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The Pepper Commission: Judgements From Various Parties

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July 1, 1988, under pressure from Representative Claude Pepper, Congress established the United States Bipartisan Commission on Comprehensive Health Care, popularly known as the Pepper Commission. Public Law 100-360, Title IV, Subtitle A gave the Commission a two-fold purpose. First, it was to study the need for comprehensive long-term care and health care for the elderly and the disabled. A report on this subject with recommendations for action by the Congress was initially supposed to be finished within six months. Secondly, the Commission was to complete a report with recommendations on the problems of health care access in America. This report, originally due six months after the first, significantly contributed to the discussion of universal health care access in the United States.

The Commission's membership as prescribed by the law was to include six Senators, six Representatives, and three Presidential appointees. Authority to acquire staff and consultants, to conduct hearings, and to request studies and cost estimates by Federal agencies was granted them. With $1,500,000 in funds (P.L. 100-360), the Commission was given the resources to produce a thoroughly researched plan with real potential for success. All of the persons eventually chosen as Commissioners were outstanding leaders in the field of health policy. Representative Pepper, the first chairman, was renowned for his advocacy for the elderly and their health-care needs. Unfortunately, he did not live to see the completion of the project that was to become his namesake. Representative Pepper's

death temporarily delayed the work of the Commission. A single final report addressing both access and long-term care was eventually issued in March of 1990.

Portions of the final report dealing with universal access will be considered here, beginning with the first chapter, devoted to the question "Why Do We Need Health Care Reform?" (21-44). The Commission found that an estimated 32 million Americans currently had no health insurance and many more had grossly insufficient coverage. Trends in surveys since 1979 indicate that the number of uninsured Americans is increasing. A surprisingly large percentage of the uninsured are young people, with young adults aged 18-24 being most at risk for having no coverage. Most of the uninsured have low incomes, but about 75 percent either are employed or live in the household of someone who is employed. The Commission pointed to less assistance with insurance by employers and the lack of expansion of Medicaid programs as significant factors in the problem (21-30).

The extent to which Americans tend to be underinsured is another growing problem which puts many at ruinous financial risk in the event of serious illness. A common measure for determining the adequacy of a policy is whether or not the holder is at risk of losing over 10 percent of his or her income. For 13 percent of the non-elderly, this definition labels them underinsured. For many, the risks are much greater (23).

By far, the most common method for obtaining health insurance now is through employment-related coverage. However,

evolutionary changes in the insurance industry have made it increasingly difficult for many small businesses to offer an insurance plan to employees. When private insurance companies first came into existence, they were based on the concept of spreading risks among a large population. Gradually, companies began to find ways to increase their profits by excluding high risk enrollees . Practices such as medical underwriting for the purpose of excluding high risk individuals or groups or charging them higher rates became common. Any company which did not become selective would have a large number of high-risk subscribers and, therefore, greater expense from claims. Such a company would have to raise its rates to compensate for the extra expense and could no longer compete for low-risk customers. Eventually, it became necessary for all insurance companies to adopt these practices in order to stay competitive and avoid becoming a pool of only high-risk subscribers (House Committee on Energy and Commerce 142-145).

Competition in the insurance market can make obtaining coverage at a reasonable rate particularly difficult for small businesses. They do not have the bargaining power of a large company and can become less attractive as a customer if even one member of the group is labeled as a high risk. Additionally, small groups make it impossible for insurance companies to use experience rating, judging a subscriber according to what the actual average of claims has been. Small groups often experience negative results from medical underwriting, tailoring of coverage

according to medical history of individuals in the group. If the underwriting process finds some members to be high risks, then, if the group is offered coverage at all, the rates may be exceptionally high, the high-risk members may be completely excluded from coverage, or preexisting condition clauses may disallow claims for the problems for which members most need help (Final Report 27-29).

For members of the low-income population, Medicaid is the primary provider of health coverage. Unfortunately, this program only reaches a few of the many poor who lack private coverage. Many poor persons do not qualify for Medicaid because, in addition to financial qualifications, they must belong to one of several specifically protected groups. These groups include many elderly or disabled persons and families with children, but exclude childless persons who do not meet disability requirements, no matter how desperate their situation may be. Inconsistencies among state-imposed regulations often make qualification even more difficult. However, what makes the problems of Medicaid most disturbing is that, despite some recent improvements, they seem to be becoming increasingly worse overall. Fewer people are receiving coverage, with the number of services covered declining and payment rates dropping well below Medicare and private insurance payments (30-32).

For those who have neither private nor public health insurance, obtaining quality care, or any care at all, may be impossible. According to one study, in 1986, an estimated one

million Americans were refused care by doctors or hospitals because of financial reasons. Even when they do receive care, it is often not provided in a way to best benefit them either physically or financially. The uninsured receive very little preventative care and often do not seek treatment for existing conditions until they become acute. This means that they suffer unnecessarily, and money is lost through inefficient delivery of care. In addition, these costs must be passed to someone. Health care providers raise their rates to cover unpaid bills. And in turn, insurance companies raise their rates to cover the increased costs. Typically, it is the privately insured who bear the final burden (33-37).

Those who are now fortunate enough to have health insurance should not assume that their position is a secure one. The cost of health care is growing at an astounding rate, and the number of individuals who cannot find affordable health insurance is growing in middle- as well as low-income groups. According to the Pepper Report, 11 percent of the gross national product is currently being spent on health care. That number is expected to rise to 15 percent by the year 2000. Even as the costs skyrocket, doubts about quality of care surface (38-40).

Finding so great a need, the members of the Pepper Commission were moved to work toward change. In the executive summary of the report, every member agreed to a common goal:

> The Commission is committed to the development of recommendations for public policies that will assure all Americans access to affordable health care coverage that allows them adequate financial protection; that will promote quality care and address the problem of health care costs; and that will provide the financing required to assure access. (14)

Recognition of the need for health care reform was an important step, but the work of developing a workable plan was a much greater challenge. Unfortunately, the Commissioners could never come to such complete agreement on their recommendations for action as they had in their commitment. At the final meeting on March 2, 1990, the recommendations on access to health care for the non-elderly and for the accompanying financing proposals were both approved by only eight of the fifteen members, a very slim margin. Certainly, a lack of complete agreement does not invalidate the Commission's proposals. Their plan of action was carefully constructed and should be considered as a real option.

The Commission began its work by examining two alternative approaches to the problem. The first possibility was to expand Medicaid to provide coverage for the uninsured low-income population. This alternative was dismissed because it was determined unlikely to reach many of the uninsured and would not deal with the problem of inadequate coverage. Also, it could produce an unfair shifting of costs to taxpayers while relieving employers of their share of the burden (Final Report 269-75).

The second alternative was to reorganize the health care system of America by replacing all private insurance with a publicly-based national health insurance. The Commission felt,

however, that this proposal would not draw widespread support and would mean the loss of many positive aspects of private insurance, such as variety of choice. This plan, too, was seen as producing an undesirable burden on the taxpayer to the advantage of employers (Final Report 275-79).

In the end, the Commission decided that the best plan would consist of a combination of the two former approaches. That is, emphasis would be placed on an expansion of employer-based coverage and, for those whose need was not addressed there, public coverage would ensure universal access. Using this dual system, the Commission created a "blueprint" for establishing universal coverage, detailed in the final report (53-82).

The first part of the plan aimed at the expansion of employer-based health insurance. Reforms in the insurance market would make it easier for small businesses to provide coverage. With due consideration for needed adjustment time, both large and small businesses would eventually be required either to provide coverage for their employees or to subsidize their participation in the public program. Meanwhile, some sort of tax credits or subsidies would be used to encourage small businesses to provide insurance (57-61).

Part two of the plan stated that "all parties - employers, individuals, and government - should share in financing health care coverage." To this end, limits should be created on the burden placed on businesses and individuals. Everyone would be expected to contribute, but beyond what they can afford, the

government must provide, in the way of tax credits and subsidies (63).

The third part of the blueprint enlarged the roles played by private insurers and the federal government in administration of adequate quality care. Private insurers would be encouraged to seek the best health care for their money and utilize managed care programs. Control assumed by the federal government from the states would be used to standardize public coverage across the nation (57-59).

The fourth part of the plan set minimum standards for both public and private insurance programs to ensure that everyone receives necessary care, including preventative care. To keep individuals sensitive to costs, reasonably limited premiums and service costs would be charged on all but preventative services (63).

Finally, the commission recommended immediate action be taken toward making the plan a reality. However, to avoid the possible problems of making drastic changes too quickly, the plan was divided into separate phases so full implementation would occur over time. In their "Recommendations to Congress," a complete outline of the various sequential phases is presented (18-20).

In order for the their plan to provide quality, cost-efficient universal care, the Commissioners believed that certain reforms of the health care system were absolutely necessary and should not be delayed. A set of recommendations to reform the

health care system were written (Executive Summary 8-9).

To this end, a "national system of quality assurance" should be established. This system would collect and use data from across the nation to guard quality of care and assess the value of treatments. Information from this data source would be available to groups to encourage the choosing of the best care providers at the best price. Efforts should also be made to address the problem of malpractice litigation.

The Commission also recommended that consumer cost sharing, within reasonable limits, be imposed to make consumers aware of the services they use and to prevent unnecessary treatment. Because preventative care helps hold down future costs, it would be encouraged by having no shared cost. Approved preventative procedures would be paid for with public funds.

The Commission designed reforms in the insurance industry that would cause the success of a company to be dependent on efficient service and control of members' health care costs. If a company elects to provide insurance to small groups, it would be required to meet certain conditions. It would have to accept any small group requesting coverage and not exclude any members on the basis of a preexisting condition. A community rating system would be used to set all premiums for similar groups in a similar area equally, and rates could not be increased for a particular group without affecting the others (Final Report 59). The Commission said that deviation from the community rate might be allowed for certain demographic categories, such as sex or

age.

The Commission praised Medicare's new payment procedures. It recommended that these methods be adapted for use in the federal insurance program to help control costs.

Realistic recognition of access problems other than the financial was a special aspect of the plan. Even if universal health care coverage were achieved, the commission recognized that "People in isolated rural areas and inner cities, and particular segments of the population - minorities and the poor, pregnant teenagers, the physically or mentally handicapped - would still face difficulties finding and getting the care they need" (56). The federal government should promote programs that bring care to these groups (56).

The last part of the strategy for improvement of the health care system recommended that the government work to give preventative care a role of greater priority. Programs should encourage individuals to promote their own health through changes not only in medical treatments sought but also through healthy daily living (56).

The Commission expected Medicare to continue to be the primary provider of health care for the elderly. However, an expansion of the program would be necessary to meet the needs of everyone over 65 years of age. Protection from impoverishment in the event of serious illness would be needed as well as preventative services. Also, some standardization and regulation of Medigap insurance should be enforced.

The Commission used their resources to thoroughly research the projected economic costs and savings for the federal government and other involved parties. The report contained suggestions of ways to finance the federal government's costs. The Commission intended for the Congress to make the final decision about which specific taxes would be used. However, they suggested that the primary source of funding be a progressive tax, affecting all age groups, which would be able to produce increasingly greater revenues to accommodate greater expenses (137-38).

Included in the final report are submissions by several Commission members further explaining their views on the recommendations (143-261). Summaries of those letters follow.

Dr. James E. Davis, a presidential appointee, voted in favor of all of the Commission's recommendations. In the letter which he enclosed in the final report, he defended the Pepper plan against a common complaint. Some members argued that the Commission had been negligent in not proposing specific sources for funding of its proposal. Dr. Davis said it was wise to give only general advice to Congress on the question of finance. He said:

> To isolate one source of revenue to the exclusion of all others would have sounded a death knell for a report which is intended to serve as a viable framework for the debate which must occur before the entire Congress and within the White House. . . The economic climate of this country is far from static and taxing mechanisms which appear viable or attractive today can easily tarnish or vanish tomorrow given the political nature of our system. (177)

a disappointment (222-23).

Senator Edward M. Kennedy also voted in support of all of the Commission's work. In his letter, he expressed his enthusiasm for the recommendations and his hope that action would be taken soon to implement them (216-217).

Senator David Pryor voted in favor of all the Pepper recommendations. His statement expressed satisfaction with a job well done, but, like Oakar, recognized that every member made sacrifices to create a plan that a majority could agree upon. He said that he would have preferred some changes in the benefits in the national insurance plan, like the inclusion of prescription drugs in coverage. He also felt that more cost-containment strategies, especially for malpractice reform and control of fraud, would have been beneficial. Like other members, Pryor also expressed concern for the well-being of small businesses. He suggested that policies requiring them to provide coverage to employees be tempered by a recognition of the rising costs of health care (226-228).

Finally, Senator Pryor called on President George Bush to lead the movement for health care reform. Every involved party must be committed to change, Pryor said, and presidential leadership is a necessity (230).

Representative Louis Stokes, who replaced the late Claude Pepper on the Commission, voted Yes to all of the recommendations. He said he would have preferred a national system in which the federal government would play a larger part.

He had several other minor concerns about the plan. Like Senator Pryor, he believed that prescription drugs should be included in the benefits of the national insurance plan and that small businesses should be protected from excessive burden. Despite these minor differences, Mr. Stokes supported the Pepper Commission's recommendations wholeheartedly (241-44).

Among the seven Commissioners voting against the recommendations on access to the under sixty-five population was Senator Max Baucus. His complaint was that requiring all businesses to provide health insurance for their employees would be excessively burdensome to small businesses. The problem, he suggested, is not a lack of willingness on their part, but a lack of ability. They cannot afford to provide coverage. He appealed to a popular image in saying, "I support efforts to make health insurance more affordable, but not to shove it down the throats of the "mom and pop" businesses that are the backbone of my state, and the country" (Final Report, 162-63).

John F. Cogan was one of only four Commissioners who voted against all proposed recommendations, both for access and long-term care. He explained his reasons for dissenting and presented his own suggestions for America's access problem in the final report. He mentioned first the Commission's failure to specify how their proposals would be paid for. This lack of detail became a major point of disagreement about the usefulness of the Commission's report. Claiming that the problem of rapidly rising health care costs was underestimated, Cogan insisted that

the success of a national health care program rests on better cost control (165-66).

Cogan claimed there are three "flaws"in the recommendations. First, he said that the working poor would pay a disproportionately large share of the cost. Forcing employers to provide coverage or pay a penalty would result in lower wages and higher unemployment for low-income workers who do not presently receive insurance through their jobs. Cogan predicted that between 500,00 and 1.4 million workers would lose their jobs as a result of the plan's implementation (167-68).

The second flaw is that businesses which currently provide better coverage than proposed public insurance would simultaneously reduce their costs and their employees' coverage by transferring employees from private to public insurance (168).

The final flaw noted by Cogan involved a prediction that health care costs will continue increasing faster than personal incomes as they have done in the past two decades. This means that the burden on taxpayers to support the plan would also grow steadily (168-70).

Cogan ended his statement by outlining his own plan to ease the access problem. He started with this claim, "There is a virtual unanimity among health researchers that our current tax treatment of health insurance encourages excessive consumption of health care services." Currently, insurance purchases are tax-exempt. Cogan suggested that a limit be created, beyond which, insurance purchases would be taxable. He believed that this

approach would make consumers more aware of their health care spending, thereby helping to control health care costs, while simultaneously raising the necessary revenue to assist uninsured persons below the poverty line in purchasing insurance from private companies (170-74).

Cogan's plan was less comprehensive than the Pepper Commission's recommendations. As it is stated in the Final Report, it contains no provisions for assisting the uninsured who do not actually fall below the federal poverty line or others who, for various reasons, have difficulty qualifying for insurance.

Senator Dave Durenberger voted against the access recommendations for those under age 65 but for access for the elderly and long-term care. He, like other dissenting members, mentioned first the successes of the Pepper Commission. The fact that fifteen prominent figures in health care policy worked together and agreed upon the need for better access was an important step. However, beyond some success, Senator Durenberger felt there were some serious errors in the specific recommendations, such as the proposal to require businesses to pay for health coverage for their employees. He believed that individuals should share a greater part of the cost than the Commission's recommendations required. Durenberger felt that federal tax-codes for employer-based health benefits should have been addressed in the report. The problems of the Medicare program were also neglected in the report, according to

Durenberger (181-182).

Representative Bill Gradison voted No on every set of recommendations. In general, his opinion of the Commission's work was very negative. Expressing his dissenting view in the final report, he said, "Regrettably, after much hard work and unquestioned good intentions by all, the Pepper Commission's report will only raise false hopes. Instead of focusing on the possible, the recommendations make promises that simply cannot be kept." He disagreed with their basic approach of outlining a complete program that will be implemented in steps. Previous federal programs implemented this way have failed. His advice instead was that it is "Best to take measured action now and evaluate our progress on a regular basis." He also complained that the proposals are too expensive to be feasible and require the federal government to enforce its will rather than allowing state and local governments and the private sector the freedom to work on the problems as they choose (200).

Representative Pete Stark also voted No on every set of recommendations. He made the common complaint that the report did not contain specific suggestions for funding sources. More significantly, though, he had a plan of his own, called Mediplan, which was essentially different from the Pepper recommendations, introduced to Congress on July 18, 1990. MediPlan was, according to Stark, superior to the Pepper Commission's recommendations because was "comprehensive and self-financing." In this program, everyone would receive basic health care coverage from the

federal government. He believed that focusing on job-related coverage, as the Commission's proposal does, would mean that some individuals, because of special circumstances, would face unfair costs or not be covered continuously. He expected part-time and seasonal workers and persons who change jobs frequently to be treated unfairly, charged extra in their deductible, or left at times without coverage (232-33).

Stark claimed that the Commissions's recommendations would be too stressful financially for small businesses. MediPlan would not have this problem. Because the risk pool for a national program would not penalize particular employers for having high-risk workers and because the government could easily impose cost-containment measures (another advantage), small businesses could afford their contribution to the plan (233).

Obviously, insurance companies would lose most of their business if MediPlan were instituted. Stark suggested they expand their sales to include the now popular "Medigap" insurance, a service more profitable than standard insurance (237).

Senator John Heinz voted against the access and financing recommendations for the non-elderly, but for the access recommendations for the elderly. He supported the emphasis on employer-related coverage. His major point of disagreement was with the federal centralization of the Pepper plan. He proposed an alternative setup in which the states would have nearly autonomous control and most of the responsibility for funding,

with the federal government providing considerable financial assistance. A state-based program, according to Heinz, would avoid some problems that the Pepper plan would face. He warned, "Historical lessons learned from our Medicare experience tell us that the public loses when the federal government pre-empts state roles in cost containment." The federal bureaucracy involved in a program such as this would be inefficient and could not accommodate variations in local health care needs (201-05).

Another plague common to the federal government is the inability to resist the pleas of special interest groups. This could easily make cost containment policies impossible to implement when health care lobbies fight them. Interestingly, Heinz accused the Pepper Commission of being too weak to stand up to special interests groups. He suggested that the Commission was unable to create any strategy for cost containment because "key provider groups lobbied hard against 'their ox being gored'" (205).

As a final comment, Senator Heinz joined with those who condemn the Commission for not offering specific funding proposals (210).

Representative Thomas J. Tauke voted against all of the Commission's recommendations. He explained his dissenting views in some detail in his submission to the final report.

Mr. Tauke vehemently opposed a job-related system of insurance as the primary means to universal coverage. He expected the results of such as system to be beneficial only to

the wealthier segment of the population. The employer requirements to provide coverage he called:

> a head-tax on labor, substantially increasing the cost of employing our most vulnerable citizens - the young, the unskilled, the disabled, the single mother or older woman seeking to enter or re-enter the workforce and the elderly seeking to remain active in the workforce.
>
> (247)

Mr. Tauke also felt that the unlimited tax deductions for employers who provide insurance benefits would be a problem. Individuals would work to acquire better and better benefit packages which many large employers would gladly provide. No matter how extensive or expensive the coverage, the employer would receive a tax deduction and the employee's benefit would be tax free. In many cases, the public would be subsidizing benefits for well-paid individuals. Additionally, more extensive benefits, especially lower or nonexistent deductibles, would create a greater demand for health care services and drive up prices. Here again, the working poor would suffer most.

According to the Pepper plan, small businesses would be encouraged to offer more coverage also, through a 100 percent tax deduction. However, this approach would only contribute to the problem of rising costs and would not assist the unemployed (247).

Like others, Mr. Tauke mentioned the difficulty in resisting special interest groups. He expected that this problem would surface as legislators tried to contain the parameters of the minimum benefit package. Health care providers would lobby for

their services to be included and the package could easily become too extensive (247).

Mr. Tauke believed that the role of the federal government is too large under the Pepper plan. He cited Medicare as an example of the results of federal control. Centralization is sometimes claimed as a route to the reduction of administrative costs. Tauke pointed out that although Medicare's claims payment and adjudication may be efficient, the additional paperwork this program forces on health care providers is extremely costly. Also, it is often claimed that federal centralization allows for better cost control since the government becomes such a large payer. However, Medicare again provides a contradicting example. As Tauke explained,

> The federal government, through Medicare, is already one of the largest purchasers of health care services, and the track record on its cost containment is bleak. While we have achieved some reduction in Medicare Part A inflation, the rate is still well above general inflation rates. Part B is out of control, with yearly increases ranging from 11 to 13 percent. (248)

After explaining his vote against the Pepper recommendations, Representative Tauke presented his own plan for providing universal access. His plan would limit the tax credit given to an employer to a federally specified amount based on the average cost of a plan with a federally determined set of benefits in the employer's area. Employees' tax incentives would also be limited by this standard.

In Tauke's plan, the unemployed and uninsured would obtain coverage through the use of vouchers or tax credits. The

Medicaid program would no longer be used. Tauke preferred a plan of this type which he believed would allow consumer freedom and encourage insurers to keep costs down and provide quality care in order to be competitive (250-251).

No member of the Commission showed as much enthusiasm for the recommendations as its chairman, Senator John D. Rockefeller, IV. He has worked, since its completion, to promote the Commission's work and similar plans. When he spoke before the Senate Labor and Human Resources Committee, he defended aspects of the report which had been under attack. Addressing the effect that the employer mandate to provide coverage would have on small businesses, he referred to the fact that the phase-in schedule would not require small businesses to do anything for five years. This period of adjustment and the figuring of business' contribution on the basis of payroll should ease the burden for small business (8).

Senator Rockefeller urged the committee to act. Warning that waiting for "the perfect solution" was a mistake, he said ". . . we are now spending $600 billion on health care in this country, and it is going to be $1.5 trillion in less than ten years at current rates of growth" (9).

Less than two months after the release of the Pepper report, representatives of the insurance industry gave their testimonies at a joint hearing before the House Subcommittee on Commerce, Consumer Protection, and Competitiveness and the Subcommittee on Health and the Environment of the Committee on Energy and

Commerce to express their opinions on the report and to offer their own suggestions for increasing access to the health care system. Among those who gave testimony at the hearing were Edmund F. Kelly, President of the Employee Benefits Division of Aetna Life and Casualty, representing the Health Insurance Association of America, an organization consisting of 320 private insurance companies which collectively serve over 95 million Americans (124-37); Robert J. Laszewski, executive vice president of Liberty Mutual Insurance Group (152-69); and Mary Neil Lehnhard, vice president of Blue Cross and Blue Shield Association (137-152). In addition, a statement was submitted for the record by the National Association of Health Underwriters, an organization representing approximately 10,000 insurance agents, brokers, and producers (170-72). The testimony given can be taken to be fairly representative of the general consensus of opinion among those in the insurance industry.

A remarkable willingness to cooperate with insurance industry reforms was displayed by all of the speakers. They all approved of excluding the pre-existing condition criterion for the continuously insured, and for accepting all individuals in small groups regardless of their medical condition. To compensate for potential losses because of these policies, they advocated the establishment of either state-run risk pools or private reinsurance of high-risk clients.

They generally agreed that a change in the basis of competition for the insurance industry was appropriate. Mr.

Laszewski approvingly said of the reforms, "They can provide a basis for insurance carriers to compete, not on whom they will underwrite, but rather on how costs can be controlled" (152). All encouraged the expansion of managed care and certain policies which could reduce specific gross inefficiencies and unnecessary expenses. Malpractice reform was a common theme, as was the elimination of state-mandated minimum-benefit requirements which often contain wastefully excessive provisions. Also mentioned were standardized payment systems, public policy to bring more physicians into family practice, government endorsement of a limited number of centralized locations for expensive technologically advanced treatments so that supply would not exceed demand for treatment as it currently does. Other than such specific requests, the emphasis was on leaving efficiency improvement in the realm of the private sector. Mr. Laszewski supported his case with a reference to national experience:

> Government is not known for managing efficiency. That is what the private sector and the operation of market forces is known for. The role of the health insurance industry over the coming years should be to use our business skills to effectively manage our customers' health care dollars.
>
> (153)

Three of the four speakers opposed the employer mandate to provide coverage. Mr. Kelly gave the familiar prediction that employers who now supply generous coverage would find it advantageous to dump their employees on to the public insurance system. This makes employers insensitive to the relationship between the actual cost of coverage and the costs which they

experience, thereby posing an obstacle to efficiency (129). Ms. Lehnhard felt that a "massive federal program" might evolve from this practice (140). According to Lehnhard, such a centralized program would not be capable of providing customized packages of benefits and personalized services as private insurance companies do (141).

Ms. Lehnard expressed concern over the possibility of a requirement that all clients of a particular insurer be charged the same rate. She said that companies which, like Blue Cross and Blue Shield, have accepted an unusually large number of high risk enrollees would suffer. Because of their greater expenditures in claims, their average price would be too high to be competitive. Those companies which had had a policy of rejecting high risk applicants could afford to offer much more attractive rates (146). She also claimed that such price equalization could easily lead to even more people choosing to become uninsured. Price averaging would increase the rates for young and healthy persons, making them more unwilling to spend their money on health insurance they do not expect to need (146).

Also present at the joint hearing before the House Subcommittee on Commerce, Consumer Protection, and Competitiveness and the House Subcommittee on Health and the Environment were some representatives of business and the private sector: Fredrick J. Krebs, manager of Business-Government Policy Department, U.S. Chamber of Commerce (51-64); Walter B. Maher, director of Federal Relations, Human Resources Office, Chrysler

Corporation (64-83). A statement was submitted for the record by Susan Engeleiter, Administrator of the Small Business Administration (172-74). At a separate hearing held by the Senate Labor and Human Resources Committee other representatives of the business community spoke, including Bruce Mueller, a representative of the National Association of Manufacturers (103-119) and Barbara Decker, Health Plans and Claims Administrator, Southern California Edison Company.

Not surprisingly, business's greatest concern with the Pepper Commission's recommendations was the employer mandate to provide insurance to employees. The Small Business Administration especially feared the result it might have on their members. Susan Engeleiter said that the mandate would mean not only fewer jobs, but also a reduced competitiveness for small business with larger firms and in the growing world market (173).

Another common complaint among the business organizations was that the Pepper Commission had not been aggressive enough in its approach to cost control. Barbara Decker and Mr. Maher were also concerned that the government not contribute to the problem of cost control for the private sector. Maher commented, "All publicly financed health programs should be operated so as not to cause providers to shift costs to private sector payers." Among the changes necessary to accomplish this goal would be expanded coverage for the poor and more adequate reimbursement rates for Medicaid. Such improvements would alleviate the need of health care providers to compensate for their losses on non-paying or

under-paying patients by over-charging private payers (64).

In general, the business community showed support for those reforms which would reduce the cost of health care insurance but opposed a legal requirement to provide it.

Familiar support was voiced for insurance reform. Mr. Krebs described the opinion of his organization, "The Chamber believes that the United States must return to the traditional concept of insurance, the spreading of risk across a wide population" (52). This theme becomes prevalent in nearly all the testimonies given. It is probably the most radical reform recommended by the Commission to experience such wide support.

Speaking on behalf of the medical community at the hearing before the Senate Committee on Labor and Human Resources were these spokesman:- Charles P. Duvall, president of the American Society of Internal Medicine; Larry Gage, president of the National Association of Public Hospitals; and Dr. Karen Davis, chairperson of the Department of Health Policy and Management, Johns Hopkins University. Also providing testimony at the joint hearing before the Subcommittee on Commerce, Consumer Protection, and Competitiveness and the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce was Gerald F. Anderson, director of the Center for Hospital Finance and Management, Johns Hopkins University (115-24).

The medical community is keenly aware of insufficiency of access to health care in America and greeted the Pepper Commission's recommendations warmly. Many proposals by members

of the medical profession for improvement of the health care system preceded the Pepper Commission's work. Many of these advocate a federal health care program which would eliminate the need for basic private health insurance. As described by Dr. Charles P. Duvall, the American Society of Internal Medicine backs a set of proposals very similar to the Pepper recommendations (27). They agreed that an employer mandate for the provision of employee coverage, in combination with an extension of federal coverage to the uninsured is the most appropriate plan of attack. They also prescribed reform of the insurance industry, cost control procedures, and patient cost-sharing like the Commission's report (27).

Every speaker from the health care profession was quick to argue against the claim that the Commission's recommendations were too expensive. Mr. Gage is the president of the National Association of Public Hospitals which he described as "90 public and non-profit teaching hospitals that serve as . . . "safety net" hospitals for the poor in most of our nation's largest metropolitan areas" (57). He felt that immediate action was needed and the Pepper proposals were a good starting point. It was his opinion that reform was long over-due:

> ". . . the only reason we have had the luxury of debating rather than enacting universal health care coverage all these years is because of the continued existence of a small and extremely fragile safety net; this safety net is comprised on no more than tow to three hundred public and nonprofit hospitals . . . the condition of many of these essential safety net providers has deteriorated substantially in recent years . . . as a result, our nation's health care

> system is facing a crisis today of unprecedented proportions." (60)

Dr. Davis saw the financial requirements of the proposals as insignificant and commented:

> The access recommendations would, when fully implemented, entail federal budget outlays of $23.4 billion in 1990 dollars -- about 2 percent of federal government revenues. Small modifications in the existing tax system would be adequate to finance such expanded coverage. Modest increases in alcohol and cigarette taxes, for example, could finance well over half the cost. (85)

Senator Riegle, a member of the Senate Finance Committee, supported the claim that money can be found once a program is given priority. He mentioned the massive amount of money that had been poured into the savings and loan system and called the fact that money was allowed to be an obstacle to health care access reform "a terrible contradiction in policy and priority" (18).

Of the medical professionals who spoke at these two hearings, only Gerard F. Anderson had a suggestion drastically different from those of the Pepper Commission. While he agreed with the expansion of employment based coverage and most of the insurance industry reforms, he disagreed with the requirement that insurance companies guarantee acceptance to all groups applying and provide coverage at standard community rates for all (117-20). As he put it, "It does not make sense, for example, for a small firm of demolition experts to pay the same premiums as a small firm of accountants" (119). His reason, then, for not

imposing these rules of equity was that they simply could not be enforced. Insurance companies would always be looking for ways to avoid enrollment of high risk groups. Mr. Anderson offered an alternative plan in which uninsured individuals be compelled to purchase coverage from a single insurance company in each state. Competition would occur on a state level where public and private companies would bid for the contract. Premiums, once determined, would be shared by individuals and employers (or the government in the case of the unemployed) (118-119).

Because the Pepper recommendations do require a substantial amount of federal spending, no matter how affordable that is, public support for health care reform will be necessary if the Commission's recommendations are ever to lead to substantial change. According to a Gallup poll in October of 1988, just before the election of George Bush, 44 percent of the people surveyed said that, regardless of who was elected, proposing laws to create a national health insurance plan should be a top priority for the next administration. However, in that same survey, reducing the budget deficit, environmental protection, and arms reduction all received votes for type priority by at least 62 percent of respondents (1988 Gallup 219). A similar question posed November 6, 1988, just two days before the election, showed concern for health care to be an issue strongly divided on party lines. Sixty percent of respondents planning to vote for Dukakis identified national health insurance as a "top priority," while only 28 percent of those planning to vote for

Bush called it a "top priority" (1988 Gallup 220).

Complicating the problem of allocating funding is the strange habit of simultaneously maintaining irreconcilable opinions. Namely, the American public wants to increase spending for practically every federal program without ever increasing taxes. This well-known dichotomy is supported by another Gallup poll, taken in October, 1989. When asked about a series of personal financial problems, "Which of the following worries you most about the future?" Fifty percent responded "Increase in taxes" (1989 Gallup 209). The same group of people were then asked, "If you had any say in making the federal budget this year, should spending be increased, decreased, or kept the same for the following programs?" Sixty seven percent said health care spending should be increased, 5 percent said decreased, and 24 percent said kept the same (1989 Gallup 209-210). However, the answers to nearly all other categories, ranging from public education to the reduction of air pollution to aid to farmers and financial aid for college students showed their highest percentages in the category "increased." Space exploration and assistance to first-time home buyers were dominated by "kept the same" votes. Only defense spending was less favored, receiving votes of 14 percent for increase, 42 percent for decrease, and 41 percent for kept the same. The pattern is clear. Americans simply want to have their cake and eat it, too. It appears that health care reform may have to depend on the manifestation of a budgeting miracle or a vision of reality by the American public.

Congressmen and the President are politically obliged not to deviate too far from the public will. However, sufficient backing by powerful interest groups is often capable of compensating for a less than perfect general consensus. As the issue of health reform builds support, certain groups will be certain to contribute to the process. Insurance companies will defend their interests and fight to the death against any program which promotes public health insurance for all. Health-care providers are strong supporters of increased access. Business lobbies will try to keep themselves from having extra financial burdens. As usual, trying to shift the cost to someone else will probably be the task of every group involved.

As members of the Commission noted, another key element for reform is an active participation by the President, something that has not recently occurred. Thus far, the only reforms the President has dealt with specifically related to medical malpractice, lowering the infant mortality rate, and promoting childhood immunization (Rovner, "White House" 1285). Though Presidential action seems to be, in great part, a product of public opinion, a President who chooses to risk popularity may attempt to set national priorities and sway the people to support them.

Even without executive leadership, many Congressmen are pressing for reform and working to sculpt legislation that can draw widespread support. Both parties show and interest in the issue, but the Democrats have been the most active. Even within

the Democratic party, the most difficult problem has been trying to achieve some consensus on what action is appropriate (Rovner, "Complex" 1437). There is considerable agreement about malpractice litigation reform and some insurance industry reform. There could be legislation on these topics soon. However, with the current climate of disagreement within the government and lack of commitment on the part of the public, it is unlikely that a major health-care system reform will become law in the near future.

Eventually, action will become necessary. America's health care system is failing. Perhaps, after a larger percentage of Americans experience the problem first-hand, as they will, enough people will be willing to sacrifice, in dollars and ideals, to bring a change.

Annotated Bibliography

Gallup, George Jr. The Gallup Poll, Public Opinion 1988. Wilmington, Delaware: Scholarly Resources, Inc., 1989. p. 219-20.

Gallup, George Jr. The Gallup Poll, Public Opinion 1989. Wilmington, Delaware: Scholarly Resources, Inc., 1990. p. 209-10.

Rovner, Julie. "Complex Issues, Turf Battles Delay Democratic Overhaul." Congressional Quarterly. 49 (22), 1991: 1437.

---. "White House, on Defensive, Highlights Its Agenda." Congressional Quarterly. 49(20), 1991: 1285.

United States. Cong. A Call for Action. The Pepper Commission, U.S. Bipartisan Commission on Comprehensive Health Care, Executive Summary. Washington: GPO, 1990. Summary by chairman of final report of the Pepper Commission. Readable, reasonable length.

---. ---. A Call for Action. The Pepper Commission, U.S. Bipartisan Commission on Comprehensive Health Care. Final Report. Washington: GPO, 1990. 300+ pages. Includes graphs and tables.

---. ---. House. Pepper Commission Report. 101st Cong., 2nd sess. Washington: GPO, 1990. Joint hearing before the Subcommittee on Commerce, Consumer Protection, and Competitiveness and the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce to examine the recommendations of the Pepper Commission.

---. ---. Public Law 100-360, Title IV, Subtitle A. Established the United States Bipartisan Commission on Comprehensive Health Care.

---. ---. Senate. Pepper Commission Recommendations on Universal Health Care. 101st Cong., 2nd sess. Washington: GPO, 1990. Hearing before the Senate Labor and Human Resources Committee concerning the recommendations for Federal action made by the Pepper Commission.

Extended Bibliography

"Access, Long-Term Care Are Topics of Study." Congressional Quarterly Almanac (1989): 169-71. Mentions the expertise and influence of committee's members. Emphasizes political conflicts.

Davis, James E. "National Initiatives for the Medically Needy." The Journal of the American Medical Association 259.21 (1988): 3171-73. Useful for comparison with the Pepper Commission Proposals.

Davis, Karen. "National Health Insurance: A Proposal. (Economists and National Health Policy) (Papers and Proceedings of the American Economic Association annual meeting)." American Economic Review 79 (1989): 349-53. Useful for comparison with Pepper Commission Proposals.

Etheredge, Lynn. "Negotiating National Health Insurance." Journal of Health Politics, Policy, and Law. 16.1 (1991): 157-67. Update on recent legislation.

Gradison, Bill. "Why a Pepper Commissioner Voted No." Wall Street Journal [New York] 8 Mar. 1990: A14. Commission member, Rep. Gradison expresses his disapproval the report.

Hey, Robert P. Hey. "Pepper Commission Offers Expensive Health-Care Remedy." Christian Science Monitor [Boston, MA] 5 Mar. 1990: 8. Includes a brief description of the commission's recommendations and reactions from some members.

Hummelstein, David U., M.D., Steffie Woolhandler, M.D., M.P.H., and the Writing Committee of the Working Group on Program Design. "A National Health Program for the United States, A Physicians' Proposal." The New England Journal of Medicine 320.2 (1989): 102-108. Useful for comparison with Pepper Commission's Proposals.

Rosenblatt, Robert A. "Divided Panel Presents $66-Billion Medical-Care Plan." Los Angeles Times 3 Mar. 1990: A23. Emphasizes significance of panel's split decision as an objection by members to the lack of funding provisions.

Rovner, Julie. "After the Pepper Commission: Now the Real Work Begins." Congressional Quarterly Weekly Report 48.10 (1990): 748-50.

---. "Pepper Commission Splinters Over Health Financing." Congressional Quarterly Weekly Report. (1990): 667-68. Shows voting record of commission members.

Saddler, Jeanne. "Health Coverage Breakthrough, U.S.-East Bloc Logjam." Wall Street Journal 20 Feb. 1990: B2. The insurance association's board is shown as cooperative.

Sakala, Carol. "The Development of National Medical Care Programs in the United Kingdom and Canada: Applicability to Current Conditions in the United States." Journal of Health Politics, Policy, and Law 15.4 (1990): 709-55. Supports premise that the United States is now ready to institute a national health care program.

United States. Cong. Recommendations to the Congress by the Pepper Commission. 101st Cong., 2nd sess. Washington: GPO, 1990. Printed before the final report. 21 pages.