty-three year old to have high pressure put him into a high-risk group—and he worked for a small business that could not offer him any protection from the insurance company's decision. And so, my kid brother is facing about $30,000 worth of medical bills that he did not anticipate having to pay. Now, he doesn't have a family or resources that can be attached, but if he were in my situation, where we have a home and are trying to take care of our kids, he would really be in serious trouble. So, I can tell you from a very personal perspective that not being able to get health insurance—he has not yet been able to find an insurance company that will include him in the group, and he is still without health insurance—is a potential threat to any of us.

5. HOUSE BILL 188 AND THE HIGH-RISK POOL

What Representative Marc Guthrie proposes to do with HB 188 is to create a risk-pool so that the state of Ohio would become a partner with private insurance companies and with the person seeking insurance in order to provide coverage for those persons who are declared uninsurable.
Under Marc’s proposal, persons seeking health insurance through this legislation would have to pay no more than 150% of what they would pay ordinarily for individual or group coverage. This Bill was passed by the House, but the Senate added numerous amendments that would make the insurance under the plan prohibitively expensive. The Bill is now under negotiation in Conference Committee. We did put money in the state budget for the creation of this risk pool, and we are hopeful that a compromise will be reached between the House and Senate so we will be able to start that program. Again, it’s one of the piece-meal programs, but nevertheless it is a program that will address a need that is very real and that needs to be addressed.

I personally think that we ought to move eventually toward a “universal health insurance” kind of coverage, and that is partly because we have created an incredible bureaucracy through the proliferation of piece-meal programs. Today, the average doctor has to employ a full-time clerk simply to bill his or her patients. There are about 1500 different health insurance plans and many kinds of different forms, and they are very confusing to both the doctor and the patient.

In Canada, with their universal health coverage, a Canadian doctor simply fills out a single form and the Canadian government sends a check to doctors once a month to cover their entire fees. The average Canadian hospital employs three clerks for the purpose of billing, while the average American hospital employs fifty clerks and a million dollar computer just to bill patients and keep track of who is paying the bills. All the dollars spent on the bureaucracy of billing and collecting are dollars that could be going to provide drugs, doctors’ services and general patient care. And so I think we ought to understand that having a universal health system may be, in fact, a less bureaucratic way to approach the problem and may allow us to have more of our resources going into direct patient care, rather than into the complexity of trying to figure out who is being charged for what and who is getting paid for what.

I understand that there are many different views on this, and I think it’s important that there are conferences like this where people can share their views. I would just say once again that I think for those people who feel that Universal Health coverage is not the right way to approach this problem, what I would offer is the challenge to come up with a better answer, because that’s what we don’t have, and that’s why we are pursuing every possible option.

C. SUSAN SCHEUTZOW

Thank you, Jane. Our speakers have asked that Representative Ray Miller be next, so please indulge me in a reintroduction of Ray. It was so nice to see him. I didn’t realize until I did a little calculation that I first met Ray about fifteen years ago when he was entering politics in Columbus. As I mentioned, I watched him go off to the White House, come back, and run successfully for state Representative where he’s had a long, distinguished career since. Looking at him, I realize that I haven’t seen him in about eight years; he doesn’t look a day older, and I now expect him to say the same thing about me.
Thank you so much Susan, it's a real pleasure to be here and to share a few thoughts. It's always bad when people start talking about how long they have known you and how you haven't changed. I used to have a six-inch Afro, and now I'm standing here with a bald spot on the back of my head.

It's good to see so many good friends. I see Frank Kimber, who served on the Commission on Minority Health that I chaired in the legislature, and many others who have worked with me to develop legislation. You know when you see the pictures of legislators drafting legislation that we put in our brochures, they say "State Representative Ray Miller drafting HB 24"; well, the real drafters of the legislation, the real authors are Peggy, Frank Kimber and Terry Grundy, and we ought to tell the truth about who does the work. Sometimes we take all of the credit for the things that have been done. Peggy, Frank and Terry did a tremendous job in developing the legislation for us and coming into the General Assembly and lobbying the members, and presenting testimony for the committees, and doing all the work back home in their respective districts—working with the legislators to get HB 24 passed, which is a good start. It's certainly not the answer, but it's a good start.

It's good to be on the panel with such outstanding legislators as Jane Campbell, my very good friend, who is an outstanding legislator, very committed, a tough fighter, and she is very smart, even if she went to the University of Michigan; and she really does a tremendous job in the legislature on the Human Resources Subcommittee.

Senator Grace Drake and I have worked closely together on a piece of legislation that was very controversial. Sometimes, I hesitate to mention it because people may start throwing rocks, but it's this new Department of Alcoholism and Drug Addiction Services that I sponsored in HB 317. Over in the Senate, Grace Drake rewrote my Bill—we had an outstanding piece of legislation that I had introduced—she decided to make it even better for the people of the state, and I think she did a very good job. So, again it's good to be on the panel with such fine legislators.

1. INDIGENT HEALTH CARE

I think that this issue of indigent health care is the most serious problem that's facing our nation. And we ought to have a national response to this issue. We ought to have a universal health care system in the United States of America, but we have got to start somewhere and it's easier, it's more immediate, to start at the state level. So, as Jane Campbell said, the Hagan Bill is very important. It's a bold initiative, but we have to be practical, and I will talk with Bob Hagan about this; we have to be practical in our approach. We have to have a multi-faceted approach to deal with this issue. We have to make sure that people are taxed in a responsible and equitable way, i.e., individuals have to contribute, employers have to contribute, hospitals have to contribute, possibly insurers
have to contribute, and taxpayers have to contribute to make sure that we have sufficient revenues to provide health care insurance to all of the people in the state of Ohio who cannot afford to pay for health care themselves.

I know that during the course of the day you have talked about the 1.4 million people in our state who do not have health care insurance, 475,000 of whom are children. And too often we just put out this data, as though there are not real human beings behind each data point. But I always try to think of the individual who needs health care, who needs to go in for some sort of treatment or some sort of operation, and simply won't do it because he or she doesn't have the money. So, of course, the individual's health problem often becomes exacerbated to an acute stage and then it's really costly to provide care. I think about that person and the real anxiety that one must feel at just the thought of possibly getting sick and not having the money to pay for the operation because you're too well-off for Medicaid, i.e., in the category where you are above the income limit for Medicaid eligibility, but do not have enough money to pay for your own health care insurance.

It is important to remember the people behind all of this data, and if we remember the people, then we will act with more urgency. This becomes more than a discussion when we start thinking about helping that person today. Hopefully, when we go into our next biennial budget period, we will be organized throughout the State of Ohio, we will have done what's necessary to develop draft of legislation, and will have built the right kind of coalition to go into the legislature and get something done.

It's critically important that we go beyond the discussion stage. All of the issues are out there, we know what the issues are, so we just have to put the pieces together to develop a reasonable approach. We're spending, as you know, a larger percentage of our gross national product on health care than a number of countries that have universal health care plans. So, it's not a lack of resources that has prevented us from getting something done on this issue.

There's a consistent rise in health care costs; we're spending six billion dollars in our state on Medicaid alone, with the largest percentage going towards the needs of those who are elderly and in nursing homes. So, it's important for us to focus on getting something done; those of us who have a genuine concern about this issue, legislators, policy makers, educators, administrators, doctors, hospitals and insurers have to come together to develop something that we believe makes sense. We need to act with a real sense of urgency about the people who are in such serious need. We need to hold hearings around the state, develop coalitions, bring pressure into the legislative arena, lobby both parties, and lobby the chief executive to actually accomplish something for the people of our state who are in such serious need.

---

It's nice to be here today. I chair the Committee on Health and Human Services in the Ohio Senate. I've said this year that I am receiving advance credit for any time I may have to spend in purgatory when I die because of the bills that we have had to address in our Committee this General Assembly. We started out with nine long hearings on the infamous AIDS bill, then we went into a number of hearings on Medicaid oversight, which was very important; then the certificate-of-need-bill, a very difficult bill because a lot of special interests want it their way in this bill. I would have gone in a different direction on that issue, if we'd had another vehicle, and I hope that in two years we'll have another vehicle in place. Last, but not least, we had language and money in the budget for drug and alcohol addiction treatment, actually a lot of new money, and a terrible thing happened—they left the money in and took the language out. But Ray Miller was our savior because he had introduced a bill in the House which came to my Committee in May, and I spent my whole summer on the bill, readdressing some of the issues and changing some of the language but really keeping Ray Miller's bill in place. So these are some of the issues that we faced this year and they have been very, very large issues.

Jane Campbell does a wonderful job in Columbus, she truly is a good legislator. We have a very good working relationship. Ray Miller does an outstanding job, and I want to tell you I don't always agree with him, but we usually are able to come together. In this instance, as I sit here today, I really don't agree with Representative Campbell or Representative Miller on this very, very large issue of health care. I do believe that we have to do something for the working poor and the uninsured and there is a joint House and Senate committee looking over insurance issues, particularly those insurance issues that affect the working poor, and those people that are not able to be insured, but I will never ever accept universal, socialized, or nationalized medicine.

1. UNIVERSAL HEALTH CARE NOT SUCCESSFUL

In my view, it has not worked in any place it has been tried: not in Canada, not in England and certainly not in Europe. Let me provide a personal experience. I was on a trade mission with the Governor in June, and I had bronchitis while in Munich. A doctor came up to my room. She appeared to be about fourteen years old, but she did have a stethoscope so I knew she was really a doctor. We had problems communicating because she spoke German and I spoke English. She wrote a prescription for me, and suggested that I go to a doctor when I reached London if I was not feeling better. She was very confused on how to bill me, because in Germany, under their health care plan, you don't bill patients directly. The bill ended up as the equivalent of one hundred and twenty dollars. When I came back home, I saw my doctor because I wasn't feeling any better. I showed my doctor the prescription, and he said, no wonder you
didn’t get any better, this prescription is for a urinary tract infection, and obviously you had “walking” pneumonia. So I really feel that my experience was not very good, and would never want to be ill in a foreign country again.

I understand that at the Cleveland Clinic most of their cardiac surgery is for well-to-do people from Canada who can afford to come in. Canadians are deathly afraid that if they remain on a waiting list for surgery under their own health care system they would not live, they would die. In England, they only give comfort care for patients over sixty-five. If you’re above the age, you’re ineligible for many forms of treatment.

I just don’t think that this is what we want in America, this isn’t what my fore-fathers came over for. People did not come over to have high taxes to finance a state-operated health care system. They did not come over for an eight percent payroll tax, for a one percent tax on gross salaries and wages, for a two percent tax on interest and dividends exceeding one thousand dollars, or ten percent on the retail price of cigarettes, cigars, snuff and other tobacco products. We have enough taxes.

2. TAKING ANOTHER LOOK AT OUR INSURANCE SYSTEM

I do believe we have to take care of the working poor. I do believe that they should be insured, that they should get good care. However, I also believe we have to take another look at our insurance system. If I were to pay twenty percent of my medical expenses, I would be shopping. I had a physical this spring that took about a day and a half, and my bill was over two thousand dollars. I was absolutely shocked. Had I gone to my own doctor, he would have sent me for a few tests; it would have taken me a little longer. Had I known that the cost for that physical would even approach two thousand dollars I would have shopped. I would have shopped three doctors like I do when I buy a new coat, a suit or a blouse. If I had to have a hospital procedure, I would shop for that. There is nothing wrong with that; that is America. There is nothing wrong with shopping for services.

Somebody in the audience asked about making doctors pay for the procedures that the insurance companies feel are not needed. That might not be a bad idea. I think doctors are putting us through many tests that we don’t need because they are so afraid of being sued. They’ve actually told me this. I do want good health care for all citizens in the State of Ohio, but I don’t think socialized medicine is the way to go. I think that we will be sorry. It hasn’t worked any place else—why should it work here?

I will tell you just one other story. One of my constituents, who is a medical doctor, discovered that his wife, age thirty-six, had a previously undiscovered, serious congenital heart condition and needed an operation. So, he searched the world for the best doctor to treat his wife and found him in Toronto, Canada. He arranged for his wife to go up there and have the surgery, and she was operated on without delay. He later wrote a piece for the Journal of the American Medical Association about their
experience because, even though he took her up there and she was taken care of, he felt very guilty and wondered whom they had bumped; because he knew someone else, some Canadian citizen, was waiting in line. They charged him a great deal, but he didn’t mind how much the surgery cost. He wanted his wife to be well; and fortunately, he could afford it. But, he was bothered by the fact that the same care was not available to Canadians themselves. Now the point of this story, of course, is that I do not want to stand in line for surgery, and while Representative Hagan’s Bill says that you can choose your own doctor, ladies and gentlemen, that’s not going to happen forever. Believe me, this will only be at the start, and then you will soon be told where you have to go.

If you want to join an HMO, that’s fine. I was on the subcommittee studying HMOs, and I know that the federal government and state government want all poor people to be on HMOs, but many people were not getting good care through their HMOs. There are some good HMOs, but there are also some very poor HMOs in this state. The state of Ohio gave $.5 million grants to allow poor people to join HMOs. At a subcommittee hearing, I asked the department how many people one particular provider had served in a year for his $.5 million grant: the answer was ten. My response to that was that I could do better on a street corner in Akron on any given afternoon.

So, I think that we have a long way to go; we have a lot to look at, and I’m willing to do that—I’m willing to start at the very base, and I’m willing to look at what we can do. I want everyone to have good health care. I don’t want to stop anyone from having good health care. But I want my choices, and I want all of you to have your choices because that’s what the United States is all about. Thank you and God bless.

F. SUSAN SCHEUTZOW

We are going to take a few minutes for questions, so please when you’re asking questions direct yours to the person you would like to respond.

QUESTIONS AND ANSWERS SESSION

Q. I wonder if Senator Drake is acquainted with the fact that Canada has a better record on coronary health care than we do. As a matter of fact, it makes you wonder whether we need all the coronary bypass surgery we are doing. Just a few statistics: Germany spends nine percent of their gross national product on health care, Britain six and one half percent, Sweden nine and one half percent, Canada only eight percent of its gross national product on health care. We spend eleven and one half percent on health care and our infant mortality rate in this country is nineteeeth in the world. Even Poland is ahead of us. Furthermore, all these countries are ahead of us in longevity, so if socialized medicine provides better health care results than we have here, what’s so bad about it?

A. Senator Drake: As I told you my experience was that I got sick in Munich, and I didn’t like the care I got. I’m not talking just about per-
percentages. You can say that surgery in Canada may be better or more successful, but those people are on such a long waiting list that some of the patients simply die before they reach the top of that list. That’s my point.

Q. Are you saying we overtreat the well and undertreat the sick?

A. Senator Drake: Well, it’s not that simple and we do have a lot of work to do, but we don’t want to jump into something like universal care. If I were to be sick any place in the world I would want it to be Cleveland, Ohio.

Q. But only if you could pay for it. Right?

A. Senator Drake: That’s right, but my insurance pays for it.

Q. Suppose you don’t have any insurance?

A. Ray Miller: If I could comment on this important question. When you come into the Ohio House or Senate and you look at the committees, there are very few health care professionals who serve in the legislature in Ohio or anywhere in the United States of America, quite frankly. We just don’t have medical doctors who run for seats in a state legislature. We have a couple of former nurses and, I don’t know why, but for some reason we consistently have a veterinarian in the legislature. So, there is really a limited knowledge base about health care issues. As well studied as we might be on the issues that come before us, we don’t have real expertise. That is why it is good for me to hear people like you, not only to be given facts, but for you to be involved in the process, to come down to Columbus and get involved on committees by making presentations.

Senator Drake said she and I disagree on this issue and that’s an understatement. I don’t think that we can afford to be so chauvinistic and patriotic about this issue and selfish, quite frankly, talking about individual needs, because all of us in this room probably have health insurance; all of us can afford to care for ourselves. What we’re talking about are those individuals who cannot afford to pay for their own insurance. And so, with all respect Senator, to talk about a personal experience in Germany. Take that argument out into the streets and talk to the people who have no health care insurance; take it out to the workplace and talk to those who have no health care insurance; and then try to explain to them that when you were in Germany, maybe because of a language barrier, you got the wrong kind of prescription from what you were seeking—I’m sure you’re not really that selfish; but that sounds very selfish and elitist. And again, we have to look at who we are attempting to respond to, and it’s not those who have health insurance. Those of us in government have to look at providing services to those in need.

SUSAN SCHEUTZOW

We don’t have time for further questions. I would like to thank our panelists very much.