The Uninsured Debate: Health Insurance vs. Health Care Access

The Uninsured Debate:  
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Report on presentations and a panel discussion  
at the 1999 annual conference  
of the California Association of Public Hospitals and Health Systems,  

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FOREWORD

With more than seven million Californians lacking health insurance coverage, the question of how to ensure access to needed health care services for all people living in the Golden State has never been more pressing—or ripe for debate.

Towards that end, the California Association of Public Hospitals and Health Systems last December presented a panel discussion on the issue of the uninsured as part of our 1999 annual policy conference, “What Matters Most: Confronting the Health Care Needs of the 21st Century.” The special session, titled “The Uninsured Debate: Health Insurance vs. Health Care Access,” featured an outstanding panel of health policy luminaries, with keynote addresses by Mark Smith, M.D., president and CEO of the California HealthCare Foundation, and Bruce Vladeck, Ph.D., senior vice president for policy of Mount Sinai NYU Health. Their remarks were followed by a reaction from Robert Valdez, Ph.D., UCLA professor of health policy and management, and a Q&A with the audience. Former Assemblyman Burt Margolin of Brady & Berliner moderated the panel.

In response to the audience’s overwhelmingly positive reaction to the session, as well as numerous requests for a post-conference transcript of the events, we are pleased to present the proceedings from that debate. The panel’s thought-provoking—and, at times, contentious—viewpoints sparked many constructive conversations, and we hope that this written record will encourage the health policy community to continue to address the important questions raised by the debate. In light of the recent passage of SB 480 (Solis), which directs the state secretary of health and human services to report on the potential for universal health care coverage in California, the insights shared during this panel discussion are particularly relevant.

When we developed the idea for this debate, we were interested in exploring a series of questions related to health insurance coverage and access to health care services:

- How do we define access?
- Is the health insurance model the only—or even the most effective—way to achieve meaningful access to care?
- Do people who lack health insurance coverage really want health insurance per se, especially if they must share in the cost, or do they value more having a place to go for their health care needs?
- What are the disincentives to purchasing health insurance and can lower premium costs alone overcome them?
- If the insurance model is not appropriate for all populations, how can public policy address those areas where the market has failed?
- How can we structure insurance expansions in a way that maximizes enrollment and provides true access to health care services, especially for disenfranchised populations?
- Why don’t policymakers ask the uninsured what they want?
We also asked the panel to address a fundamental reality that often goes unmentioned in the current debate over the problem of the uninsured. That is, even if the most ambitious proposals to expand health insurance offered during the 1999 legislative session had been enacted, and every single individual made eligible by such proposals were enrolled in a health insurance program, roughly five million Californians would remain uninsured.

As we know, many of the insurance expansion proposals were not enacted last year. Furthermore, enactment of such expansions is no guarantee that newly eligible individuals will actually enroll in a program, and enrollment does not assure that these individuals will actually receive needed health care services. Our experience in California has made it abundantly clear that eligibility for health insurance does not necessarily equate with health care access.

Recent studies and experience suggest that a patient’s identification with a provider, not his or her insurance status, is often the most significant factor in ensuring access to care. For many of the uninsured, their primary identification is with one of the state’s “open door providers”—a hospital, health system or community-based clinic that serves all members of the community, regardless of insurance status or ability to pay. This being the case, it is perhaps time to challenge the notion that a so-called two-tiered system of care is necessarily bad, and that the “second tier”—i.e., the public health care system—is an inferior one. Indeed, over the past several years, open door providers have taken considerable steps to improve their facilities, enhance customer service, streamline operations and otherwise make the patient experience a positive—and preferred—one.

Accordingly, we must also ask: How can we balance the need to maintain a viable health care safety net with the desire to expand access to insurance in public policy debates around the issue of the uninsured? How can California design and finance expanded health care coverage in a way that recognizes the unique and special role of open door providers in providing accessible, culturally appropriate health care to low-income and uninsured patients as well as a host of public goods that benefit everyone in the community? Is there a way to look at “coverage” as a combination of expanding health insurance and strengthening our health care safety net?

Our panelists clearly agree that we must address both insurance expansions and the viability of the health care safety net. At the same time, they raise different and occasionally conflicting perspectives on the ongoing role of open door providers and on the economic, social and political factors informing the debate over health care access. Both of our keynoters provide compelling challenges to the conventional wisdom of the debate over the uninsured, and we believe that this debate can only benefit from careful consideration of these challenges. I am confident that you will find their remarks to be fresh, stimulating and valuable.

To obtain additional copies of this report, visit the CAPH Website at www.caph.org or call us at (510) 649-7650. We welcome your comments.

Sincerely,

Denise K. Martin
President and CEO
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Special thanks to our distinguished panelists—Burt Margolin, Mark Smith, Robert Valdez and Bruce Vladeck—for their generous contribution of time and expertise. We could not have managed the transformation of an interesting idea into such a rich and eloquent discourse without their involvement.

This report is supported by a grant from the California HealthCare Foundation. The California HealthCare Foundation, based in Oakland, California, is a non-profit philanthropic organization whose mission is to expand access to affordable, quality health care for underserved individuals and communities, and to promote fundamental improvements in the health status of the people of California.
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Burt Margolin (moderator) is the director of public policy for the firm of Brady & Berliner and leads a team that provides clients with strategic analysis and legislative advocacy on health issues at both the state and federal level. He currently serves as the chief legislative strategist for the Los Angeles County Board of Supervisors. He is a former member of the California State Assembly, a position he held for twelve years. In the Assembly, he chaired the health committee and specialized in health care reform. In 1995, the Los Angeles County Board of Supervisors appointed him “Health Czar” for the troubled L.A. system. In that capacity, he assisted the county in successfully negotiating the Section 1115 Medicaid waiver that has served as the blueprint for the restructuring of the L.A. health care delivery system.

Mark D. Smith, M.D. (keynote speaker) is president and CEO of the California HealthCare Foundation. Dr. Smith is also a member of the clinical faculty at the University of California at San Francisco. Prior to joining the foundation, Dr. Smith was executive vice president of the Henry J. Kaiser Family Foundation, where he was responsible for the Poverty and Health, HIV/AIDS Policy, and Changing Healthcare Marketplace programs. Dr. Smith has written and spoken extensively on AIDS-related issues and the health care marketplace. He serves on the Committee on Performance Measurement (HEDIS) of the National Committee for Quality Assurance. He also served on the editorial board of *Annals of Internal Medicine*. He received an A.B. from Harvard College in Afro-American studies; an M.D. from the University of North Carolina, School of Medicine, Chapel Hill; and an M.B.A. in health care administration from the Wharton School at the University of Pennsylvania.

Bruce C. Vladeck, Ph.D. (keynote speaker) is senior vice president for policy of Mount Sinai NYU Health, director of the Institute for Medicare Practice, and professor of health policy and geriatrics at the Mount Sinai School of Medicine. From 1993 through September 1997, Dr. Vladeck was administrator of the Health Care Financing Administration of the U.S. Department of Health and Human Services. In that position, he directed the Medicare and Medicaid programs, providing health insurance to more than 65 million Americans with combined annual expenditures of more than $300 billion in 1997. He also played a central role in the formulation and enactment of the Medicare, Medicaid, and child health provisions of the Balanced Budget Act of 1997. Before joining the federal government, Dr. Vladeck served ten years as president of the United Hospital Fund of New York. He has also held positions on the faculty of Columbia University, at the Robert Wood Johnson Foundation, and, from 1979 through 1982, as assistant commissioner for health planning and resources development of the New Jersey State Department of Health. A nationally recognized expert on health care policy, health care financing and long-term care, Dr. Vladeck has published widely, perhaps most notably in his book, *Unloving Care: The Nursing Home Tragedy* (Basic Books: 1980). He received his B.A., *magna cum laude*, from Harvard College, and an M.A. and Ph.D. in political science from the University of Michigan.

Robert Otto Valdez, Ph.D., (reactor) is professor of health policy and management and director of the doctoral studies program in health services research at UCLA. Dr. Valdez received his Ph.D. from the RAND Graduate
School for Public Policy Studies where he specialized in studies of health care financing and quality of care for children. He continues to pursue research in these areas at the UCLA Center for Healthier Children, Families, and Communities where he serves as associate director and at RAND where he is a senior health scientist. In addition, he serves as the national research director for the Inter-University Program for Latino Research, a consortium of 14 university-based research centers. Dr. Valdez recently served as special senior advisor to the White House Initiative on Educational Excellence for Hispanic Americans. He has also served in a dual capacity for the U.S. Department of Health and Human Services (HHS) as deputy assistant secretary for health at the Public Health Service and director of interagency health policy at the Health Care Financing Administration. Prior to joining HHS, he served as a senior advisor to the White House on health care and as a member of the White House Task Force on Health Care Reform. Dr. Valdez is the author of numerous studies on children’s health, health care finance and the uninsured, as well as works on California’s changing demography, economy, and society.
Introduction

Burt Margolin: Our topic this morning, “The Uninsured Debate: Health Insurance vs. Health Care” is a very timely and critically important topic. What we’ll be addressing today is a fairly simple issue: Does health insurance coverage mean the same thing as providing care? Is one the same as the other? What are the strengths, and what are the limitations, of the current state and national strategy of incrementally expanding health coverage? How do we incrementally expand health coverage at the same time that we assure the survival of health care facilities dedicated to serving members of the population that remain uninsured?

I don’t need to remind this audience, but it is still worth noting that even if every single idea on the table in Sacramento involving expansion of Healthy Families and Medi-Cal were implemented, not just enacted but implemented, we’d still have an uninsured remainder of five million out of the current seven million uninsured population. In other words, is the debate over incremental coverage expansion in danger of crowding out consideration for the safety net, or as CAPH now calls it, the open door provider system?

The question is, are we too focused on modest Medi-Cal fixes, and too unconcerned about DSH cuts and FQHC reimbursement phase-outs? Does this have to be an either/or debate?

This is a debate, as we all know, that has grown in urgency and significance. Here we are in 1999, witnessing the rebirth of the health care reform debate nationally, with presidential candidates returning to a topic that most of us here in this room thought, in 1994, was lost for another generation. Well, a generation turns out to be approximately five years, which is in the interest of all of us here in this room. Whether it’s Al Gore talking about universal coverage for children as a building block to a broader expansion, or Bill Bradley discussing the replacement of Medicaid with the new voucher system that would establish as its objective near universal coverage, the pendulum is swinging back to a more constructive public policy debate. It may not be a debate that contains proposals that everyone here in this room agrees with all the time, but the proposals move us back to issues that, again, are critically important to be addressed.

California has even put its toe in the water (some might argue foot, I think it’s toe) with respect to universal coverage options. [California State Senator Hilda] Solis authored a bill, which the Governor signed, which directs [California Secretary of Health and Human Services] Grantland Johnson to report to the Legislature by December 1, 2001 on options for universal coverage. So even in the state of California, where, in the legislative arena, it’s fairly slow going, we do have this gubernatorial decision to reengage, at least, on a discussion of universal coverage. So instead of viewing health care reform as the lethal “third rail” of American politics, which was the standard view in 1994 after the death of the Clinton plan—you touch universal coverage or
fundamental health care reform and you die—we now have, with all the differences in style and substance and scope, a renewed debate about this problem which impacts a largely politically invisible population of over 40 million Americans.

So where are we in California as this debate begins nationally? What are we doing in California in the effort to expand access?

Incremental expansion of coverage is clearly the order of the day, no doubt about it. Thanks to Governor Davis and the Legislature, Medi-Cal and Healthy Families expansions approved in this year’s budget have the potential of reaching some 400,000 uninsured Californians. That is useful progress, without question, but it has to be put in the context of the fact that the number of uninsured in California continues to grow. We had over seven million at the last survey point, and in the previous year it was expanding, according to a University of California study, at the rate of some 50,000 per month. In the Legislature this last year, at a time when these incremental expansions were being approved, other initiatives were frustrated. We had proposals for continuous eligibility for children under Medi-Cal defeated, not enacted; we had efforts to dedicate tobacco tax revenue to health care killed; we had broader proposals to consolidate Healthy Families and Medi-Cal and rewrap our whole safety-net system stalled.

So we had a step forward this year, but we also had some regression; maybe not quite a step back, but we had some backward motion. The major issue that millions of Californians are still uninsured was not fundamentally addressed.

Now one of the chief criticisms of this incremental coverage strategy is that eligibility for coverage, as important as it is to achieve, does not always equal health care access, or for that matter even health coverage enrollment. We know how difficult it was to get the Healthy Families Program going; there was a period when we were all watching those first year enrollment figures, and they seemed to be single digit, you know, 37 enrollees to 43. I’m exaggerating a bit, but the first year was incredibly difficult. It’s doing better now, but it was off to a painfully slow start. The grand promise of this population covered didn’t translate into this population enrolled as quickly as some would have hoped. Medi-Cal enrollment is declining, and there are still some 800,000 children who are not enrolled although they are eligible.

Moreover, even if you have an insurance card, there are still barriers to access. These barriers are based in some cases on language, in some cases on cultural beliefs, transportation, lack of education, and, in a lot of cases, the simple explanation is confusion about the health care system. Imagine that. Confusion about the health care system—a syndrome that I think most people who run the system also suffer from. So you can imagine how someone new to eligibility reacts when confronted with this system.

There will always be, on top of these other factors, some percentage of the population that is homeless, mentally ill, or undocumented, and that is not going to be easily covered. And there will be another percentage of the population that even though they have the potential...
to pay for coverage, don’t see the need for coverage, and for whatever reason will not enroll, even if they are eligible.

So we have this large remainder population of uninsured, and the question we are going to try to address this morning in many ways, and from different vantage points, is this: Is a health insurance model the most effective or the only way to achieve access to care? A question that our topic today poses for state policymakers is: Do we have a need to move from a primary emphasis on coverage expansion—which is the primary, almost single-minded focus of state policymakers—to a more complex set of strategies designed to mix and match coverage expansion with subsidies for open door providers that have the expertise and mission to serve low-income, culturally diverse populations without regard to insurance status? In other words, a big chunk of the population—numbering in the millions—will continue to lack health insurance coverage no matter what we do in the immediate future. Is a strategy that ignores the role of safety-net providers doomed to failure if ultimate access to care—not just how many new eligibles are theoretically available to the system—is the criterion that we use to measure success?

So that’s our topic for this morning. Again, we have a superb panel, and I’d like to begin now with our first panelist, Dr. Mark Smith, the president and CEO of the California HealthCare Foundation. Please welcome Dr. Smith.

Keynote Presentation I

Mark Smith: Thank you, good morning. I want to take on a little of this discussion about health insurance, health care, the safety net, etc. And let me start by answering Burt’s questions in the following way: No, Yes, Yes, No and No.

In answer to the questions: Are health insurance and health care the same? No. Is there a danger that the discussion of insurance and expanding coverage will crowd out discussion of funding residual safety net/open door providers dedicated to the care of those who don’t have coverage? Yes. Does there need to be a vigorous discussion about how such providers are funded? Yes. Is insurance the only way in which care can be accessed? No. And perhaps most importantly, Is insurance always the best way, the most efficient way, to provide funding for coverage, for care? I think the answer to that is “no” as well.

My hypotheses to which I’ll return from time to time, are that 1) our general concept of “health insurance” combines several contradictory concepts; and that 2) we, all of us—right, left and center, but particularly the more wonky we are the more likely we are to make this error—make ideological assumptions about individuals’ preferences which are not supported by empirical evidence.

What is insurance? One definition is, “A means of guaranteeing protection or safety.” A more comprehensive and, I thought, interesting one comes from Compton’s. It says, “Insurance may be considered a game of risk in which individuals and businesses protect themselves, their families and their property from possible losses resulting from unpredictable events such as storms, fires, accidents and illnesses. The first rule of the game, devised centuries ago, is ‘share the risk.’ To play by this rule many people take a small loss in place of one person’s taking a large one.” Does this fit with most people’s notion of what insurance is? It does with mine.
What is insurance? It is financial protection against catastrophic loss. That’s what insurance is. Car insurance, homeowner’s insurance, health insurance. Let’s see if various events fit an “insurance” model. In the realm of your house, does a fire fit the insurance model? Would you expect your homeowner’s insurance policy to cover a fire?

(Audience: Yes.)

Yes. Would you expect it to cover a new paint job?

(Audience: No.)

No. You got that one right. Very good!

Now, let’s talk about your car insurance. Would you expect your car insurance to cover a crash?

(Audience: Yes.)

Very good! Would you expect your car insurance to cover the cost of gasoline?

(Audience: No.)

No! Very good, four out of four!

What are the characteristics that we can derive from our little test here about the nature of insurable events? They are rare, they are severe, they are unpredictable, and they are outside of the control of the insured party. Would people agree that these define the characteristics of an event against which it is reasonable to use an insurance approach to protect against catastrophic financial loss?

(Audience: Yes.)

So if we’d agree that if for the most part, insurance events are rare, severe, unpredictable and outside the control of the insured party, let’s examine some health events. Suppose you are hit by a truck. Is that an event against which one might seek insurance?

(Audience: Yes.)

Yes. How about if you’re diagnosed with lymphoma?

(Audience: Yes.)

Yes. How about cosmetic surgery?

(Audience: Yes! Laughter.)

I know we’re in Southern California! But for most of us, we would say no, and part of what I’m trying to get you to do is to deconstruct why, when confronted with this, we would instinctively say “no.” Why? It’s because it doesn’t fit one or more of these categories, these characteristics of what we consider insurable events.
Now, how about a mammogram? Doesn’t really fit that category, does it? A mammogram is not only not rare (hopefully)—it is under the control of the insured party, and a mammogram is actually something we want people to get. So we hope, under optimal behavior, that a mammogram is a common, desired effect. How about insulin for a long-standing diabetic? Rare? Severe? Unpredictable? Outside the control of the insured party? If you’ve been a diabetic for five years, the answer is no.

The point I’m trying to make is that what we commonly call “health insurance” combines some features of insurance in the sense in which we normally use that term, and some things that are very much unlike the insurance model. And therein lies part of our problem with health insurance in America.

So what is health insurance? It is financial protection against catastrophic medical expenses—like what happens if I get hit by a truck—and it is also prepayment for regular, expected, minor and desired expenses such as those for colds, sprains, mammograms, Pap smears, chronic medications. Now please understand, I’m not arguing what it should be in some Aristotelian fashion. I’m saying what it is. What it is in practice. And the fact is that this combination of features makes it unlike insurance in almost any other domain, which leads to part of our difficulty in disentangling the role of insurance from the provision of care.

Is health insurance a good thing? Yes, I believe health insurance is a good thing. Why do we want people to have health insurance?

(Audience member: To pay providers.)

Ah. We’ll get to that. But providers rarely put that one forward first in the public debate. That’s a little like auto-body shops putting forward the notion of universal collision insurance as a fundamental American right.

Why do we usually say we want people to be covered by health insurance? We say, “What happens if you’re hit by a truck?” We want financial protection. We want people to be protected from catastrophic, unexpected medical expenses. But why else do we want insurance? There’s a whole body of literature about how people with insurance behave differently from those without insurance. And so, within the health care profession in particular, the moral authority for the call for universal insurance has to do with the fact that we know people with insurance get their mammograms, get their Pap smears, go earlier for diagnosis. That is to say, it has the behavioral effect of increasing the likelihood that the individual will seek services for which they do not budget and do not save. Is this true or not? People save for vacations. People don’t save for colonoscopies. So we’ve discovered over time that behaviorally speaking, if you are “covered,” that is to say if you have prepaid, you are more likely to seek care than if you have to go in your pocket to come up with the 260 dollars. That’s why we want health “insurance.”

And then the dirty little secret is we also want health insurance, if we’re providers, to be assured of payment. So let’s go back. Who invented Blue Cross?

(Audience member: Providers.)

Providers. Who invented Blue Shield?

(Audience member: Doctors.)

Doctors. What was the impetus for the creation of this mechanism of financing? It was not, “Oh, what happens if you’re hit by a truck?” It was, “I want to get paid.” So recognize that the interests in the debate over

The better we make the safety net, the less disincentive we give people to remain uninsured if they’re eligible [for publicly sponsored health insurance].

Mark Smith
insurance come from different places, because our reasons for wanting people to be covered have different origins. What social needs does health insurance fill? Protection against unexpected catastrophic expenses, payment for smaller expected expenses, and an assured income stream for providers. It is clearly the case, therefore, that people want protection; the level of prepayment is the area where we have much debate. What should be mandated, and what should be expected to be paid for out of people’s pockets?

Let’s talk a little bit about California’s uninsured. 22 percent of the population, seven million people. Most, as you know, are working people or their dependents. I actually have some propaganda. I want to talk about three segments of people. First, the people who make less than 200 percent of the federal poverty line. These we will call, for right now, the “poor uninsured.” Let’s assume that these are people who really cannot “afford” health insurance in the sense in which most people would mean that term. Of them, roughly half are eligible for an existing government insurance program, under existing eligibility regulations, and we cannot get them to sign up.

Now, please understand. I understand there are a variety of reasons why people do not sign up for Medi-Cal and Healthy Families. They’re afraid of the INS. The form is not in Hmong. They don’t understand insurance. The form is too long, too difficult to fill out. They don’t like going to the welfare department. The California HealthCare Foundation has been at work trying to assist in each and every one of those areas. And yet, I would argue to you, if there were a million low-income Californians that were eligible for $2000 a year in cash, how much “outreach” do you think we’d have to do? Would we be putting out RFPs for community-based organizations to explain it? Are you kidding me? Many of us have struggled our whole lives to pass bills to give the poor what they desperately need. We tend to think that the reason they’re not battering down the door is simply that we haven’t yelled loud enough or in the right language. This is an illusion.

Now, let me ask you a moral question. Those of you who work in public hospitals: how many of you think it would be moral or ethical to allow people who have insurance, including Medi-Cal, to be treated preferentially in your institution compared to people who don’t? How many of you think that’s a good thing? How many of you think that’s a bad thing? A little unclarity. Then let me ask you this: If I’m a poor person, and I’m treated exactly the same by you whether I have insurance or not, why should I sign up? Because we are “open door providers,” we wouldn’t do anything nasty to people like discriminate among them or create distinctions among them. But the fact is that most of us, including low-income people, do what we do by some subtle combination of incentives and disincentives. And so, please don’t get me wrong, I don’t want anybody saying “Oh, Smith said we should tear down the safety net.” Smith did not say that. Smith said, “The better we make the safety net, the less disincentive we give people to remain uninsured if they’re eligible.”

So let’s talk about this group that’s more than 200 percent of the federal poverty level, what I’ll call for these purposes the “non-poor uninsured.” I understand these are not mainly wealthy people. 45 percent of these people, however, make more than 300 percent of the federal poverty level. That is, 27 percent of the uninsured in California make more than three times the federal poverty limit. These are not people for whom health insurance is “unaffordable” in the sense in which most of us would use that term. For those of you who are interested, I left outside some copies of our recent report on this subject. This report asks, for the first time, people for whom the “market” should work; they “should” buy health insurance—and don’t. 45 percent of these people own their own homes! 60 percent have personal computers, but they’ve chosen not to have health insurance. That is to say, their sense of the value of what they can “afford” says health insurance is not high on their list. So I think that’s very strong evidence that the notion that there is any voluntary way to achieve universal coverage is not borne out by the data.
And in fact, we know that the employer-based system is declining. Another recent report that I’ll put outside for you to look at is a recent survey of employers, including small employers who don’t offer health insurance coverage. Interestingly, 85 percent of the owners or presidents of small businesses who do not offer health insurance coverage to their employees have it for themselves. So it’s not that they don’t value health insurance, but that on the relative value scale of the competitive set of benefits they need to offer to attract workers, health insurance is apparently not very high.

So let’s end with a few facts and my own sense of what those facts mean. One, the employer-based system is problematic but resilient. What do I mean by this? Every year we know the number of uninsured goes up; every year we know the number of people insured by employers goes down. But I think the rumors of the “death of the employer-based health insurance system,” like those of Mark Twain, are highly exaggerated. I’ve been hearing for at least fifteen years that the employer-based system is just about to crumble; I think no such thing is the case. The employer-based system has strong political and economic roots that are not going to go away any time soon, and therefore while it will continue to weaken, particularly given our labor market, we’ve got to see it as a continued part of the basis of health insurance.

Second, the safety net is built in part on an involuntary monopoly of patients. Now this is a very difficult issue, and I was actually intrigued to hear a previous speaker mention Rosa Parks’ name. Is anybody here from Atlanta? No? Anybody here know a hotel and restaurant called Pascal’s in Atlanta? You know Pascal’s? Pascal’s was the premier black-owned business in Atlanta during the days of segregation. Hotel and restaurant, famous throughout the South. The SNCC* people, the CORE** people, the NAACP people, when they were in Atlanta, they stayed at Pascal’s. If you were going through Atlanta, you ate at Pascal’s. It was the crown jewel. It is now a shadow of its former self. In fact, you who have lived in the South know that there is a whole range of institutions that grew up in the black community during the era of segregation that are now gone. Some of them had a very proud history. That is not to say that the circumstances that created them are something of which we should be proud, but it is to say that those institutions which grew up in an era where people did not have alternatives forged out of that situation a proud and noble history. But once those circumstances were changed, while some of those institutions survived, many did not. And you can bemoan the passing of those institutions with proud histories, but once black folks could go to the Holiday Inn, they were going to go to the Holiday Inn, for the same reason that white folks go to the Holiday Inn, or the Westin or the Hyatt, or all the other places in Atlanta that didn’t used to take black people, during the time in which Pascal’s grew up.

I would argue that any institution which is based on an involuntary monopoly will face problems for its survival once people have choices. So those of you who work in public hospitals who find that once Medi-Cal patients have a choice of institutions, you have lost market share in deliveries or ambulatory visits, and feel hurt because of your proud history of special competency in the care of the poor, should recognize that it’s not the first time it’s happened. And so safety-net institutions that are built on an involuntary monopoly, to the extent that insurance coverage expands, will lose market share.

Third, the hospital sector is shrinking. The fact of the matter is it will continue to shrink, and there will continue to be the need, particularly in the public sector, to move resources from inpatient care towards outpatient.

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* Student Nonviolent Coordinating Committee
** Congress on Racial Equality

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Mark Smith

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So what are the implications? One, I think it an incontrovertible fact that public hospital numbers and size will continue to decrease. Second, providers will need to reorient themselves to be competitive. I went to medical school at UNC; I trained at UCSF at the San Francisco General program, and I work at Ward 86 in San Francisco General every Friday morning; I have for years. I had an interesting discussion several months ago when a colleague of mine had just come back from a trip, and he was talking about how good he thought the care was at San Francisco General compared to another public hospital in another city which shall remain nameless. "Oh, man, we’re better than this, we’re better than that…" I said, "You know what? You’re not in competition with a hospital in Chicago; you’re not in competition with a hospital in New Orleans or Harlem. You’re in competition with CPMC [California Pacific Medical Center].” And so one of the features of having a monopoly is that you’re not really oriented towards a competitive framework because, like Lily Tomlin used to say, “We don’t care, we don’t have to, we’re the phone company.”

The fact of the matter is, if these institutions are to survive, even given the small patient base who have a choice, they will need to be competitive. These institutions will need to reorient their thinking from “charity” to understanding what their patients want and need, and serving those needs.

And lastly, providers will need to adopt industry benchmarks for quality and service. An example is the PEP-C program, the Picker Institute survey, in which I know a number of you are involved, and which the Foundation is supporting. I think this is a very good thing, because I think it is important to make the case to county supervisors—and others who control purse strings—that if you are doing as good or better a job as the voluntary hospital down the street in such domains as educating patients about their discharge medicines. You can help dispel some of the mythology that the hospital isn’t good because it’s a public hospital. If you’re not doing as good a job, then you need to know that, and you need to work on it. So my sense is that public institutions will be entering a new era in which they will increasingly be held to the same standards of accountability as the private sector is being held to, and they will need to manage to those standards if they are to be competitive.

So in conclusion, my sense about all this is that health insurance will continue to be the dominant political agenda item, because it has a certain persuasiveness. It serves not one function, but several for people. It protects them against financial catastrophic loss, it gives them a measure of reassurance, and because of the prepayment element that we’ve wrapped into health insurance, it assures them access to providers. I think the politically enfranchised set of the uninsured, that is, the working people and people who are concerned about them, will always prefer that they have that financial mechanism available than that they go to an institution which is by definition a residual institution for those with little or no choice. For those institutions to survive in this era, we will need to do these competitive things that I’ve talked about, and also debate what is a fair and rational way of supporting the institution in addition to the insurance mechanism.
My last two points are this: The most telling way in which you can see this debate, is in almost every debate over Medi-Cal. And it is because Medi-Cal serves two contradictory purposes. Medi-Cal’s purpose is, on the one hand, to provide the most efficient, highest quality care for the people who are its explicit beneficiaries, Medi-Cal enrollees; and on the other hand, to be inefficient enough to subsidize a class of providers whom we want to survive, to take care of patients that we want to be cared for but are not willing to explicitly cover. Isn’t that the fact of the matter? So the argument over Medi-Cal payment rates and DSH payments and preferential treatment in Local Initiatives is “We need this money to help subsidize our care to people whom you give us the assignment to care for, but whom you will not explicitly cover.” My sense is that, although this may be irrational as a matter of public policy, it will continue indefinitely in California, unlike Wisconsin, unlike Minnesota, because of the large proportion of undocumented people in the uninsured or uninsurable workforce in California. Maybe I’m wrong about this; maybe the political winds will change to the point where the populace is willing to explicitly cover people who are in the country illegally, but I don’t think so. And that’s part of the reason I think that no matter what they do in Wisconsin, no matter what they do in Maine, it will be of limited applicability here in terms of financial insurance mechanisms for covering the uninsured. Whenever friends of mine say, “Well, they do it this way in Sweden, why don’t we do it that way?” Because we’re not Sweden. And we never will be Sweden.

The last point is this. I think that within the group of people who work in these public sector institutions there is on the one hand, a great and noble tradition of service, particularly service to people whom no one else would serve, and understandable fear that they will be left out of the financing streams in the political debate. I would love to be able to tell you that that will change, and we’ll reach some kind of plateau and things will be OK; some bill will be passed; some switch will be flipped; some funding mechanism will be agreed upon. But I don’t think that will ever happen. I think the nature of this beast, of caring for people in institutions that are residual institutions, means that we will face a constant, never-ending struggle to maintain the quality of these institutions. And it is because we’ve chosen this way to subsidize the care of people who can’t afford it. If you think about how we subsidize food for people who can’t afford food, we don’t set up separate grocery stores for the poor. If you think about how we subsidize housing for people who can’t afford housing, we’ve had two different sets of experiences in America, one with separate housing for the poor, and another with vouchers, or ways of subsidizing people into a mainstream housing market.

In the case of health care we do both. We have programs like Medi-Cal and others that subsidize people’s way into seeing mainstream providers, and then we have institutions that care for the poor. It is that contradiction, it is that schizophrenia that gives us all these problems, because I suspect if everybody in America truly did have an insurance card, we would say, “Let ‘em go where they want to go, and let the chips fall where they may.” The fact of the matter is we’re unlikely to do that anytime soon. So while it would be nice for us to have a nice, clean, neat public policy solution to this dilemma of whether we simply pay for their care, or give them insurance and let them go where they want, for a variety of reasons (particularly in California, because of interaction with the issue of the undocumented) I think we will live with that tension for some time to come. Thank you very much.
Burt Margolin: Thank you, Mark, for an outstanding presentation. Next we will hear from Dr. Bruce Vladeck, senior vice president for policy, Mount Sinai-NYU Health. Please welcome Dr. Bruce Vladeck.

Keynote Presentation II

Bruce Vladeck: Thank you very much, Burt. I’m going to begin with a rhetorical question, and try in the rest of my remarks to answer it, at least in part. We are, as we approach the new century and the new millennium, in the midst of probably the most extraordinary protracted period of economic growth and prosperity in this nation’s history—perhaps in the history of the industrialized world. And the question I’m posing is: How did we get to the point, in the midst of this extraordinary set of economic circumstances, where of the two Democratic candidates for president of the United States, the one who has been identified as the most liberal on the issue of the uninsured has proposed approaching the problem by abolishing Medicaid, and replacing it with what is essentially an individual voucher program; and where the other, “more mainstream,” Democratic candidate for president has criticized his proposals largely on the grounds that they are too expensive? This is an extraordinary and profoundly disturbing turn of events. I think it’s important to try to understand how we’ve gotten into this intellectual and political fix, and I’m going to make seven points to try to help explain that. Some of them Mark has made already, and some of them he hasn’t, and some of them may be places where we disagree, which may help fuel the conversation after I’m done talking.

The first point I want to make is this. Five years is not a terribly long period of time by some measures, but in this day and age, it’s a whole generation in the policy community. I believe it now exceeds the expected tenure of a member of the California Legislature or, for that matter, a member of the New York City Council. And empirically, looking at the evidence over at least the last five years, since the time when the Clinton Administration finally gave up the ghost in its efforts at health care reform, and we all began talking about the need for incremental strategies to expand health care coverage, we have a growing body of evidence that those strategies just flat out are not going to work.

The most compelling evidence I find in that regard is that almost exactly two years after the enactment of the Balanced Budget Act, sometime this past summer the number of kids enrolled in the CHIP [Children’s Health Insurance] Program nationally exceeded the number of kids who had lost Medicaid coverage in exactly the same period of time. And however quickly we are bringing new health insurance coverage through CHIP or through state initiatives, the growth in the number of the uninsured continues to outpace the increments in publicly financed insurance programs.

Bruce Vladeck

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Now, that’s the empirical evidence, and I think there are two issues underlying that. My first point of disagreement with Mark is that I think the system of employment-based health insurance that has been the core of coverage for the majority of the population of this country since the period after the Second World War continues to unravel. At the moment, it is unraveling a little bit more slowly than it has in prior years precisely because the labor market is so tight, and employers have become more willing over the last several years to add
benefits and inducements to compensation arrangements in order to keep or attract employees. This is probably about as high as it’s ever going to get.

Nonetheless, the proportion of all working people in the United States who have employment-related health insurance continues to fall, although it has fallen more slowly in the last year or two than in earlier years, and there is no conceivable set of circumstances under which I can envision it going back up. There have been so many permanent changes, both in the economy and the nature of our labor market—we’ve all talked about the migration from manufacturing to service industries, the change in the nature of employment, and very significant changes in the age distribution of the workforce.

It’s not fashionable to talk about it in most intellectual circles these days, but if you look across industry sectors, and you want to predict the proportion of all employees in that industry that have health insurance through their work, the single most powerful predictive variable you can find is the percentage of the workforce in that industry that is unionized. And the proportion of unionization in total employment, and particularly in private sector employment, continues to fall in this country, and I don’t think that’s going to turn around very soon.

And increasingly in California, as in New York, particularly in the bottom half of the income distribution, the issue of health insurance and the dynamics of the labor market are totally intertwined with the issue of immigration—legal and illegal. And again, given the demographic changes among workers and potential workers in the United States, that’s not going to change any time soon either.

Mark reminded us, appropriately, that private health insurance in the United States was essentially invented by the provider community, and that’s entirely correct. But his recounting, which, to be fair, he didn’t undertake to do systematically, overlooked another point. Specifically, the norm of employer-provided health insurance in the United States occurred largely in the period during and after the Second World War, when every other democratic industrialized nation in the world was choosing to assume public responsibility, whether with private or public financing, for universal coverage.

Bruce Vladeck

The other reason why I think incrementalism has run its course is that there really are only two alternatives that have worked at the national level in the world over the last 60 or 70 years to provide health care coverage to a population. One is basically an employer based-system and the other is basically a publicly financed system. And so in characteristic fashion, the public debate in the United States has now shifted towards a completely different alternative, which is that we are going to solve the problem by establishing individual responsibility for obtaining health insurance, and by developing financing mechanisms that will permit individuals who couldn’t otherwise afford it to buy health insurance. That’s what the Bradley plan is all about; that’s what much of the rest of the debate in Washington policy circles and elsewhere is about. And the only problem with that as an approach is that it makes no sense and has been empirically demonstrated not to work. Unfortunately, this has not been an obstacle to it becoming the dominant paradigm for policy discussions in universities, in Washington or throughout the United States.
Mark has already reminded us of all the reasons why health insurance is different from other kinds of insurance; what people want to purchase is access to health care. They want to separate out the financial decision-making process from the process of deciding whether or not to seek care, and when, and from whom. Every economist will agree with you that employer-based health insurance is, as an economic model, indistinguishable from individually provided health insurance because employees get a dollar less in wages for every dollar their employer pays in health insurance premiums; employees are basically bearing that cost. No actual working person in the United States really believes that; they really believe that their employer is paying for all or part of their health insurance. (In fact, the working people are partly right, because some of the conventional economic wisdom is a little bit overstated.) But the fact of the matter is that individual health insurance is intrinsically more expensive, less administrable, less rational than group health insurance, however you define the group. There is a critically important temporal dimension to health care insurance and expenditure decisions, which is to say, people care a lot more about health insurance when they’re sick than when they’re healthy, and you can’t get over that in trying to design financing schemes.

We have become slaves to the ideological preference for the notion of individual choice and individual consumer behavior. Again, there’s a whole lot of literature, both empirical and theoretical, that explains why this doesn’t work and makes no sense in health care, but that doesn’t stop anybody from continuing to focus on it. Now part of that’s ideological, but part of it is for another reason, that’s best illustrated by an experience I had in January of this year.

I was spending a fair amount of my time as a member of the National Bipartisan Commission on the Future of Medicare, and in the course of the discussion I said something that I knew was, from a political point of view, likely to stir a little bit of concern and controversy. I said that we had looked at the whole range of Medicare reform options from very modest things to radical premium support or voucherizing the Medicare program. And even if you went in the most radical direction, and saved twice as much money as a result of voucherizing or privatization, the simple demographic realities were such that you couldn’t solve Medicare’s long-term financing problems solely on the cost side. You could never save enough money to make the program financially stable when all of us baby boomers begin to cash in on our benefits. You were going to need some more revenues to support the program, and I thought the commission was ultimately going to fail to produce a report, because most of its members refused to talk about revenues. And you could not make an intellectually coherent, defensible set of recommendations unless you addressed the revenue side as well. In fact, as a prediction, that turned out to be relatively accurate.

Nonetheless within an hour there was already an enormous wave of political hysteria going on because a reporter at my speech had called the White House and said, “Vladeck says in order to solve the Medicare problem you need to increase taxes. Is this a trial balloon on the part of the administration?” By the time I got back to my hotel that evening there were about 12 telephone messages. And the long and short of it is the White House person asked, “Did you use the word ‘taxes’?” And I said, “I don’t know. I clearly said that we were going to have to put more revenues into the program. Now whether I equated revenues with taxes I honestly don’t remember.” And he said, “It’s OK; our position is you’re definitely going to need more revenues in the program, but you can’t use the word taxes.” So, I said, “Wait a second. What kinds of revenue does the federal government have that aren’t derived from taxes?” And the answer was, “The tobacco money. That’s not an increase in taxes.” And it was clear that in Washington you’re not allowed to use the “T”-word, but you can talk about the “R”-word because it’s sufficiently indistinct.

I had a conversation with my mother a day or two afterwards, in which I said, “The problem I’m having is, what revenues are there other than taxes?” And she said, “Well, we can get all the beneficiaries to take their cans

We have become slaves to the ideological preference for the notion of individual choice and individual consumer behavior.

Bruce Vladeck
back to the supermarket for recycling.” I think casino revenues might count, too. I kept saying the way to solve the problem of the Medicare trust fund was to buy enough Powerball tickets.

But this leads into my next point which is, in my own view, the single most important reason why the Clinton administration’s efforts at health reform failed, which is that the president refused to include any new revenues or any new taxes in it. He was told by [presidential health care reform advisor] Ira Magaziner and a few others that he could get to universal health care without a tax increase. And to do that, and get numbers that people wouldn’t laugh at too loudly, you had to go through all this incredibly complicated stuff which nobody ever understood, and which was horribly bureaucratic and delayed the bill for six months.

Well, the fact of the matter is, health care costs money. Health insurance costs money. And if we’re going to solve the problems of the uninsured in this country, we’re going to have to spend some money to do that. Now, because in Washington you can’t talk about spending money, but you can talk about tax credits, everybody is now talking about solving the problems of health insurance by tax credits. Of course people who are sophisticated about budgets know that a dollar of foregone revenue is exactly the same as a dollar of spent revenue in economic terms, but not in political terms. So whether it’s health policy or health insurance policy or financing policy, tax credits make no sense whatsoever. You can talk about them, because you’re not admitting that the alternative is taking existing or new tax money and spending it on the same benefit, even though the latter is more likely to actually work.

Nonetheless, the underlying issue here—it’s really my fourth point, and Mark got at the edges of it, but I’m not sure he got quite to the heart of it—is that what health insurance is about, from the social level, from a community level, from a political level, is finding some mechanism to assign responsibility to pay for health care for people who need health care. And the fact of the matter is that there is such an enormous disparity between those who need health care and those who have the most money, that you need some kind of mechanism to take money from those who have relatively more money or have relatively less need for the health care system, and reallocate it to people who have less money or more need for health care. That’s what health insurance does, it’s what the private system or universal publicly financed health insurance does, it’s what happens within the Medicare and Medicaid programs, and it’s why individual health insurance makes no sense as a concept and is so difficult to operationalize.

But we have to be honest about this. Maybe at the state level we’re being a little more honest and explicit than we are at the federal level. A mediocre policy in a tightly managed HMO for a single working-age adult costs, on average, something on the order of $2000—maybe $1700 if you’re real tightly managed, maybe $2500 if you’re on the island of Manhattan. And you can provide a full package of services, if there’s not any chronic illness in the population, to relatively healthy kids, for $1000 or $1200 per kid per year, in many parts of the United States. And that’s what it costs, and you have to find that money, and it’s clear that people whose income is $10,000 a year or $12,000, $15,000 or $18,000 a year, if they have two or three kids, can’t afford it, given the cost of housing, transportation and food. And unless we find some other way to pay for it, they’re not going to have insurance and they’re going to use less care.

That’s what it all comes down to: who is going to pay for this? And everybody’s attitude is that somebody else should pay for it. But we’re at a point in our political system where we seem to be having difficulty even having an honest discussion about it at the federal level. Maybe in some states—I think maybe in New York—we’re starting a semi-honest discussion about it, which is at least helpful.

If we’re going to solve the problems of the uninsured in this country, we’re going to have to spend some money to do that.

Bruce Vladeck
Now that gets into my fifth point, which is that all of the economic and theoretical models have some assumptions about the kind of society they are describing, which bears less and less resemblance to the society in which we live. This is particularly relevant, I think, for open access providers. Major news for all of you: the United States, in 1999, is not a very homogenous society. There has been a renewal of interest in the long and increasingly sophisticatedly documented fact, that all other things being equal, in the United States in 1999, being African American is bad for your health. Controlling for education and socioeconomic status and location and everything else, blacks still do worse in terms of access to care and outcomes from care than whites do. For some illnesses, and not others, Latinos do systematically worse when you control for education and socioeconomic status, and, as some of you know, depending on the subgroup in the Asian Pacific Islander community, they are all over the lot.

But the fact of the matter is they have different health problems, they use the health care system differently, they have different issues of access and so forth. Controlling for income and insurance status and so forth, illness is not randomly distributed in this society, and comfortable access to health care providers is not randomly distributed in this society. The safety net, the open access provider, is not solely an economic phenomenon. It is a social and cultural phenomenon, and one of the reasons why the insurance card in and of itself has not tended to be an automatic guarantee of access to mainstream health care for poor people. One of the reasons why it has been a necessary but not sufficient condition for access to mainstream quality health care is because of all the other dimensions of the characteristics of individuals seeking health care in this country. And I don’t know that anyone has done the analysis, but I bet that you could look at Los Angeles County, and you could control for income and insurance status, and that still would not entirely account for who uses a County Medical Center and who uses other providers, whether among the Medicaid population or the uninsured population.

Mark used the example of the hotel and restaurant in Atlanta which had depended for their existence on a segregated society and which now cannot compete with the Holiday Inn, and that’s a very relevant example. On the other hand, Atlanta is also the home of Atlanta University and the site of five of the leading historically black colleges and universities in the United States, which have continued to exist because it is important to the African American community that African American institutions continue to exist and to thrive, for the same reason that we continue to have women’s colleges, although not men’s colleges. And I would suggest that unless and until we get to a world in which people celebrate and acknowledge and recognize differences in ethnicity and culture and other status, but in which these differences have no practical implications in terms of access to the benefits that the society has to provide, we ought to be a little bit careful about just abandoning institutions which historically have been the only institutions prepared to provide services to underserved populations.

Bruce Vladeck
In fact, the mainstreaming of populations in other sectors of American life in the last 40 years or so, the disappearance of essentially every private black-owned hospital in the United States—and there were probably a hundred of them before the enactment of the Civil Rights Act—has not always meant that the “mainstream institutions” are going to provide a level playing field for historically disadvantaged people. This is what’s happening in higher education throughout the United States these days, including California, abandoning the institutions which were historically most receptive to minority and underserved populations. And we have to be very careful not to assume that since we’re into a new millennium, these things will take care of themselves, and if you have a Medicaid card or insurance card, Cedars-Sinai is going to treat you just as well as they treat their patients from West LA or from Beverly Hills, because they’re not today. Maybe twenty years from now they will, but they’re not today. And we shouldn’t kid ourselves about that, and we should be realistic about what that implies.

Two final points I want to make. The first is that we know for a fact that people without health insurance get less care than people with health insurance. That’s been very well documented for many years. If that’s true, then the conclusion of many people that if we just took all the money we are now spending on institutional subsidies to provide services to the uninsured, and put it in insurance premiums, we would be able to insure all the uninsured, doesn’t compute. It doesn’t add up. The fact of the matter is, that we are so desperate for money, that we make this false argument that “Well, we’re taking care of all the uninsured anyway because they can go to emergency rooms.” We say that if somehow we could redirect those funds that are paying for uncompensated care in the emergency rooms, all those people could have insurance. But if you take that nice theoretical concept and actually try to do the arithmetic, it’s not even close.

So, my last point is that for a variety of reasons, the debate over insurance expansion tends to pit insurance expansion versus continuation or improvement in the subsidies to open-access or safety net institutions. It’s clear that in the foreseeable future, we need to do both. We need to get more people health insurance and improve our subsidies to these institutions whose subsidies have been so seriously cut in the last number of years.

How is it that we end up talking about one versus the other? Well, I think there a few hypotheses. The first is that nobody wants to spend new money in the political system. You’re not allowed to talk about the “T”-word, and you only talk about the “R”-word if you have to. So here’s a bunch of money you’re now spending, let’s see if we can steal that to pay for health insurance rather than putting new money in. That’s the conversation we’ve had a lot of in New York. The Citizens’ Budget Commission in New York City, which is ordinarily a semi-sane organization, actually did a big policy paper that concluded that if you took all the subsidies to uninsured people in New York and used them instead to buy health insurance, you’d insure all these people, and everybody would be better off. They are only off by one order of magnitude in their economic calculations, but in order to be a member of the Citizens’ Budget Commission, you have to swear an oath that you will never support a tax increase. So if that’s your given and you acknowledge the problems of the uninsured and you’ve gotta do something about it, then you can only spend the tobacco money so many different times before you run out, and so people are looking to raid this pot, because it’s a pot.

There’s also this enormous bias, as you all know, against the public sector. What’s pushing much of this talk—“Let’s take this money out of subsidies to safety-net institutions and put it in buying insurance”—is taking
money away from public organizations and public employees and giving it to private firms and their stockholders, which is a very powerful bias throughout our political and cultural system at the moment.

The third issue is the legitimate notion that people ought to have choices, and monopoly providers and public services have often not done as good a job as they should because they had a monopoly. But if you think about the 44 million people in the United States whose only real access to health care is through the safety net, and if you think about how bad their health status and their health outcomes are, but how much worse they could be, the flip side is that the American public has been getting an extraordinary bargain from the existence of the safety-net institutions. Because in fact most routine care to the uninsured, to the extent that they get it, is provided by underfunded institutions at marginal cost. And it’s an incredibly cheap way of getting people that service. It’s far from an optimal way, but it’s incredibly cheap. But we assume, because it’s not an optimal system and because it’s a public system, that it must somehow be more expensive, and that leads the discussion in all kinds of crazy ways.

And the fourth reason I think we’re having this debate about insurance expansion versus subsidization of the open access facilities, and again it gives me a chance to tweak Mark a little bit, is because of this enormous institutional bias in our health care culture. There has been this enormous migration of care out of general hospitals into outpatient settings in this country over the last 20 or 25 years. Uwe Reinhardt suggested in a piece in Health Affairs that one of the reasons health care costs have gone up so much faster than anyone had predicted is because much of this migration of services from inpatient to outpatient has been driven by the illusion that it’s going to save money, when in fact it’s costing us more money.

And most of the reduction in inpatient hospital capacity in the United States in the last decade has been in the public sector. You can look at what happened in New York City when I was gone. In the five years I was in Washington, average hospital occupancy rates went from about 90 percent to the upper 70s or the low 80s—beginning to look more like the United States—and there has been a very significant reduction in inpatient bed capacity in New York City during that period of time, entirely in the public sector. So in fact, as care has migrated from inpatient to outpatient over the last 20 or 25 years, the shrinkage in the institutional inpatient side of the health care system has occurred almost entirely in the public sector. This is one of the reasons that the public sector has been able to survive at all given the continuing diminution in resources and the increase in demand coming from the number of uninsured people. But the notion that we should continue to shrink the safety net to absorb the excess capacity in the private health care system again doesn’t quite compute.

So where does that leave us? I have a great deal of difficulty these days speaking usefully to an audience like this, because there is a risk that the message becomes so cynical and depressed that one does exactly the opposite of the role that a speaker is supposed to serve in this kind of discussion. I do think it’s healthy that we are talking about the uninsured again. I do think it’s healthy that Bradley, for all the stupidity, and I use that word advisedly, of his health care proposal, is talking about spending $60 billion dollars. And the fact is that our state governments, and in most of the country, our county governments, are awash in money, at least in comparison to where we were in the late 1980s and early 1990s, just as the federal government is awash in money, because the economy keeps doing a lot better than anyone thought it was going to do, and because the governments have not been able to cut taxes fast enough to give away all that increase in revenue. And there is
all that tobacco money floating around. So we may indeed have an opportunity to make some progress on some of these issues in the next few years at the state level, if not at the national level.

But if we do it we have to be as clearheaded as we can about what the issues are and what the facts are. And again, my bottom line in this conversation is two things. One is, if you’re going to address the problems of people who don’t have health insurance, or for other reasons don’t have access to health care, you’re going to have to spend some money. We’re out of miracles and magic in that regard. Second, for the foreseeable future, which is until we have a system of real, true universal insurance by right in the United States, we must dismiss the notion of a conflict between expanding health insurance and improving subsidies to institutions that serve both people who have no insurance and the historically disadvantaged with health insurance who still don’t have mainstream access to the private sector providers. The fact is it’s not one or the other. You have to do both. Thank you very much.

Burt Margolin: Thank you, Bruce, for that excellent presentation. The only point you made that I have to take brief but strong exception to is the way in which you dismissed so cavalierly your mother’s suggestions involving the use of bottles and cans for health care. In 1985, here in California, I authored the California bottle bill, our own beverage and can recycling program, and I did spend some serious time thinking about how we could divert that money to health care. The grocers threatened some actions that would have been rather unpleasant, and it didn’t happen, but it’s not quite as frivolous an idea as you were suggesting. I would now like to introduce our responder, Dr. Robert Valdez, who is professor of health policy and management at UCLA. Dr. Valdez.

Reaction

Robert Valdez: I can think of only one thing more difficult than responding to a presentation by Bruce Vladeck, and that is trying to respond to presentations by Bruce Vladeck and Mark Smith. I have a great deal of respect for both of them.

I want to return to the theme of today’s conference and discussions: What matters most? Thanks to Mark’s foundation and to his former foundation, I’ve had the opportunity to sit and talk to people who are uninsured in California, people who are part of the Medi-Cal program, and people with private insurance, to find out what matters most to them. And not surprisingly, what matters most to them is that they want medical care when they are ill, or when they are injured. They separate the notion of medical care and how it gets financed (insurance). Care is where their concern is. People confuse the two issues to some degree, because what they are fundamentally interested in is the care. The degree of frustration and confusion that exists in our communities would blow your mind if you had the luxury that I’ve been given to talk to people about this issue.

Now in this debate about health insurance versus access to care, we’ve taken our eye off the ball. We’ve been focusing on the bat. And by that I mean that instead of focusing on adequate access to appropriate medical care, we’ve focused on how to get insurance coverage for everyone . . . And even for those who have insurance coverage, the real thing that matters to people . . . is better medical care and promoting health in our communities.

Robert Valdez

Instead of focusing on adequate access to appropriate medical care, we’ve focused on how to get insurance coverage for everyone . . . And even for those who have insurance coverage, the real thing that matters to people . . . is better medical care and promoting health in our communities.
But these safety-net systems do more than simply provide services to the uninsured. They are part of an overlapping set of health care delivery systems that serve the uninsured, and the insured who are injured seriously, or who need specialized services, such as burn services. And even for those who have insurance coverage, the real thing that matters to people, at least the people I’ve been talking to, is better medical care and promoting health in our communities.

In 1983 we experienced a trigger event. That event was the shift of responsibility for the adult indigent population to the counties. When that occurred, counties began to develop their safety-net systems in a variety of ways. As a result, California’s care for the uninsured is publicly financed through a mix of realignment revenues to counties, Proposition 99 revenues, county contributions, Medi-Cal SB 855 and SB 1255 revenues. The safety nets—community clinics and county providers—depend on this fragile Medi-Cal revenue stream. The 1997 Balanced Budget Act, which is phasing out FQHC supports for clinics and further restricting DSH spending, makes this already fragile system even more fragile. The financial incentives in those streams are at odds with this move to Medi-Cal managed care, and these streams have also seen a shift away from county contributions. The general fund contributions have been declining. As state realignment revenues to counties have increased, these other funding streams for care to the uninsured have decreased. County contributions decreased. SB 855 revenues to county hospitals have declined due in large part to reduced numbers of Medi-Cal patients, some of whom are now going to other, non-public hospitals. Private hospitals’ share of the Medi-Cal patients and DSH dollars have increased. Medi-Cal revenues for the provider-type counties have fallen. SB 1255 revenues for provider counties have increased, and Proposition 99 funding has decreased.

We need to evolve a true delivery system, I think, and this is the challenge to those of us in this room and many people outside of this room. We need to consolidate funding and create a stable funding base, while at the same time developing a true willingness for public and private providers to collaborate in developing a system of care.

Burt Margolin: Thank you, Bob. Now we’re going to move to our interactive town hall meeting format, and I’m going to ask anyone with a question to address their question to the panel from the microphone at the front of the room.

Questions & Answers

Robert Sillen, Executive Director, Santa Clara Valley Health and Hospital System: Burt, as you’re well aware, I usually end up giving a speech, not asking a question. But I just want to give you my perspective, from out there with a public hospital, in a community that is more and more becoming a for-profit hospital community. I’m in San Jose, where Columbia and Tenet between them have way too much of the market. And everybody’s been predicting that this march of Medi-Cal patients away from public hospitals into the private sector is going to be short-term. The hope of Medicaid was never realized in terms of mainstream. That was one of the problems with Medicaid. It was a lot better than not having Medicaid. But those patients were never mainstreamed. The private sector never went out and tried to recruit Medicaid patients, and they still won’t for the medically needy, or the aged, blind and disabled, who still smack of high cost. I don’t think it’s any mistake that the state of California said, “OK, the mandated population of California for Medi-Cal managed care is the population that a buck can be made off of, and it’s not the other population.”

We have offered to pay the private sector better than Medi-Cal rates to take some of the load off of us in terms of uninsured patients. They will not do it.

Robert Sillen
So I would predict that we’re going to see private hospitals in this state, and maybe across the nation, rejecting Medicaid patients again, because they’re going to get greater reimbursement from the private insurers. In San Jose, Sutter took on Blue Cross and forced the rates up, as Columbia did before the attorney general told them they couldn’t do it anymore. And they have finally figured out that one of their major problems, in the hope of gaining market share, was giving 60 percent discounts. And so they shot themselves in the foot.

But, in terms of open door providers, I see it all the time. We have offered to pay the private sector better than Medi-Cal rates to take some of the load off of us in terms of uninsured patients. They will not do it. It is not an economic matter. They do not want those patients, sitting in those waiting rooms, mixing with “Mr. and Mrs. Gotrocks” from Los Altos Hills. The social phenomenon, I think, is equally important as the economic phenomenon, and if that’s not recognized, then we’re just going to miss the boat and do a lot of damage.

**Bruce Vladeck:** Bob, the big academic medical centers in New York City are unusual hybrids, unlike anything else. For example, at our very academic, very private health system at the Mt. Sinai Hospital, slightly more than 25 percent of our days are Medicaid. And as mandatory Medicaid managed care comes glacially to New York City, we’ve been working with our faculty practice and other physicians around “integrating” all the outpatient activities at the hospital, which is to say the clinics with the faculty practice. And we have enormously enthusiastic support from the chairman of the department of medicine, and that is coming along relatively well. We’ve done it in cardiology. We have no problem doing it in pediatrics, because we don’t have any paying patients in pediatrics, and we are never going to do it in OB, and it’s precisely to your point.

**Mark Smith.** Well, I have two responses. One, this is the “Where was the Holiday Inn in the bad old days?” argument, and “They didn’t take ‘em before, they won’t take ‘em again.” This is true particularly in OB. I remember a front page article in the New York Times last year about Emory Hospital, going out and recruiting Medi-Cal OB patients, like a number of California hospitals that didn’t used to during the “good old days” of regulated hospital rates and guaranteed profits. Now, the over-capacity hurts, and they have changed their tune.

You are really making two arguments. One is that Medi-Cal rates will be so low and so uncompetitive with the private sector that mainstream providers will not accept Medi-Cal patients. And if that’s the case, the question is, the interests of the public institutions aside, is that a good thing for public policy or a bad thing? I think it’s a bad thing. And the other argument you’re making is that, for nonfinancial reasons, for reasons of sociology, of racism, of bigotry, these institutions will not culturally adapt to the needs of these patients, in which case, I would argue, the people who will know that best and first will be the patients themselves. And I would not want to put me or you or anybody else in charge of deciding whether or not Cedars-Sinai or UCLA is “responsive to my needs” as an African American. I would rather make that choice myself. And I would have confidence that if the institution is hostile to my culture and needs, that I will know that, that word will spread, and I will choose a place that serves me well, as people often do.
The other point I want to make is this. How many of you think we should increase Medi-Cal payment rates? How many of you think that we should have guaranteed eligibility, that is to say, we should increase the guaranteed number of months for which Medi-Cal patients would be enrolled? How many of you think we should increase eligibility income to qualify for Medi-Cal? All right. Now do the math. The amount of money you spend on Medi-Cal is $A \times B \times C$, where $A$ is the number of people insured, $B$ is the number of months they’re insured, $C$ is how much you pay for them per month. I would argue that we have an atmosphere in which providers and advocates want all those things, and the issue in our current environment is this: if you had an extra three billion dollars to spend on Medi-Cal, which of those coefficients would you want to increase?

Bruce Vladeck: But see, you’re doing it, Mark, when you’re saying “in the current environment.” If you spent the extra three billion dollars on Medi-Cal, then California’s Medicaid expenditures per beneficiary would be at the national average. And the fact is, you’ve been getting it on the cheap out of county levies and out of the public sector in this state, and it’s not an accident, and it’s not all because of all the people coming from Mexico that you have seven million people uninsured in this state. Relative to its wealth, California spends less of its own money on health care for its citizens than any other state in the United States.

Mark Smith: I am agreeing with you, Bruce. I’m not suggesting . . .

Bruce Vladeck: Then don’t say there’s a tradeoff. The tradeoff is between the willingness of the political system in this country, in this state, to support a level of health care for its citizens, or for that matter a level of other things, and its continued focus on forcing tradeoffs, when the tradeoff is between taxpayers and the ability to provide healthcare. That’s the tradeoff.

Mark Smith: Let me try to state it again, and maybe we just disagree, but maybe you misheard me. Let’s assume that we could all get together and persuade the governor and the Legislature to increase Medi-Cal spending by three billion dollars. I’m not arguing for less Medi-Cal money. I’d be glad to stand up here and argue for more. My point is, from a policy perspective, increasing coefficient $A$ versus increasing coefficient $B$ versus increasing coefficient $C$, will have differential impacts. So I’m saying, of those three things, of increasing payment rates for Medi-Cal, versus expanding eligibility, versus guaranteeing the longevity of eligibility, in general, everyone who’s in the Medi-Cal world wants all of those things. We would like all of those things to happen. What I’m suggesting is that if you had more money, if we are to push for more money, increasing those coefficients has differential impacts in terms of the scenario that Bob described. And that’s my point.

Bruce Vladeck: I understand that too. But the fact is, to the extent we define having to make tradeoffs . . . analytically, I get it. Analytically I run a little research shop and I’d be very happy to take a grant to look at the relative number of incremental people covered under those three strategies. But the fact is, if we start talking about “there’s only so much money, we have to make the tradeoff,” we are playing their game, not our game. The fact is if two billion dollars will only permit you to do $X$ and $Y$, and not $Z$, then we need three billion dollars. This is a nation that bought seven million sports utility vehicles last year. Why we have to have this conversation is the underlying political problem, not the relative benefits of expanding eligibility versus increasing provider payments. And we’re playing their game, defining the discussion in those terms.
**Burt Margolin:** Thank you, Bob, for kicking this off. Denny?

**Denise Martin:** Yes, I want to build on some of the comments that Bob made, and some of the reactions from both of our distinguished speakers. And I’d like to challenge a little this notion of choice, and that if folks are given a choice they’re going to exit the public health care system and go into the private health care system. I don’t think that’s an accurate picture of what’s actually going on in our systems. Certainly people have exited our systems with Medi-Cal managed care; there’s been no question about that. And it very much coincided with the time when everybody fully understood the role and the value of the Disproportionate Share Hospital program. So the Medi-Cal managed care rates continued to be low, but if you were able to get enough Medi-Cal folks in your hospital you could qualify for DSH, which made a Medi-Cal card actually a gold card, every bit as good as a Blue Cross card. So that was part of the incentive, and again it was a financial incentive on the private sector side, to market and target that relatively healthy population.

That being said, it’s very clear to me that we need to do a lot more education in terms of talking about the value of our systems, because we don’t see ourselves as a provider of last resort anymore. We don’t see our role only as the good-old Section 17000 county mandate, that we have to just be there, and take the crumbs, and be second class institutions. We don’t think of ourselves like that anymore. We think of ourselves as premier institutions of first choice for many of the folks in our communities. And as testimony to that, there have been about eight county hospitals already that have been totally rebuilt, that are totally seismically safe, and there are a number of others in the works to do that same thing. So with that renovation and the new hospitals has come a whole upgrade in the way the patients are treated, this reengineering, whatever the magic words you want to use, in terms of having the folks in our hospitals understand the value of the patients that we serve, and no longer take them for granted. I think it’s important to keep in mind that the old county image is really an old county image. And, in fact, some of our hospitals, to try to avoid that image, when they renamed their facilities, dropped the word “county,” because it had this bad, negative connotation.

So we can’t undervalue the strength of these institutions, the knowledge that they have about various patient populations, the hundred years of serving those populations; we must really recognize that and support that. We can’t think that those kinds of experiences over all these years don’t continue to have real value in the communities that we serve. And in fact, while we saw the exodus of Medi-Cal managed care patients, we’re seeing them come back to our systems, and we’re seeing our numbers rise, because of the respect that they receive and the comfort that they feel in our facilities, and the special connections they have with docs that work in the outpatient clinics. The most important connection is actually where they feel comfortable going, as opposed to having the insurance card. Thank you.

**Burt Margolin:** Implicit in Denny’s commentary is the notion that a two-tier system is not necessarily a bad option or bad choice. There’s been this move in recent years to argue that unless you’re mainstreaming all the populations, unless everyone’s in one system, preferably private, the people not in that preferably private system are being disadvantaged. And Mark, your commentary earlier on suggested, and even more recent comments suggest, that given choice people are going to move to the private sector. So I wanted to raise the question of whether or not you feel there are virtues to a two-tier system, and how you see this market dynamic working out.

**Mark Smith:** I’m glad to have the opportunity to clarify. Let’s repeat. I work at San Francisco General, OK? This is not about bashing the public hospitals. Given a choice, some people will choose to go elsewhere, which
is the difference from not being given a choice, where no one can go elsewhere. And I am, believe me, familiar with Atlanta University. I’m also familiar with Johnson C. Smith, and Alcorn State, and Mississippi Valley State, and even so prestigious an institution as Fisk, which fell on hard times, because it was now competing with Vanderbilt for the students who, two generations ago, would have to have gone to Fisk. Do some people who could go to Vanderbilt now choose to go to Fisk? Of course they do. Are there people who could go to Cedars-Sinai who will go to LA County? Of course there are. But it’s less than when they had to. The difference is that one’s orientation toward their coming there has to be that you must attract them there as opposed to assuming that they will come. That’s number one.

My second point is this. You know, it’s hard to say this in an environment without being misunderstood, so I don’t want to be misunderstood. How do you all feel about public school teachers who send their kids to private schools? I mean, outside of this room now, outside the relatively small community of people who are involved with public sector institutions, in the broader political discourse, there’s a certain kind of credibility problem from someone who’s on the school board who sends their kid to private school. Yes? And there’s a certain kind of credibility problem, particularly among those of us who are pushing for locally based plans that would improve our institution when our police and fire and teachers and others won’t accept a plan in which they would be required to use the public institution. And you all know that reality. So this is not me talking about what I’d like to see. The reality is that the institutions in which we work, for the most part, serve people who have little choice. There is a broad enough cross section of government employees, who, given a choice, would not want to have to come to those institutions. There’s a certain credibility problem in saying they’re exactly the same as everybody else. Now, it may not be politically correct to say that, folks, so please, I hope you don’t hear that as an attack, but if we leave this room pretending that’s not a reality, then I think we’re on some different astral plane.

Bruce Vladeck: I understand that, Mark, and I’ve dealt with those issues. Let just put into place two other facts. One is a dispute that’s now going on between the executive branch in Washington and the state of Arkansas, because the state of Arkansas basically wants to play games with federal match, and use the CHIP program to enroll low-income kids who are eligible for Medicaid. And the argument that the state of Arkansas is making is that Medicaid is so stigmatized that working class people, particularly white working class people, won’t apply for Medicaid, whereas they will apply for CHIP. Now that may be true, and there may be nothing you can do about it, but it’s also true that to get CHIP in the state of Arkansas is a one-page document in which the individual can attest to every bit of the information by signing the document, and to get Medicaid in the State of Arkansas, if you’re not categorically eligible through SSI, is a 40-page application, cross-examination by a welfare worker, and a whole bunch of notarized documents. And so, in Arkansas, they are saying people choose CHIP because they don’t want to be in the public sector. Well, we have spent so much money and resources stigmatizing the public sector and making it almost impossible for people who in fact have any choices to use the public sector institutions. Then we come back and say, “Oh, you know, given a choice, people don’t go there.” Well, of course they don’t go
there; this is a principle that goes back to the 17th century welfare law, called “less eligibility.” The idea was that you make it so unattractive to use public institutions that only the people who are desperate will use them. And that’s public policy toward Medicaid in most of the United States to this day.

Another issue to the same point: I am very much involved in the administration of Elmhurst Hospital, which I’m sorry to tell all you people in the audience is the best public hospital in the United States. It really is an absolutely excellent hospital. I’ve spent a lot of time over the past six months on the issue of cardiology services for Elmhurst Hospital, which are staffed by the Mt. Sinai School of Medicine. And the fact is that a 55-year-old man with symptoms X, Y, Z who goes from the outpatient clinic or the emergency room with chest pain or just high risk to get a cardiology workup at Elmhurst, as opposed to the private faculty practice at Mt. Sinai, is going to have fewer tests and a less complete evaluation. Now, we don’t know that that patient is any worse off as a result. We do know that all those folks getting stress echocardiograms and other kinds of nuclear medicine tests and EPS studies and all that kind of stuff at Mt. Sinai are using a lot more resources, controlling for illness. We don’t know whether their likelihood of dying from cardiovascular disease over the next ten years is any higher than Elmhurst patients, but the fact of the matter is, that whatever we’re doing to make our facilities more attractive, we are not in fact providing the same standard of care yet to the folks who are in the public institutions either because they have no choice or because they choose us. And the teachers, and the cops, and the firemen aren’t stupid, they understand that. And so until we are prepared to say that, “Yes, we want people to have choices,” and “Yes, we are prepared to try to provide a level playing field for them to make choices on,” then I think it’s very hard to do an objective analysis of how people behave.

Robert Valdez: Bruce, you don’t have to go all the way to Arkansas to illustrate your point. The hoops we make people jump through in an eligibility process from county to county in California are just as complex, and it’s related to this fragmented financing scheme that counties and county providers and community clinics have to put together annually. They create these eligibility processes that even the uninsured have to jump through to figure out whose dollar gets to pay this time around versus next time around. And you’re absolutely right, people do not want the invasion. I mean, I am certainly going to choose to go to a place that is going to serve me, versus a place that wants to invade my privacy first before they’ll serve me.

Leona Butler, CEO, Santa Clara Family Health Plan: First of all, Mark, to respond to something you said. I had to move heaven and earth to get into the county plan, because I’m not really eligible, to be able to use the county facility, but I did it, and I do it, and I’m very pleased to do it. But this is part of the problem. The county hospitals are not part of commercial medical insurance or HMOs or anything else.

Mark Smith: Why not?

Leona Butler: Why not? That’s the issue, that’s exactly what I’ve been sitting here trying to understand. We just had an interesting set of focus groups done. As a local health plan, we’re very aligned with the county facilities, and we’re often seen as part of the county, and we’re often seen as Medi-Cal. And as we try to move into low-cost commercial coverage, one of the problems is whether we are seen too much as a “Medi-Cal plan”? Do we have the “stigma” of Medi-Cal? So we had this series of focus groups with potential recipients, potential beneficiaries, and with brokers. And interestingly enough, at least in Santa Clara County, that is not an issue. It’s disturbing to me to hear that you’ve almost negated the possibility of the county facilities becoming more a part of the “mainstream” (which is a word I really hate). But we’ve seen in Santa Clara County, that
as Columbia has taken over more and more of the facilities, they are actually losing share in Medi-Cal because people are voting with their feet back into the county system. Why? Because it’s not-for-profit, because it’s the public sector and they feel their interests are being more looked after. And so I think there’s a somewhat more positive way to be looking at what Bruce was talking about, because we’ve seen the same phenomenon here. People want Healthy Families, they beg to get into Healthy Families, our CHIP program, rather than into Medi-Cal. Why? Part of it is the ease of administration for them, but there’s another issue too, and that’s the issue of respect. Self-respect, and respect by the providers. And that’s something not to be ignored. So I’m saying to you, is it not possible to turn some things around a little bit relative to the perception of what a county hospital is and what it can do?

Mark Smith: I apologize if I’m stating this in a way that people don’t hear. I think I said not only was it possible, it was imperative. So I think it is possible. I think the capacity to do that in a local area will be highly locally dependent. It depends on what the unused capacity of other hospitals is, it depends on the relative generosity or responsibility of county governments with regard to serving the indigent. So I think the solution in Santa Clara may not be the same solution in San Joaquin, or in Sacramento, or in San Diego. But that’s again like most of the health care system, and less like the way it used to be. Like most of the health care system, you have to look at the local circumstances: your competitors, what they’re offering, what niche you might play, what you need to do to improve your image. In one place it might be a building, in another place it might be actually letting people know about the quality of care you’re delivering, in another place it might be improving the quality of care. But that is a different model from the way these hospitals used to work, from the way all hospitals used to work. That’s my point.

Burt Margolin: Thank you. Next question, please.

Steve Ebert, Hospital Administrator, San Joaquin General Hospital: Maybe we can go back a step to where we started: insurance versus access. Five years ago, we all watched the federal attempt at health care reform fail. Universal coverage, which sounds really great, never got out of the blocks. AB 480, the Solis bill, creates that opportunity for the discussion again in California. How do we get that discussion past all the pitfalls that we saw take place with the federal attempt? If it’s all tied to money, as has been suggested in the initial discussion, are we right back to where we were where it’s not going to succeed for lack of funding to make it a reality?

Burt Margolin: Who’d like to respond?

Bruce Vladeck: I would. I said earlier that people disagree with the economists. They don’t believe that money that employers spend on fringe benefits is coming out of their pockets directly. I said that, therefore, by definition, they’re wrong and they don’t understand. But the part about the Clinton health plan that actually was correct in some tortured, attenuated way is that there’s probably almost enough money in the system now to cover more people if you used it more efficiently. The incremental cost [to cover everyone] is only a tiny fraction of the total cost, but people don’t understand where the money is coming from at the moment. And I think that’s educational part that is missing and that we have to do. I think we should not tell people, “It’s going to cost you, the taxpayer in the state of California, an extra hundred bucks to make sure everybody in California has health insurance,
and that you have health insurance if you lose your job, and that your kids will have health insurance when they turn 22.” I think what you have to say is, “It’s already costing you fifteen hundred bucks to provide health care to yourself and your fellow Californians. For an extra hundred bucks, we can give you the assurance and the security that you’ll always have it.” We just have to start from scratch, I think, in terms of that educational conversation. You are already paying a lot, not only for your own health insurance, but for everybody’s health insurance. In order to cover everybody, we’ve gotta be honest about it, the incremental cost is not zero, but it’s only a small fraction of what you’re now spending. And I think the public opinion data we have suggest that when the proposition is put to the American people in that form, they are much more willing to at least contemplate spending the extra money or paying the extra taxes than the behavior of political leaders would have you believe.

**Burt Margolin:** Bob, on that question of lessons learned from the Clinton health plan experience and how we might apply that to our own emerging debate around the Solis bill and the planning options the Governor has called for. You were part of that process in Washington; what thoughts do you have?

**Robert Valdez:** I’m thinking about the funds that are currently spent on the uninsured county by county in the state, and if I remember correctly, depending on what county we’re talking about, we’re already spending about $900 per uninsured person in some counties, up to $2000 per person. But we’ve never really done the arithmetic for people. People don’t really understand. I’ve had this discussion in Sacramento, and members of the Legislature don’t see that as dollars being spent to provide health services for people. And so the education that Bruce is talking about in the larger general community, is perhaps even more needed among public policy decision makers and in our circles. Because I think many of us dissociate those dollars from the ultimate end, as I was trying to say a little earlier. Ultimately we’re talking about providing care to those individuals and their families. Clearly, one of the things that we failed to do well during the health care reform debate in 1993-94 was to explain what the proposals were, what they were going to cost, and why they were to everyone’s benefit.

**Burt Margolin:** Thank you. All right, yes, Mark.

**Mark Smith:** I’ll be perhaps more optimistic in some ways and more pessimistic in others. I think that there is actually a chance that you could have a reasonable discussion about how to rearrange the system. My pessimism probably comes out of a sense that such discussion will be sparked by a crisis. As Bruce said, this growing number of uninsured, and providers and doctors and plans all feeling financially pinched, is happening during a time of record profits and a prosperous economy. So, people are feeling pinched with 12-percent-a-year premium increases. What happens when the employers are no longer willing or able to give those increases because their profits are down? What happens when people are laid off and lose their insurance? I think that most likely it will be the threatened instability of the provider system that will lead to people being willing to make some tradeoffs, because one man’s efficiency is another man’s layoff. So if you’re really going to rearrange the way the money goes it will be because some historical deal is struck, in the same way that a deal was struck to get Medicare passed. It wasn’t the ideal program but you had to strike a certain deal with physicians to get that done.

**Burt Margolin:** Thank you, Mark, and thank you to Bruce, Bob and all of you who responded and questioned from the audience, for a very challenging and thought-provoking discussion today. I’m sure that we will all be reflecting on the points raised in this session for a long time, and with positive effect. Thank you for coming.