

1994 Southeastern Pennsylvania State Legislators' Post-Conference Report: The Impact Of Health Care Reform On Southeastern Pennsylvania

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INTRODUCTION

The University of Pennsylvania's Center for Greater Philadelphia organized the 1994 Southeastern Pennsylvania State Legislators' Conference to explore the impact of health care reform on Southeastern Pennsylvania. The Legislators' Conference, now in its ninth year, offers a unique forum for state legislators and corporate leaders to advance issues of importance to the region.

Conference co-chairs Robert Cawthorn (Chairman and CEO, Rhône-Poulenc Rorer), Fred DiBona (President and CEO, Independence Blue Cross), and William Kelley, M.D. (CEO, University of Pennsylvania Medical Center and Health System) established a pair of goals to better define the focus of the Legislators' Conference:

- First, the Conference should offer a simplified introduction to the national debate on health care reform.
- Second, the Conference should provide a bridge between national issues and local concerns by assessing the impact of health care reform in Southeastern Pennsylvania.

The Conference, which was held on June 2-3, 1994 at the Sunbrook Conference Center, began with a welcome by Robert Campbell, Chairman and CEO of the Sun Company, followed by the Keynote Address given by Dr. Uwe Reinhardt, James Madison Professor of Political Economy at Princeton University.

KEYNOTE ADDRESS: THE NATIONAL DEBATE

Dr. Reinhardt was charged with the unenviable task of simplifying the national debate on health care reform, and he proved to be more than up to the assignment. Dr. Reinhardt offered insightful commentary on existing problems and preferred solutions, interspersed with a few editorial (and amusing) remarks on what is likely to happen instead. In one such lighter moment, he showed a slide of his holiday greeting card -- a festive red and green line graph projecting health care expenditures as a share of GNP to the year 2080.

Four Problems with the Status Quo

Dr. Reinhardt began his talk by highlighting four shortcomings of the present health care system.

Too many people do not have any medical coverage. The fundamental problem with the current system, according to Dr. Reinhardt, is that an estimated 40 million Americans are uninsured at any given point in time. Over half of this group will get insurance during the year as they re-enter the labor force, with the remaining 15-20 million qualifying as "chronically uninsured." According to Dr. Reinhardt, there still is no consensus on how serious this problem really is. "If you are one of those without insurance, you think it is a problem; if you have it, you don't," he observed.

The "unsured" versus the uninsured. While 40 million people lack health insurance, far more Americans are vulnerable to losing their jobs and their health insurance benefits with them. "I describe the 'unsured' as anyone who is not a tenured professor at a fiscally-sound university," remarked Dr. Reinhardt. "This is a broad middle class problem and, I believe, a major driver behind reform. If insurance companies could develop a product with portability, then health care reform would probably die."

The pace of health care expenditures. Between 1960 and 1985, health care spending grew three percentage points faster than GNP each year. If this trend continues, health care will consume 18 percent of GNP by the year 2000. Extrapolating this trend into the next century suggests that we are fast approaching a limit. At current growth rates, health care spending will reach 50 percent of GNP by year 2050, 81.5 percent by year 2100. "What will happen in the future is that there will be king-sized beds from coast-to-coast with two Americans in each bed -- each with a M.D. degree -- giving each other check-ups," quipped Dr. Reinhardt. More realistically, he suggests, health care will grow at GNP plus one percentage point in the long run.

Anxiety over quality of health care. The enormous variation in per capita health spending and utilization rates across the country raises serious questions about quality of care. The Urban Institute recently reviewed Medicare spending in several cities, adjusting the data for differences in age, illness, and other factors affecting health. They found that consumers spent \$1,874 on health care in Miami versus \$954 in New York and \$822 in Minneapolis in 1989. The difference in per capita health spending between Canada and the U.S. is smaller than the difference between Minnesota and Florida. Whether this variation reflects too little or too much care, it fuels consumer concerns that the U.S. health care system is not delivering an even quality of care.

Ideology and Health Care Reform

After Dr. Reinhardt's rendering of the system's problems, he turned to the subject of reform. In his view, the fundamental obstacle to reform is not about cost or know-how, but rather about ideology. "Forget all the talk about costs and access. The real question is, 'To what extent am I obliged to be my brother's keeper?' Health economists could develop a viable plan in a week if they only knew where the politicians wanted to go," he contended. "But America wants universal coverage only as long as it is for free."

Dr. Reinhardt began by demonstrating that low-income households are priced out of the market for health insurance. In 1990, 18 percent of the population earned \$15,000 or less while an insurance policy for families in this income group costs between \$4,000 and \$5,000. "Do you think these people can afford to pay that plus everything else that they need?" Dr. Reinhardt asked rhetorically.

Dr. Reinhardt estimated that it would add \$50 billion to current national health spending of \$1 trillion for universal coverage, a sum the country can well afford:

Divide \$1 trillion by \$50 billion -- a New York City taxi driver would probably shoot you if you called the resulting percentage a tip. If you want to be kind, add another \$30 billion to lift health care off the shoulders of the poor and put it on the people who could pay for it. So \$80 billion max would cover everyone, which is less than the difference in what we're paying for health care this year as opposed to next year (about \$90 billion). This is a 'tip' we can afford.

Dr. Reinhardt acknowledged that asking the top third of the income bracket to pay for universal access -- a policy that primarily benefits the bottom third of the income bracket -- is a difficult sell. While the politics are complicated, Dr. Reinhardt believes the merits of the idea are straight-forward. "It won't sink the republic. It won't make us uncompetitive. It won't wreck our position in the global economy. You won't even notice it. The real problem is a social-class issue. Do we in the upper-third tier want to be our brother's keepers?"

A Simple Model of Health Care Finance

Dr. Reinhardt next described a simple two-part model of health care finance. In the first part, money flows into a giant pot to pay for health insurance. There are three possible sources to tap for funds: individuals, employers and government. At present, about 11 percent of individuals buy their insurance directly while the majority of Americans get their coverage through their place of work. Noting that the bulk of employer-financed health insurance costs are shifted back to workers in the form of lower wages, Dr. Reinhardt dubbed this arrangement "the system of mutually fooling each other." Government is the final source of funds, with Medicaid, Medicare, the Veterans Administration and the like currently accounting for 42 percent of health care dollars.

With individuals, employers and government all pumping money into the system, part two of the model shows how this money is pumped out. There are two alternatives. First, health services can be paid for on a piecemeal basis (i.e., pay as you go under the fee-for-service system). Second, coverage can be contracted for on a capitation basis (i.e., an annual lump sum payment to an HMO-type provider). Most of the reform activity on the payout side is being driven by the private sector motivated by cost control considerations, according to Dr. Reinhardt.

Forks in the Road to Reform

Dr. Reinhardt has been a keen observer of the health care reform debate long before it was making front page headlines. He believes that health care reform could have taken the form of a regulated fee-for-service system modeled after either the Canadian or German systems. Congress didn't pursue this route mainly because of opposition from the American Medical Association (AMA). Many physicians, according to Dr. Reinhardt, are now rethinking the wisdom of this strategy as they recognize life under capitated managed competition is somewhat akin to the "road to serfdom."

In the meantime, the AMA has reacted by trying to stymie reform by:

- Seeking the right to form a doctors' union,
- Lobbying for an "any willing provider law" that would require HMOs to contract with any physician who accepts their terms and
- Institutionalizing a "mandatory point-of-service option" that would allow HMO participants to buy out of the system. If adopted, these three measures would effectively destroy the viability of a system based on managed care and managed competition. If the AMA wins these battles, Dr. Reinhardt concluded, they will deal a serious blow to cost control efforts.

Dr. Reinhardt characterized health maintenance organizations (HMOs) as "private bounty hunters that wring-out the excess capacity and fat from the health care system but also perform social good." In short, HMOs turn a profit by making tough deals with doctors, hospitals and other providers and consumers benefit in the process. Dr. Reinhardt estimated that in new markets ripe with cost cutting opportunities, HMOs pay out about 72 cents of every patient dollar. Over time, however, HMOs exhaust the easy savings and profit margins inevitably tighten. Kaiser Permanente, one of the nation's oldest HMOs, reportedly pays out 92 cents on the patient dollar, a lower but still healthy rate of return.

Dr. Reinhardt brushed aside criticisms about HMO profit margins in no uncertain terms. "Is that fair? Yes, it's fair -- their premiums are still competitive. HMOs are not cheating you, they just have the ability to beat up on doctors and hospitals and they keep the change -- that's the American Way."

Federal Outlook

Dr. Reinhardt concluded his remarks by sharing his prediction about Congress's next move. While he expected little action in the House absent Representative Rostenkowski, the Senate, he hypothesized, can and will produce a viable bill. Senator Moynihan has the ability to reach bi-partisan consensus which puts the spotlight on the Senate Finance Committee. House leadership would respond with a bill similar to the Senate's in order to avoid a huge fight in conference. In the end, Dr. Reinhardt predicted that the President will sign the bill whether or not it calls for universal coverage.

"My bet is it will be Chaffee Lite -- no mandates, some attempt to help the poor to get better coverage, insurance reform and some malpractice reform. I don't believe we will get universal coverage, but you never know in this country," Dr. Reinhardt concluded.

HEALTH CARE REFORM AND COST CONTROL

The Conference continued on Friday, June 3 with a working session designed to make the connection between the national debate and regionally-specific concerns and priorities. Joseph C. Scodari, Senior Vice President and General Manager for Rhône-Poulenc Rorer's North America operations, introduced the morning session by welcoming the opening speaker, Dr. Alan Hillman, Director of the Center for Health Policy at the University of Pennsylvania's Leonard Davis Institute of Health Economics.

Dr. Hillman is an authority on managed care and cost control and his remarks reflected both the clinical knowledge of a physician and a business professor's awareness of costs and tradeoffs. He argued that economics, not altruism, is the driving force behind health care reform. Drowning out the chorus of uninsured individuals are corporations that have traditionally provided health benefits to their workforce and now need relief from escalating health care costs. The sticker price of a new car, explained Dr. Hillman, includes some \$800 worth of workers' health care premiums and auto-makers and other large employers want help shouldering the burden.

While there is a general consensus on the need to control costs, there is far less understanding about the means to control costs. Dr. Hillman remarks' focused on four basic points about cost control:

- Health care costs cannot be cut without rationing. Alvin Toffler predicted in Future Shock that new technology would ultimately outstrip society's ability to pay. Dr. Hillman argued that Toffler's vision aptly describes the U.S. health care system where demand for expensive new treatments seemingly bears no relationship to price. Case in point, there are currently five to seven MRIs in operation at the University of Pennsylvania versus eleven machines in all of Canada. We simply can't maintain a "more is better" attitude and expect to control costs, contended Dr. Hillman.
- Treatment for the terminally ill has a profound effect on medical costs. Medical resources are finite and a disproportionate share of these resources is devoted to persons in the final six months of life. In contrast to British culture where it is customary for elderly and terminally ill patients to die without extreme intervention, American doctors and families tend to utilize every available means to prolong life. While the moral issues are complex, the prevailing attitude toward what constitutes appropriate treatment of the terminally ill does, in fact, have a significant effect on the nation's ability to control health care costs.

- Global budgets are not a radical concept. Noting that global or capped budgets are already part of the health care system (in Medicare Part B spending, for example), Dr. Hillman urged his audience not to reject the notion out of hand. He argued global budgets are common-place for other types of social spending. The highway budget, for example is fixed and pre-determined even though society could save additional lives by building better, safer roads.
- Managed care and managed competition are the only viable approaches. Doctors exercise control over approximately 80 percent of total health care costs through the way that they practice. Accordingly, any successful cost control effort must change the way doctors practice medicine. Managed care creates powerful incentives for the practitioner to do just that. Author of numerous managed care studies and clinical trials, Dr. Hillman is a strong believer in the potential of managed care and managed competition to slow costs without sacrificing quality.

Dr. Hillman was aware that his prescription for cost control would not be universally popular. He concluded by reminding his audience that we already ration health care today -- on the basis of ability to pay. Other forms of rationing are no more extreme.

HEALTH CARE REFORM: SOME VIEWS FROM SOUTHEASTERN PENNSYLVANIA

The remainder of the Conference consisted of three different forums for elected officials, corporate leaders and health care representatives to share their views on the implications of health care reform for Southeastern Pennsylvania.

Round Table Participants

G. Fred DiBona, Jr., President and CEO, Independence Blue Cross
 Edward G. Boehne, President, Federal Reserve Bank of Philadelphia
 Susan Hansen, President and CEO, Jeanes Health System
 A.J. Henley, CEO, HealthCare Management Alternatives, Inc.
 Alan L. Hillman, M.D., Director, Center for Health Policy, Leonard Davis Institute
 Charles B. Inlander, President, People's Medical Society
 Dr. Jerry Karabelas, President, North America, SmithKline Beecham Corporation
 William N. Kelley, M.D., CEO, University of PA Medical Center & Health System
 Stephen H. Male, Director, Bureau of Health Financing and Program Development,
 Pennsylvania Department of Health
 Sidney D. Rosenblatt, President, Zitner Candy Company
 Charles Schaffer, Jr., Administrator, Teamsters Health & Welfare and Pension Funds
 Joseph Swift, Vice President, Government Affairs, Sun Company, Inc.

Roundtable Discussion

The morning program continued with a roundtable discussion among the Southeastern Pennsylvania interest groups with a major stake in health care reform (see box). Edward G. Boehne, President, Federal Reserve Bank of Philadelphia, served as moderator for the discussion which centered on the question of market-based versus legislative reform. Panelists were asked to consider whether in light of the rapid changes in the health care system occurring today, do we need major new federal or state health care reform legislation or can market forces alone achieve such goals as cost containment and universal access?

With some exceptions, members of the roundtable generally concurred that market forces are and will continue to be more important than new legislation for reforming the nation's health care system. Most participants felt that regardless of the fate of pending state and federal legislation, competitive market forces are already rewriting the rules for the major players and segments of the health care market in Southeastern Pennsylvania. Although several articulate critics argued that market-based reform alone was inadequate, there was no consensus on the proper role for government and relatively few demands for specific state or federal health care legislation.

In the process of this and other discussions that took place at the Conference, several paradoxes about the impact of health care reform on the region and the nation took shape.

Crisis, what crisis? Some people argued the U.S. in general and health-rich regions like Southeastern Pennsylvania in particular are the best places in the world to get sick while others insisted that our health care system is teetering on the brink of catastrophe.

Universal coverage: a ticket to bankruptcy? At the same time that defenders of the status quo contended that universal coverage will bankrupt the nation, advocates of change calculated that reform can be paid for simply by trimming the fat from the system.

Will health reform make the regional economy sick? Southeastern Pennsylvania is relatively more health care oriented than the state or nation, with one-quarter or more of the region's job base directly or indirectly related to health care. With relatively more of the jobs, will we also bear relatively more of the economic pain associated with reform?

Can we radically reduce costs, but leave my doctor out of it? While everyone favors the concept of cost cutting to hold down medical expenses, almost nobody wants his or her doctor to spare any expense (or withhold any MRI) where they and their families are concerned.

What does universal coverage mean? While the notion of universal coverage has considerable appeal, hammering down the specifics has proven extremely difficult. Most Conference participants supported the concept of universal coverage, but could not agree on the level of coverage. For example, should we strive for "Cadillac or Hyundai care?"

Small Group Discussions

The roundtable discussion also served to inform the small group sessions of legislators and corporate leaders. Upon the completion of the round table, the Conference divided into six small groups in order to allow individual Conference participants to air their views about the impact of health care reform on Southeastern Pennsylvania. The groups were moderated by six neutral and respected small group leaders -- Edward Boehne (Federal Reserve Board), Robert Butera (Pennsylvania Convention Center), John Claypool (Greater Philadelphia First), Bruce Crawley (Crawley, Haskins and Rogers), Walter D'Alessio (Latimer and Buck, Inc.), and Joanne Denworth (Pennsylvania Environmental Council) -- and technical points of the discussion were clarified by resource people assigned to each group.

Each group was given ninety minutes to tackle the assignment: "In light of everything you've heard at this Conference, what are the three most important things that you now would like to tell state legislators considering health care reform in Pennsylvania?" While hesitant to embrace comprehensive reform, there was overwhelming consensus on two specific legislative actions: insurance reform and tort reform.

Insurance reform, also referred to as small group market reform topped the list. Nearly every group advocated measures to promote portability of coverage, prohibit firms from denying coverage on the basis of pre-existing conditions, and mandate a community ratings system to set individual premiums. The overall consensus was that the state should create uniform and equitable policies governing all insurance companies.

Tort reform was the second issue with near universal support. Conferees were convinced that the threat of malpractice suits results in defensive medicine which, in turn, increases costs. Recommendations for tort reform include caps on jury awards, limits on pain and suffering awards, and granting judges the power to award legal fees as a means to discourage frivolous suits.

A number of other policy recommendations came out of the small group discussions that, while they lacked the same level of consensus as tort and insurance reform, highlight several worthwhile options for the legislature to consider.

- **Medical Assistance Reform:** In addition to the obvious health care issues, Medical Assistance reform also has major budget ramifications for the state. While groups supported the concept of managed care for Medicaid populations, the Health-Choices program for Southeastern Pennsylvania was criticized for its poorly established zone boundaries, its implementation schedule and its reliance on too few franchises.

- **Employer Mandates:** There was no support for funding universal coverage through employer mandates, primarily due to fears that mandates would destroy small business.
- **Distributing Doctors:** Although there is no absolute shortage, there are too few primary care doctors in underserved inner city and rural areas. The distribution of doctors can be partially influenced by providing financial incentives for physicians (or physicians in training) to practice in these underserved locations.
- **Academic Health Centers:** The region's four academic health centers provide vital health care services including medical education, research and state-of-the-art patient care. Several small groups expressed a desire to continue or expand support for these valuable centers and to ensure that state-level reforms adequately support these institutions in an increasingly competitive, HMO-dominated environment.
- **Quality Assurance:** Although the system is rapidly changing, no one seems to be responsible for monitoring quality. One group worried that given big budgets and the unregulated markets, the next S&L scandal will play out somewhere in the health care arena. To reduce this risk and simultaneously improve the quality of care delivered, state oversight should be strengthened and expanded to cover unregulated services such as radiation centers and un-affiliated ambulatory services.
- **Remove Obstacles to Reallocating Resources:** At the same time that some unregulated services need more scrutiny, other counterproductive regulations that restrict more efficient use of resources should be rescinded. For example, state regulations that prohibit hospitals from converting to nursing homes should be lifted.
- **Preventive Care:** Dollars for preventive care for children will go further if care is administered by qualified health care teams featuring trained physicians assistants, nurses and social workers, rather than -- according to some statutory edict -- by doctors alone.
- **Disclosure:** In order to offer more complete information to consumers, doctors and hospitals should be required to disclose medical outcomes for their services. Standardized definitions must be adopted to make comparisons meaningful.

Caucus Leaders Panel

The Conference concluded with a luncheon panel of four members of the regional delegation who are playing a leadership role on the health care issue: Sen. Hardy Williams (D-Philadelphia), Rep David P. Richardson (D-Philadelphia), Rep. Elinor Taylor (R-Chester), and Sen. Earl Baker (R-Chester). These four leaders offered both a

review of what the four caucuses have done to date and a glimpse of their likely postures on health care reform over the next legislative session.

Sen. Hardy Williams, who serves as the Minority Chairman of the Senate's Public Health and Welfare Committee opened the panel by stressing his view that the private sector is not capable of reforming the nation's complicated health care system without legislation. While he credits President Clinton with bringing the subject of health care reform to the forefront of the political agenda, Sen. Williams does not think that Pennsylvania should wait for Washington, D.C. He would like to see a state health care system that provides universal coverage for all residents of Pennsylvania.

Rep. Elinor Taylor, the Minority Chairwoman of the House Health and Welfare Committee, noted that the House has held exhaustive debates on the subject of health care reform over the past year. Not surprisingly, legislators have not been able to formulate an all-encompassing plan that pleases all interest groups, and Rep. Taylor believes it makes sense to address the most pertinent health reform issues in separate bills. Affordable insurance measures for small businesses, medical savings accounts, pilot programs to try new approaches, primary care and portability are the five issues she recommends the legislature tackle.

Sen. Earl Baker spoke next, expressing the Senate Republicans' viewpoint that minor alterations of the current health care system are all that is necessary rather than comprehensive reform. A member of the Senate Public Health and Welfare Committee, Sen. Baker believes that Governor Casey's plan has many problems and is unlikely to pass. He recommends waiting to see what occurs on the federal level before acting in Pennsylvania.

Rep. David Richardson (Chairman, House Health and Welfare Committee) wrapped up the panel by affirming his support for a combination of the single payer plan (HB 1967) and HB 1958, part of the Casey plan. While noting that there is not actually a single caucus position on health care reform -- only individual positions -- he stated that his priority is to pass a comprehensive reform plan and then tort and other reforms. Rep. Richardson also commented on the interrelatedness of health care to other major social issues like welfare, crime and employment. Measures that attempt to solve these problems simultaneously will likely lead to the greatest success in the long term.

It is evident that the four caucuses have adopted different approaches to health care reform. The House Health and Welfare Committee, for example, held 33 public hearings over a 14-month period in search of a workable formula for major reform while their counterparts in the Senate have been focusing on more modest alternatives to the status quo. Although certain initiatives such as insurance reform have gained attention by both parties, there was at the time of the Conference no consensus to support comprehensive reform measures like the Casey and Richardson bills.

CONCLUSION

The Ninth Annual Southeastern Pennsylvania State Legislators' Conference assessed the impact of health care reform on the region from a variety of perspectives. During the round table discussion alone, legislators heard from representatives of big business, small business, hospitals, consumers, the insurance industry, the pharmaceutical industry, state government, labor, academic health centers and academic think tanks. Given the diversity of interests present and the complexity of the topic at hand, it is almost surprising that the Conference yielded any definitive areas of consensus. At least two such areas emerged.

Market Reform over Government Reform. Although the news media has focused almost exclusively on prospects for legislative reform, participants at the 1994 Conference clearly viewed the market as the more potent and preferred agent of change. In short, the health care system is evolving and will continue to change with or without new government intervention. Implicit in this approach, however, is the notion that some people will not receive health care as competitive forces do nothing for those who are outside of the confines of the market.

Pennsylvania Should Wait for Federal Action. The conventional wisdom at the Conference was that Pennsylvania should adopt a wait-and-see attitude about enacting major new state legislation. Absent a clear view on what is likely to come out of Congress this year, it was felt that too much is at stake (namely, the multitude of health care jobs and related establishments) for the state to act blindly. There was also great concern about damaging the Pennsylvania business climate via state-imposed employer mandates. Several dissenters, however, argued persuasively that given the need, the legislature should take the initiative and implement reform now before the federal government constrains the Commonwealth's options.

In short, the sheer size and complexity of the state's and region's health care systems helps to explain why so many parties in the health care debate favor market over legislative-based approaches as well as why the Pennsylvania state legislature is hesitant to explore new turf before Congress has established a clear course.

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