

CATO INSTITUTE

POLICY FORUM

ACCESS TO "FREE" HEALTH CARE

RESTRUCTURING THE SAFETY NET

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of Health Policy Studies, Cato Institute

Featuring:

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Randall R. Bovbjerg, Urban Institute; and
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P R O C E E D I N G S

MR. MILLER: Good afternoon. Welcome to the Cato Institute. I'm Tom Miller, Director of Health Policy Studies. Today we are speaking about Access to "Free" Health Care -- we put it in quotation marks, because, as we know, it is not free; it may be unpriced in some circumstances -- How to Restructure the Safety Net for Health Care.

In the United States we have, loosely speaking, a voluntary health insurance system with a lot of regulations and mandates attached to it. And as a result, people choose to have health insurance. And we have approximately 38, 39, 40 million people who are uninsured on any type of regular basis in the course of a year by the most recent statistics.

Now, despite those folks being uninsured, they still receive health care without having health insurance, not as much health care as folks who have more comprehensive health insurance, but perhaps 50 percent, 60 percent of the health care that the insured have. And they pay for a portion of this out of pocket. Maybe roughly about one-third of the costs are coming from the individual's resources and financial assets.

So where do the uninsured get the rest of their health care in what we loosely call the safety net? There are a range of different ways in which health care is provided to the

uninsured, the folks who are not necessarily in the Medicaid program or other type of public programs, such as the Children's Health Insurance Program, S-CHIP; there is charity care; sometimes just bad debt that is written off by both hospitals and physicians -- as I mentioned, out-of-pocket payment accounts for a good bit of this care; public hospitals are receding in their role but continue to provide health care to the uninsured; there is also federally-mandated provision of care, primarily through the emergency room of most hospitals; there are uncompensated care pools that finance the charity care after the fact through different means of spreading that financial burden around; and there are also State-based, high-risk pools for individuals who are said to be medically uninsurable.

So, in looking at this mixture of different ways in which the uninsured receive care we first ask, is this a carefully woven, fine mesh that catches everyone who needs health care at anytime, or is it just a fine mess? Or are there some market-oriented alternatives which can improve access to health care by other means?

We have three speakers today. Our fourth speaker, Richard Carlson, failed to diversify or hedge his risk of weather-related problems in flying here from Illinois. You have some material from him which talks about the experience in Illinois with their high-risk pool approach, but he will not be

able to be here for today's forum. I will remind you that all the material and the readings will be on the exam, so I encourage you to look through it carefully.

Our first speaker is Brad Herring. Brad is a Robert Wood Johnson Foundation Health Policy Scholar at the Institution for Social and Policy Studies at Yale University. He received his Ph.D. at the Wharton School of Business at the University of Pennsylvania in the Health Care Systems Department, with a concentration in economics. Before then, he was at the Tulane University School of Engineering, where he majored in biomedical engineering, with a BSE degree. And I guess now, Brad, you're reengineering the tax codes in order to get tax credits for individuals.

Among his many articles -- I mentioned his work on tax credits briefly -- a forthcoming publication from AEI Press, "Cutting Taxes for Insuring Options and Effects of Tax Credits for Health Insurance," with Mark Pauley. We also have a copy outside of his NBER working paper on tax credits, "The Distribution of Subsidized Health Insurance Premiums and the Uninsured," also with Mark Pauley, and David Song. His earlier publication with Mark Pauley, "Pooling Health Insurance Risks," took a rather innovative look at exactly how much pooling goes on in both the individual health insurance market and in group, employer-based plans. He has also written a lot about medical

savings accounts, both in Health Affairs and the Journal of Health Economics, on how employers might deal with multiple plan offerings, that include MSA's, and what might happen if large firms are offering medical savings accounts.

But what particularly drew my attention to Brad recently was his working paper at Yale called, "Does Access to Charity Care for the Uninsured Crowd Out Public Health Insurance Coverage?" And you have a copy of that outside.

Today, he is going to first review how the safety net for charity care for the uninsured operates, who gets it, how much, and in what manner. Then he will discuss how access to the safety net of charity care for the uninsured might make paying for private health insurance less attractive for certain individuals, and then maybe briefly conclude with some policy options that that may present to us. Then we will move on to some discussions of emergency room care and uncompensated care pools for hospital-based care as well.

Brad Herring.

BRADLEY J. HERRING,

YALE UNIVERSITY

DR. HERRING: Thank you very much, Tom. I should first off say it is a great pleasure to be here in such a nice

auditorium, as opposed to a crusty, old basement at Yale University. And also thanks to David and Randall and Tom for including me in this panel. I am definitely interested in hearing what they have to say, so please kick me in the shins after 15-20 minutes so we can move on.

As Tom mentioned, the main focused of the paper that has been distributed, I looked at the demand for insurance as a function of variation in the safety net for charity care. And as the precursor to that in the paper, I looked at this MEPS data, and essentially wanted to analyze how much free care the uninsured get, essentially to set up that this is not really a trivial matter.

And so for the presentation today I am going to flip that around and more or less talk about what I observed with the MEPS data and how much free care people get, and then talk briefly about the demand for insurance. With that, I guess I am going to break the cardinal rule of public speaking and presentations and just dive right in to the data. I am assuming that you all have a four-page handout that was circulated.

First off, I just wanted to look at how much charity care is provided to the uninsured and what type of care is it. The best data for that is the 1996 and 1997 Medical Expenditure Panel Survey. It is a household survey of individuals that primarily focuses on their insurance status and their medical

expenditures throughout the entire year. So I wanted to look at a sample of year-long uninsured. And this is mainly because the data for expenditures is at the year level, so I want to make sure that I do not look at people who are in and out; although, that is, of course, an important group of the uninsured.

With that, I looked at total utilization and out-of-pocket expenses, essentially to see what percentage of care was provided free. I should make some notes that I looked at discounted charges, because I wanted to really concentrate on what medical expenditures people would expect to pay, because we all know the charges that hospital physicians put out there are not really what people are expected to pay fully.

The main result when I do that is I look at the sample of year-long uninsured, and their out-of-pocket expenses are, somewhat surprisingly, only \$242. Their total expenses are about \$681. So the main conclusion is that about two-thirds of the medical care they receive is provided free.

As a reference, if you compare this to the insured throughout the whole year in this same MEPS sample, their out-of-pocket expenses are about the same, 211, but their total expenses are significantly higher. So you can kind of look at this from two perspectives. The glass half full is, well, great, we are doing a great job; we are providing a substantial amount of charity care to the uninsured. They only pay a third of the

medical care they receive. But the glass half empty approach is well, there is really a pretty large discrepancy between the 681 and 1,272. And there is substantial literature out there that looks at differential health status and the effect that insurance has on birth outcomes, for mental hospitalizations and the like.

With this data I want to do some more refinements, so I look at three things essentially. I want to look at it by income, by the level of utilization, and by the type of expenditure. If you were to look at this next page, Table 1, I break the sample into high and low income. I break it into above and below 300 percent of the poverty line, and find -- what I think is a pretty plausible result -- that the amount of free care provided to low-income individuals is somewhat higher than the amount to high-income individuals. You can see, the 31.7 versus 47 percent is the proportion out of pocket that the uninsured pay. But, still, that is a little bit surprising to me, that high-income people receive that much charity care.

The other thing I want to do is break this down into the level of utilization. I have these five cutoffs of no utilizations, 0 to 250, et cetera. And if you look at the people who had little utilization, the amount that they pay out of pocket is about 77.2 percent, relative to the people who had the highest amount of utilization, which was 12.5 percent.

So if you look at this, this somewhat mimics a catastrophic health insurance policy, in that as your utilization increases, the amount that the safety net provides, in some sense, increases. When you look at this break down by utilization for low income versus high income, you can observe that at each level of this cutoff the uninsured who are low income receive a higher amount of free care.

Still sticking with this half-empty/half-full approach, looking at, for example, the low incomes with the highest utilization, above \$10,000, that they receive 90 percent free. That is a half-full examination. But then, on the flip side, \$27,000 is still not a non-trivial amount for a low-income uninsured individual to face.

Flipping on to the next page, I wanted to look at the source of these expenditures. The MEPS breaks it down by hospital, inpatient, emergency room, et cetera, and this might be a good starting point for the next conversations. But as you can see, the majority of care, and also the majority of charitable care to the uninsured, is derived from hospital inpatient. The percent out of pocket that they pay is around 9 percent for hospital inpatient.

I guess this provides somewhat of an intuition as to why we see what we see with the expenditures by utilization, and this is essentially a small-ticket/big-ticket differential.

Small-ticket things, such as office-based physician visits or these other insurable services, the percent paid out of pocket is relatively high. But as we move to these large-ticket items, like hospital facility, et cetera, the percent out of pocket lowers substantially.

This leads into the work that my paper mainly focuses, which is the demand for insurance. There is a tremendous patchwork of safety net providers, and, obviously, this is where we are heading with the rest of the discussion today. But within hospital facilities there are teaching hospitals, public hospitals, not-for-profit hospitals, and there are uncompensated care pools. As far as physicians and such, there are community health centers and physicians themselves. And so we have a real patchwork of safety net providers. And not only is this patchwork within a community, but across different communities there is a tremendous patchwork. So I focused on that geographic variation as the source of my empirical test to see how this access to charity care affects the demand for insurance.

In doing so, there are two "problems" with the empirical estimation. One is if we observe a relationship in a market where there is increased availability of charity care and more uninsured, we are not sure which way the causation runs. Because I would be quite certain that charitable providers of medical care are responding to an increased demand for that care.

But the story I am interested in instead is that individuals are rational actors, and they are less likely to purchase insurance when there is an increased availability in charity care. So in that sense I want to use this instrumental variables approach and look at truly exogenous sources of this charitable giving. I used a bunch of instrumental variables, which I will skip over.

But the other problem is we have this patchwork of care, and so measuring it and developing a unit of measure is somewhat difficult. So I focused on cost-related difficulties in obtaining care. What you observe in the household survey data that I used is there is a question in there -- you ask the uninsured: Within the past year, did you have a medical condition which you thought was necessary that you did not obtain care? And for those who responded affirmatively, they asked the follow-up questions: Is it the cost? Is it travel time? You couldn't get off work? And such.

What I use in my paper is I assumed that the number of uninsured who report that they did not put off care due to a cost-related difficulty proxies for this aggregate availability of charity care within the market. And if you look at that measure at the market level, and even the county level, there is substantial variation across communities in the U.S. That is my main source of variation that I include in a model of insurance. I look at workers in the community tracking study. You could

say, workers, if you are talking about the uninsured, why are you focusing on workers? Well, it turns out that almost 75 percent of uninsured families have a family member who actually works.

I look at simple probate models that are essentially looking at whether or not an individual is insured or uninsured. I look at more detailed models which examine this interaction between firms offering insurance to their employees and then individuals deciding whether or not to take up that insurance.

The main result is that availability of charity care does impact low-income workers in their decisions to work at firms offering insurance. I can return to this if anyone is interested, but I think it is an interplay between workers sorting into these jobs and then also their firms deciding to not offer. And if anyone is interested in the magnitude of the effect, we can talk about it a little bit later.

Finally, I will talk a little bit about this other work that I have done, mainly with Mark Pauley at the University of Pennsylvania, where we have examined how these proposed tax credits subsidies might impact reductions in the uninsured. On the surface, I think these results of mine, which show the relationship between access to charity care and demand for insurance, pretty much explains why these subsidies in the form of refundable tax credits are going to have to be really large to get the low-income uninsured to buy coverage.

If you look at the main data I present, out-of-pocket expenses for the uninsured is 242. Compare that to out-of-pocket expenses of the insured of 211; on the surface it does not seem like insurance is doing much good in reducing out-of-pocket expenses. There are other pieces to that, which we modeled, included in the analysis. There is variation in out-of-pocket expenses; the difference in utilization, which I think is very important -- this 681 versus 1,272; and then also presumably, some form of disutility that the uninsured have in being a bad debt charity case, whether this is waiting in queues or such.

With these MEPS results that I highlighted earlier we did two things, one of which is examining these take-up rates as a function of these reservation prices for insurance. And what we did is compared them to premium quotes minus a hypothetical \$1,000 credit. These results are what is presented in this NBER working paper, which I think you have access to as well. David Song is a co-author on that as well. He helped us obtain these premium quotes off the Web.

In an earlier paper with Mark we used this MEPS data as well to somewhat assume, or suppose, that the charity care safety net still exists and we provide these \$1,000 credits for people to buy insurance. We ask the question, assuming this person just bought a \$1,000 insurance plan -- a pretty bare-bones plan -- what plan would be optimal for them? And, like I said, assuming

that this charity care network still exists, we found that the individuals might prefer a moderate deductible, or moderate cap, on benefits. The cap on benefits is that when they use a lot of care and use up the amount of insurance that is available, then they can, perhaps, rely on charity care.

With that, I will take a seat and listen to the next couple speakers. Thanks.

(Applause.)

MR. MILLER: Thank you, Brad.

Our next speaker is Randy Bovbjerg. Randy is a Principal Research Associate at the Health Policy Center of the Urban Institute here in Washington. He is richly experienced in many areas of health care, including public medical programs, private insurance, safety net care, the changing medical marketplace, public administration, regulation, and the law. Most recently, he has led several State- and local-level case studies for the Urban Institute's Assessing the New Federalism Project, which includes changes that affect safety nets for health care.

Some of his recent publications -- a couple of which we have copies of outside -- include, "Health Care for the Poor and Uninsured After a Public Hospital's Closure or Conversion," another study, "Market Competition and Uncompensated Care Pools,"

and another one, "Health Insurance and Health Access: Reengineering Local Safety Nets."

Before coming to the Urban Institute, Randy was a practicing State insurance regulator in Massachusetts. Those regulators just keep practicing until they get it perfect, or imperfect.

(Laughter.)

MR. MILLER: He was educated at the University of Chicago and Harvard Law School. He also currently teaches at Duke and Johns Hopkins.

Today, Randy will be discussing recent trends in safety net care as communities have moved away from reliance on public hospitals and explored other means to pool the burden of financing uncompensated care for the uninsured. One of his findings is, as Tip O'Neill had said of politics, all safety net care is local, but perhaps there's other means to spread the financing of that beyond the particular local community.

Randy Bovbjerg.

RANDALL R. BOVBJERG,

URBAN INSTITUTE

MR. BOVBJERG: How many people picked up the handout? A few. Well, I will do that, but I think I will do more talking

and less relying than I would if there were a screen up behind me.

Tom, thank you very much.

Of course, the reason I came was I have never actually been in this building; I have read about it before. I have been on the Web site but never actually been here. And the rate of payment was just irresistible. I mean, the prospect to be able to say, for 20 years now, that I got a free lunch at Cato is just overwhelming. Think of how many talks I'll be able to start like that.

(Laughter.)

MR. BOVBJERG: We have had a little bit of the background that I was planning to go through in Tom's introduction. Basically, we start with insurance as our main way that we finance access to health care. Insurance is a relatively new thing, as ways of financing go, being, really, in this country a development since the thirties. And ever since the medical societies and the hospital associations invented the Blues plans, the trend has been up, more or less, in insurance coverage. So those of who study these things, that is where we start.

Basically, through the seventies, ESI, as we call it -- the work place insurance, the employer-sponsored insurance -- went up, starting in the mid-sixties, with the Medicare and

Medicaid programs. Public insurance rose. But the high watermark was really about 1980, in terms of the proportion of the population that was covered. During the eighties and nineties, the private sector coverage -- the work place coverage -- tended to trend downward, not completely steadily, but tended to go that way down.

Since the mid-nineties or so, the public sector has gone down, partly as a result of welfare reform, a lot as a result of the improving economy; the private sector coverage has not gone up as much, and it has mainly gone up not because more employers are offering but because people are getting wealthier. And wealthier people, people with higher incomes, get more insurance.

Nonetheless, no matter how well we do, we still have this approximately 40 million people, mainly under the age of 65, who do not have coverage. And one can argue about the numbers. We were talking about the numbers in the green room in there beforehand. The latest numbers from Census -- which are now about a year-and-a-half old I think -- is about 38 million people. I left 40 million people on the slide. I think that as we stand here, that's probably about the number that there is.

For those of you that have the handout, you can look. One of the things about the localness of the problem is that there is an awful lot of variation in extent of insurance

coverage, and it varies a lot by State. In the big surveys that we have done at the Urban Institute -- the National Survey of America's Families -- we focused a lot on State-by-State variation, because this New Federalism Project that produced these nice purple reports is a State-by-State study of State and, to a certain extent, local policy. But the gaps left by private insurance and, on top of that, public insurance are substantial in many States.

Of the 13 States that we looked at, the low -- and this is 1997 -- was in Wisconsin, was about 10 percent of the under 65's uninsured among adults. It is a little better among kids. And the high was in Texas, where 27 percent of adults -- the working-age population -- lacked coverage. And the role of Medicaid varies quite a lot by State, too, but it is always relatively minor compared with the role of private coverage, which is almost all work place coverage.

Now, you start to think about, well, look at these people in the gap, how do they get care? That is the role of the safety net. One of the issues is, well, the lawyers have something to say about this. Aren't people somehow entitled to care? Isn't there a legal right to get care? And the short answer is no. Ironically enough, the only real constitutional right to care is for prisoners and mental patients, who are held

against their will. And how much care you get, that is another issue, but there is a constitutional right to it.

In terms of a legal right to access, the main national -- if you want to call it that -- entitlement is the so-called EMTALA requirement on hospitals that participate in Medicare or Medicaid, which is almost all of them -- and David could talk about this at great length I think -- that was enacted in 1985, that says if you come to a hospital in true emergency or active labor, they have to at least look you over and stabilize you for transfer, presumably to a public institution or other safety net hospital willing to take you. There is also the prospect -- although I think it probably is not too serious -- that if you turn someone away, you could face a malpractice suit if you had been found to accept the patient to begin with.

This gap in insurance leaves a lot of people who are reliant on State charity or public institutions to get care. It first really became a national issue in the early eighties, when we had rapidly rising health care costs, especially hospital costs, and hospitals really focused on what they called uncompensated care, that there was a problem of uncompensated care. The solution, of course, was that hospitals needed more money.

That's where we get to slide number 7, the two ways to feed the birds, which I have stolen from Uve Reinhardt. There is

what I have dubbed rather unfairly the AHA way, namely the American horsey way -- the American Horse Association way -- to feed the birds, give the oats to the horses. Now, a few months ago it might have been tempting to call that a trickle-down effect; you put in some oats at the top and some come out the bottom. But, obviously, in the past couple of months it's more appropriate to refer to this as the carpet-bombing approach -- just put the money out there; some of it is bound to find its way where you want it to go.

The other way to feed the birds, of course, is to take the oats and give it to the birds, which I call the NAS way in this slide, for the National Audubon Society. It is the targeted approach, the smart bomb, laser in on the target. And maybe you will only get 50 percent, but at least it is better than the carpet-bomb approach. So that is basically my attitude about how the insurance and safety net discussion ought to go. Mostly, we started with this notion of uncompensated care and it became more targeted over time. So let me talk about two types of developments that reflect that.

One of them has to do with the so-called uncompensated care pools, or free care pools, which were started in a number of States under mandatory State rate-setting. In the early eighties -- if you cast your mind way back then, despite the objections of people in this room, I'm sure -- a number of States

did mandatory rate-setting controls in hospitals, price controls. And one of the effects of that was to attempt to allow internal cost subsidies to cover people without insurance by "overcharging" people with insurance and shifting the money internally to people without it.

One of the problems of that, of course, is that location matters a whole lot, and hospitals differ a lot in their ratio of uncovered to covered people. And that's no accident. A lot of other things are made by location like that. So in these States a number of them formed pools under which hospitals all paid, or at least were obligated to pay, a uniform assessment to cover the average rate of uncompensated care in the State. And those that had above average uncompensated care then got a net payment from the pool; those with a below average amount of uncompensated care were net payers into the pool.

And that worked fine for a while. But under competition it has turned out to be difficult. There are also some pretty bad incentives, as you can imagine. If you may more for uncompensated care, you tend to get more of it. In many of these States where there was beginning to be more price competition, and certainly Medicare was controlling prices much better in the late eighties than in the early eighties, hospitals were getting more from the pools in some cases than they were getting from their other payers.

That arrangement broke down with deregulation and the end of mandatory rate setting. These States, in general -- not Maryland, but in general -- the States said, okay, well, let's go to competition, let's negotiate, let's let the market work to hold down hospital prices. But that left this old problem with a new vengeance: if we squeeze down on payments, then who is going to cover the poor and the uninsured?

So the States that were examined in this paper explicitly decided, well, we are getting rid of rate setting as a price control device, but we want to keep this associated device of the pool to create some equity across hospitals in who bears the burden of paying for people without insurance. And over time they moved from the carpet bombing of the uncompensated care approach towards a more targeted way of delivering the dollars.

For the most part they retargeted the funds from uncompensated care as a general matter, which includes bad debt of the people who are over 300 percent of poverty, to targeting on people who really needed it, covering only emergency bad debt and free care for the people who are uninsured, and low income who had no opportunity to pay. So they targeted really on charity and emergency bad debt rather than uncompensated care.

They also tended to target more on true safety net hospitals by jiggering the formulas so that places that were higher in need got a greater percentage because the total pool of

funds were shrinking relative to the need. They have also brought in some non-hospital funding, usually by tapping assessments on payers, health plans, including the self-insured, which in the case of New York set a precedent under ERISA law, which is still influencing events at the State level.

The story continues. This is a constant battle at the State level. There is a lot of tension between maintaining support for this redistribution and being able to afford it. The more you are taxing a broad group to target on certain needy people in certain needy hospitals, the other hospitals that are paying tend to complain. So this has been a battle back and forth in the different States and was part of the reason for seeking different funding sources.

Another thing has been that there has been a lot more emphasis recently on expanding insurance. That takes State resources, too; and so there is kind of a tradeoff between putting resources into the safety net versus putting resources into insurance. That tradeoff is over-emphasized, I think. In work that is underway now, my colleague and boss, John Holahan, is finding that States that are high in insurance -- namely Medicaid -- are also high in safety net contributions. It is not really at all a one-for-one tradeoff; there is a positive correlation between the efforts.

At any rate, pools are an intermediate option between relying on completely targeted safety net help for public hospitals, say, and covering insurance. Because nobody thinks that States can cover everybody. So in between you can target to some extent, you can give broader access to some extent, and it really is a reasonable option, I think, for States that have a relatively broad-based safety net and are not reliant on a few public hospitals.

Let's pass from that to the other type of targeting that has occurred, that is really something that surprised me. We started a project about three to three-and-a-half years ago to look at what happens in communities where a public hospital closes. There are people who have been in this for a long time who remember when San Diego or Philadelphia got out of the business. And more recently, in the mid-nineties, several localities got out of the hospital business in one way or another. We went to three of them. We went to Boston, where they privatized. We went to Tampa, where the same hospital continued operating yet itself privatized; in Boston, it was privatization by a merger. We went to Milwaukee, where they shut down the public hospital, basically selling it to the next-door private hospital.

The story originally was expected to be, okay, the public hospital closes, what happens to the other hospitals?

Because one of the factoids out there is that the people who are most opposed to closing a public hospital are not the poor and the uninsured but the CEO's of the neighboring hospitals. They are worried about kind of a doughnut effect. You take the center out, and the people are going to migrate out to them. And then they will be stuck with the uncompensated care, and they are not public and do not get as much money.

What we found was that this really was not that story at all, though it did happen to a certain extent. There was a little bit of a shift towards the surrounding institutions. The story was that these three communities, at least, had gone to considerable effort to have a different safety net model. Those are laid out here in slides 3 and 4. In Milwaukee and Tampa, they were more like managed care insurance, where people enroll and sign up, where the locality runs a quasi-insurance and enrollment arrangement. They do not have a risk-bearing HMO-type arrangement; it is a direct contracting model, and they differ in their eligibility requirements and so on.

But the interesting thing is that they really went about this systematically. They said, well, if we don't have the public hospital anymore, what are we going to have? And they did reengineer the safety nets quite consciously.

The same way in Boston. The City of Boston, like the other places, was fairly glad to be out of the payment business,

because the Boston City Hospital had been a direct city department, and profits and loss flowed right through. And for a while it was a lot of profits, but it was a lot of losses in the nineties. So they were somewhat glad to be out of the business. But they really believe in health care in Boston -- it is like another universe up there -- and they set up a system where the newly privatized operation, with a neighboring university hospital, does the same kind of stuff, but, again, has a managed care program. They got a sweetheart deal, with a Medicaid waiver, that allows them to finance that much better than is available in many other places. But they have started systematically trying to manage the care of people without insurance.

Again, they try to get people to enroll; they try to keep people out of emergency rooms. It is certainly the case that the uninsured get a lot of care, but it is also the case that they get a lot of care that comes quite late. They have an awful lot of what in a normal managed care context would be called inappropriate utilization; that people are coming to a emergency room or they are getting a procedure that could have been avoided with good ambulatory care. So these operations try to do that.

The preliminary results, at least as we could get them qualitatively, are pretty good. And even the advocates for the

poor would tell us that access and quality were pretty good, and people knew where to go. They now had a clinic that they could go to rather than driving across town to the emergency room. And for the people who were enrolled, that was pretty good. But the enrollment is quite limited in most of those States; it is broader in Boston.

The hospitals do still act as a safety net, the surrounding hospitals, for all those people who are not covered. And it is always a minority of the uninsured who are covered. And there is at least thought to be a somewhat less open door, in Milwaukee at least. In the other cities we were told, no, it is no different than it was when these institutions were public.

The early indications were that the care was more appropriate, that there were more early interventions and fewer frequent flyers in the emergency rooms. There is also, however, a lot of enrollee turnover. And it appears that, even if the premiums are free, that can be too expensive. People do not necessarily re-enroll. You have to go after them. Oftentimes it is the providers that do that.

The fiscal results are pretty positive for those localities. Most of them save money, and sometimes a lot of money. And they converted, really, an open-ended entitlement, which is what a public hospital constitutes -- it has a budget, but there are lots of demands to expand that budget -- they

converted that to a closed-end, more financially-based operation, something more like insurance, and the bond markets recognized that. And they stopped saying, well, they have this public hospital and they are in trouble. That saved them a lot of money on their borrowing ever after. So in Milwaukee, for example, their borrowing to help pay for the new stadium for the Brewers was cheaper.

The good news is, fiscally, for the localities, this was good. The programs are performing better than expected in the kinds of ways that you might expect. Well, what is the bad news? I think the bad news is that although maybe this is a better mouse trap, that it is better to target to resources, that it is possible to manage care for people who really need some management, the world is not beating a path to this door. And part of the reason, of course, is the customers are not paying customers. But the localities are not putting in more money because they have a good model. They're holding the line, basically.

And we did go to San Diego and Philadelphia, where this type of thing happened much long ago. And there, the long-term record, from the point of view of the advocates of the safety net, is not so great; the public support has tended to dwindle over time. So for whatever you want to say about the carpet-bombing approach and throwing money at the public hospital

type approach, the bricks and the mortar and the private sector demanders for public support are helpful in keeping the budget up. The good news is you could be more efficient; the bad news is you may get less money as a result of that.

One of the conclusions I reached was that while this was local and the needs are very local, but local funding just is not going to do the job on this. No one locality can do this. In Boston they have a lot of State money and then also a lot of Federal money because of the Medicaid waiver. That is not true in Tampa or Milwaukee, but a little bit true in Milwaukee. They worked a dish fiddle to get some more Medicaid money and thereupon took some more county money out of the pot. But I think that, as with local education, where there is a recognition that there is a real State interest in equalization across areas, that is certainly appropriate for safety nets but that is not generally the rule. In general, there is more local spending.

So the final thoughts in my final five seconds here are that I still would go for insurance; that that is better targeted and lets people control their care. There are arguments, which I am not getting to, about a lot of poor people who are chronically problematic and have few social skills and maybe need more help than an insurance policy can give them. That is a whole other discussion than this one.

It is also true that safety net efficiencies are possible, but the need is just overwhelming compared to what local resources can be brought to bear. And I think that it is only getting worse absent policy change. So my conclusion is, if you want to take care of people like this, even at the level of one-third or one-half, we are probably going to need broader and higher governments involved.

Thank you.

(Applause.)

MR. MILLER: Thank you, Randy.

Our final speaker is David Hyman. David received his B.A., his J.D., and his M.D. from the University of Chicago. He is also currently a professor at the University of Maryland Law School. He has been a visiting professor at the University of Texas and George Washington University Schools of Law. He teaches health care regulation, health law, insurance law, civil procedure, professional responsibility, and tax policy.

And he has published articles on a wide variety of issues relating to the regulation and financing of health care, including one that you have, an article in the Villanova Law Review from 1998, "Consumer Protection in a Managed Care World: Should Consumers Call 911?" That article examines in some detail emergency room health care and the legal mandates to provide it for free.

Prior to becoming a faculty member, David was a associate at Mayer, Brown & Platt in Chicago. He practiced in the areas of tax controversy and health care law, and he has done both trial and appellate work. He is a member of the Illinois and District of Columbia Bars and the American Law Institute.

Today he is going to be discussing the unfunded Federal mandates that EMTALA, the Emergency Medical Treatment and Active Labor Act, imposes on hospitals and some of its effects, such as much greater utilization of expensive emergency room care for non-emergency conditions. Or as Yogi Berra once said of a popular restaurant, "Nobody goes there anymore. It's too crowded."

David Hyman.

DAVID A. HYMAN,

UNIVERSITY OF MARYLAND SCHOOL OF LAW

DR. HYMAN: Well, I don't think I can top Yogi Berra, so I will not try.

We have heard a fair amount so far about the deliberate safety net and the crowd-out or incentive consequences that can result. I am actually going to talk about a slightly different part of the safety net, which I think is more fairly characterized as the accidental safety net.

EMTALA, or, as Tom has reminded us, the Emergency Medical Treatment and Active Labor Act of 1986, was a statute that was designed to address a problem known as patient dumping. And the way that it was addressed was with a law that prohibited discrimination against individuals in treatment based on, really, any criteria, including ability to pay. And that ended up being transmuted into a safety net for broad access to not just emergency care but inpatient care more generally.

Now, some of you in the audience probably know Bill Sage, who is a professor at Columbia Law School, and a good friend of mine. I told him yesterday I was going to be speaking here about EMTALA, and he said, well, tell them it is a great law and Congress should pass more like it. I am not going to say that, although I have a certain fondness for EMTALA because I got tenure partly on the strength of an article criticizing it, and more of the same instances in store for today.

Before we talk about the incentive consequences, I just want to sketch out how the law works more generally. One of the handouts is the actual text of the statute, and I will just go through the basic framework.

EMTALA is a law that is tied to the receipt of Medicare money by hospitals, so it is a spending power allocation. But its scope goes far beyond Medicare beneficiaries and it includes everybody. And since pretty much all hospitals take Medicare

money, it really binds all hospitals. What it says is that if someone comes to a hospital that has an emergency department and requests examination or treatment -- so the first step is you have to actually come to the hospital -- the hospital is required to provide, what I have underlined in the statute, an appropriate medical screening examination. And if they determine that the individual has an emergency medical condition, they are required to either stabilize the individual or provide for what is described in the statute as an appropriate transfer.

All of these terms have specific statutory definitions, which, as it happens, do not really map neatly on to how physicians think about treatment. And if the individual is unstabilized, the hospital is prohibited from transferring the individual either to another hospital or to anyone else. And the way the statute is structured, that includes discharging them. So you cannot send them home if they have an emergency medical condition which you have not stabilized.

And there have been all sorts of border fights about the meaning of the particular language. We can talk about that in the questions if you want but the basic insight here is this reverses the no-duty rule that those of you who went to law school are probably familiar with, and obligates hospitals to treat people regardless of their ability to pay, or anything else for that matter, if they have an emergency medical condition.

You cannot delay treatment or examination to inquire about their ability to pay or their insurance status. And if the hospital has specialized facilities, like a burn unit, a neonatal intensive care unit, or a trauma center, they are essentially required to accept all transfers from other hospitals as long as they have capacity. And on-call physicians who are not physically present in the institution, or employees of the hospital, are subject to its provisions as well.

Now, this is enforced by a bunch of different provisions. First of all, the Office of the Inspector General can impose civil penalties on hospitals that violate the provisions, ranging between \$25,000 and \$50,000 per occurrence, and similar penalties on physicians, \$50,000 a time. There is also civil enforcement. Individuals can bring a lawsuit against the hospital -- not against physicians, but only against the hospital -- and obtain damages for personal injury. The physician can be excluded from Medicare for violating the provisions, as well, and the hospital version of that is termination of the provider contract. Now, since most hospitals get about 30 percent of their total income from Medicare, this is obviously a very big penalty with which hospitals can be threatened.

What the statute effectively did is it created a right to obtain care regardless of ability to pay; essentially, free

emergency department care and potentially other care within the hospital. And I think the widely shared assessment at the time was that this was not going to be a huge burden on hospitals because it was a problem that was relatively minor -- all hospitals were not dumping everybody -- and the distribution of the costs that would result would not be a significant burden. That is not really how it has worked out, partly for reasons I think Randy sketched out in his comments. I am going to talk about it first from the demand side perspective -- that is from patients -- and then the supply side -- providers, hospitals, physicians.

The first problem on the demand side that I will be talking about, although not the first problem that materialized, was the insured problem, with the rise of managed care. EMTALA, remember, was intended to deal with dumping. Hospitals did not historically dump insured patients; they dumped uninsured patients. But the interaction of EMTALA in managed care created some very interesting problems.

Managed care organizations, or MCO's, tried to limit utilization of an emergency department for a couple of reasons. First of all, they viewed it as very expensive. Second, it was intermittent, so continuity of care was not really going to be sustained. And, third, there were a number of studies that indicated most emergency care provided in an emergency department

was not really for an emergency. So it was unnecessary utilization, at least in that context.

So MCO's developed a number of different strategies to try and deal with this, including requiring pre-authorization before they would agree to pay for the care; retrospective denial of claims; demand management, so call up a nurse and explain your symptoms and they will attempt to determine whether you really need to be seen in an emergency department; and selective contracting -- if you go to this emergency department, we will pay a lot for the care, and if you go to this other one, we will pay very little or perhaps not at all.

So the problem that that creates is, for patients at least, their ability to call 911, go to the hospital and be treated. Suddenly, although the ability to be treated is maintained by EMTALA, the ability to have it paid for, which is the function of the insurance contract, is suddenly very much an issue. And what results is EMTALA creates a situation where managed care organizations do not have to spend much at all on emergency care because they know the emergency departments are required to provide the care. So you have a real free-rider problem that is suddenly created. Managed care organizations can free-ride on the existence of emergency departments.

Secondly, you also have the possibility of patients free-riding; that is, agreeing to be subject to very restrictive

managed care contract terms limiting their access to emergency departments, and then showing up at an emergency department, knowing that they can get the care and not having to worry about the cost. So you have simultaneous free-rider problems going on, both of which create real difficulties for hospitals from a financial perspective -- and more about that in just a minute.

The States tried to deal with this problem by passing a number of statutes. It really does not solve the problem. The Villanova article that Tom referred to goes into this in great detail.

Now, let's talk about the uninsured, who EMTALA was supposed to help a lot. The difficulty here is, if you are uninsured, you historically went to the emergency department in order to obtain care because it was more or less the only game in town. But to the extent that you start developing other mechanisms for delivering the care -- the sort of thing that Randy mentioned -- EMTALA actually makes it very hard for you to divert people into that unless they choose to do so voluntarily, because they know they just keep going to the emergency department. So the sort of cultural norm that you get your care at the emergency department is going to be very hard to break if they are obligated to provide care. That is part of the problem.

I think the more significant problem is if you look at the supply aspects of this, which is the uninsured get access to

care through emergency departments, but if EMTALA's long-term consequence is to decrease the supply or the availability of that care, they have traded off short-term access against long-term losses and capacity. And if you look at emergency departments, you see substantial overcrowding and queuing costs that are imposed on the uninsured that were certainly there when EMTALA was passed but they are much worse now. And there are a variety of reasons for that. You cannot lay all of the blame on EMTALA, but I think the incentive consequences are quite clear.

Now, let's talk about hospitals, the supply side. The real problem here is that the cost of compliance with EMTALA vary tremendously. And they vary because of the demographics of the patient population that is served by the individual hospital, and how sick they are, and how good their insurance is.

For example, in Maryland, if you contrast Shock Trauma with GBMC, Greater Baltimore Medical Center, or any nice suburban hospital, you will see a huge disparity in the amount of money that is spent by the hospital on uncompensated care. In Maryland, if you look at hospitals, the lowest spends about 2 percent of its budget on uncompensated care; the highest spends about 20 percent on uncompensated care.

You also see huge State-by-State variations. The Northeast has much lower rates of uninsurance than the South and the Southwest. Rhode Island, actually, right now is the lowest,

at about 6 percent of the population. New Mexico is the highest, at 21 percent. So there is a huge variation in the burdens imposed by EMTALA if you are a hospital in Rhode Island than if you are one in New Mexico. And I have a really cool Power Point slide that shows each of these, but I was prohibited from using it on technological grounds.

You have similar sets of difficulties with the kinds of care for which hospitals systematically take losses. Burn units do not tend to do very well. And you see, as a result of EMTALA, which creates an unrestricted entitlement for utilization as long as you have capacity, a pretty clear incentive not to expand and to think about constraining. Neonatal intensive care units actually point somewhat in the opposite direction because the mix of patients receiving care looks very different, so they get paid for that. EMTALA has not really had as big of an impact on NICU's as it has had on burn units.

Next, you have a sort of boundary problem; that is, how broadly do we think about EMTALA operating? What does it mean to come to the hospital? For a long while it seemed to be pretty clear, to come to the hospital, you had to come physically to the hospital. But over the last few years there has actually been an expansion of what EMTALA's scope means; first, to encompass 250 yards around the campus. So it is no longer physically in the emergency department; it is the furthest building, 250 yards out

from there. And then you obviously start to have people going out with tape measures trying to figure out where it is that their obligations end. And that creates real uncertainty costs for people who are involved.

You have a similar problem with ambulances. If it is owned by the hospital, then you come to the hospital as soon as you are loaded into the ambulance. If it is not owned by the hospital, you have not come to the hospital unless you are in the 9th Circuit and you use a radio to call and are told, whether you are on bypass or not, the physical contact is going to be sufficient. So there are all sorts of complicated consequences that I do not think anybody really thought very hard about in 1986.

There is a similar problem with off-site, outpatient centers. That is obviously not an emergency department, but you have similar sorts of problems. The big issue is really capacity -- when hospitals go on bypass, what are the consequences from an EMTALA perspective? Really, the incentives system, though, I think is pretty straightforward.

Now, how about physicians? Well, the answer to this depends on when you ask the question. If you asked emergency department physicians between about 1986 and 1990 whether they thought EMTALA was a good idea or not, they were ecstatic about it, because suddenly they had a mechanism to force specialists to

come in and treat patients; whereas, previously they did not have any legal sanctions to encourage that.

I think the picture looks a lot different now, partly because of the crowding problem, partly because if you are a physician that has privileges at a hospital but you do not want to see patients there because of EMTALA, the incentive is to decrease the number of hospitals at which you have privileges, and, perhaps, not to have privileges at a hospital entirely. And you have actually seen real consolidation in the patterns of distribution of where physicians have privileges. People basically just exit when they are forced to take all-comers without the ability to be paid.

Now, to some extent that is not a bad thing, because the more concentrated your practice is, the more likely it is safety issues are going to be satisfied. But you are really trading off safety and quality against access. There is also lots of uncertainty about the scope of EMTALA among physicians.

How about enforcement? I think the intention was certainly to deal with really flagrant dumping, but the statute has ended up becoming a way of enforcing quality of care in the emergency department. Most of the civil cases involve very thinly disguised malpractice cases. And if you look at the civil penalties, virtually all of them involve disputes about the

quality of care that is rendered, not whether the patient was really dumped.

I spoke here four months ago about HIPAA and fraud and abuse. This is actually, like Randy, my third time here this year. I don't know if I get the gold star. At some point, it is no longer a free lunch I guess.

But the sorts of complaints that people made about the fraud statutes -- that is, big sanctions allow the government to extract favorable settlements, essentially extortionate behavior -- was the assertion of providers. You see the same sorts of complaints here. When the government can yank your Medicare contract, no matter how firmly you believe you have not engaged in an act of dumping or anything that violates the statute, you essentially have to fold. It is just not worth the risks that are associated with fighting on that. I think a similar problem is that the region of the country you are in has a great deal to do with how vigorously EMTALA is enforced.

So let me just wrap up. Let's just walk through the incentive structure that EMTALA creates. For patients, it is sort of a mixed picture to some extent. But if you did not have access before, your incentives are it is free at the emergency department and so you might as well go as often as you like. Certainly the import of the RAND study is that free emergency care gets used more often than emergency care with even a

relatively modest co-payment. In the long run, though, you are looking at decreases in access. And so it really depends I guess on your discount rate.

For physicians, the incentive is to affiliate with as few hospitals as you possibly can. And if you can figure out a way to be unaffiliated, you avoid EMTALA's burdens entirely. For hospitals, because they do not make up on volume what they lose on every transaction, the clear lesson is to modify capacity in order to limit your exposure. Now, of course, that is traded off against the possible benefits of having an emergency department open 24 hours that people come through, some of whom are paying. But I think there is really very little question that EMTALA, in 2001, bears very little resemblance to what anyone in 1986 thought they were getting.

So the last point is, what shall we do about it? A lot here depends upon what you think the paradigm case is that we are trying to deal with. Is it the person who shows up at the emergency department bleeding and with no insurance who is booted out or sent to the public hospital, or is it, depending upon the study, between 30 and 70 percent of ED utilization that is inappropriate? I think how you come out on this depends a lot on your picture going in.

Since we are in the Hayek Auditorium, I think the answer that we have to start with is to repeal the statute in its

entirety and start from scratch in doing a deliberately designed safety net rather than an accidental safety net.

I see Bob is in the audience. If he had asked me to give this talk at AEI, the answer there I would give would be to repeal it for the insured. Because what has happened with EMTALA is it really has not made things better for the insured; it has actually made things much more complicated. And then figure out a way to pay for the uninsured rather than trying to depend on mandates to do it.

Since we are in Washington, neither of those things is going to happen. So I think the right thing, from a policy and political perspective, is to build on what we have, which is tax exemption for some hospitals and a strong community obligation that many of the others feel tie the obligation to provide charity care to tax exemption; meter it based on the value that the institutions receive; allow for private contracts to coordinate the provision of charity care through outpatient clinics, community clinics, the sort of purchasing pools that Randy was talking about; but you really need to figure out a way to back off the open-ended commitment that EMTALA represents.

Thank you.

(Applause.)

MR. MILLER: Thank you very much, David.

As I mentioned earlier, we are missing our final scheduled speaker, Richard Carlson. I will just mention briefly, the State-based, high-risk pool concept, which he would have illustrated, there are about 29 States that have one version or another of high-risk pools. Some of them were doing that in response to the 1996 HIPAA requirements, beyond their more traditional coverage. But the core of the high-risk pool was to cover the so-called medically uninsurable individuals, who would face either extremely high premiums or the inability to get private health insurance under any circumstances. And the high-risk pool, in effect, caps the premium payment by the individual, and then subsidizes the remaining costs, ideally through some type of general revenue financing.

And, if adequately financed, as is done in Illinois, it has had a pretty positive record. It allows the individual insurance market to do what it does and operate efficiently, while carving out the high-cost individuals who are beyond the capacity of the individual market to handle. Otherwise, the alternative is to load those costs onto other voluntary purchasers in the individual market who tend to drop out when the cost gets too high.

We would like now to go to some questions from the audience. If you could wait for the microphone to come to you, and identify yourself when you have a question for one of the

speakers. If you wish to voice a lengthy commentary, you may revise and extend your remarks for the written record, but in the short-term please address a direct question to one of the speakers.

MR. SMITH: My name is Gordon Smith. I am a builder and developer in the local market here.

A question for Mr. Bovbjerg. I enjoyed your little chart here. Actually, there is a Cato way to feed the birds also. And that is, you don't feed them; you let each one develop the best they can. Which led me to another thought. Instead of providing insurance for my employees, why don't I cut it out altogether, since two-thirds of any of their costs are going to be picked up free?

And why don't I have a Ms. Jones here who tells them where the best place to go is? And I can increase my carpenters from \$30,000 to \$33,000, because it costs me \$3,000 for medical. And I will get the best carpenters, build better houses, and the carpenter is on his own to get his health care, which he has \$3,000 a year to build up, so he eventually pays for it.

MR. BOVBJERG: What you are describing has a new name. People are talking about self-directed health care. With the exception that people really do need insurance, there are lots of very expensive bad things that can happen at the catastrophic end, as Brad was alluding to. And, of course, it is nice to

encourage people to go in and do the things where medicine actually does do some good, when it is timely. So both at the very high end.

And at the low end there are some real advantages to having insurance coverage. The notion is that one could provide that through insurance, and then give people the 10 percent of their money, maybe tax sheltered if that is acceptable, and let them direct the care themselves, possibly with help from a lot of management tools that would be made available through the Internet and all kinds of other good things. That is a new model. Whether that will succeed in winning adherence and then actually working, we have to wait and see.

But that is absolutely right; people ask that question. And it is a huge burden. Certainly, at the Urban Institute we see the same thing. There is a percentage loading on our salaries that goes to benefits and it is very direct.

MR. MILLER: Another question from the audience? Bill Niskanen.

MR. NISKANEN: Bill Niskanen, Cato.

David, what is the magnitude and pattern of hospitals completely dropping their emergency rooms?

DR. HYMAN: Well, that was, of course, the obvious immediate strategy, which the obvious bureaucratic response was to say, "We don't care what you call it. As long as you open

your doors, you've got an emergency department." And the short version is it covers all hospitals whether they have an emergency department or not. So you cannot evade it in that fashion.

You can make life much more difficult by decreasing the number of beds in your emergency department or whatever you choose to call it. But hospitals that do not have what anyone would call an emergency department have been found to be in violation of EMTALA because of that sort of classic response to the obvious initial stratagem. So closing your ED does not get you out from under it. Closing entirely will, but that is not a strategy that lots of people like.

MR. MILLER: Another question.

MR. NELSON: Wayne Nelson from Communicating for Agriculture.

I have a question for Mr. Herring concerning tax credits. Or two questions I guess. One, I did not get a chance to look through your whole paper on tax credits. Do you have a general amount you think that would be needed to really substantially decrease the number of uninsured? Secondly, do you have another vehicle that would do more than refundable tax credits?

DR. HERRING: Regarding the first question, we generally found, to start off with, that a tax credit that was in the neighborhood of 25 percent to a third would probably do

nothing. Because, essentially, the uninsured currently have the opportunity to work for a firm at lower wages, and there is a tax subsidy there in the form of its exemption. And then, moreover, there is a difference in loading between the individual market and group market. So we first came up with the conclusion that, under 25 percent, or in that neighborhood, would probably do nothing.

Then as we raised this credit to about 50 percent of the premium, some of our more optimistic simulations indicate that maybe as many as 50 percent of the uninsured might actually obtain coverage. There is a lot of variance in our estimates based on different assumptions we make about parameters. But, at the end of the day, it really might be the case that a tax credit covering half of the premium might do that much good.

I think there is also some uncertainty with how much do individual insurance premiums actually cost. In some of our previous work we just took industry loading of 40 percent of premiums and did some simulations that way. With this new paper we looked at quotes that were obtained off the Web. And I think we generally thought that those quotes we observed were lower than most of us thought in general. I guess the question now is, are these quotations that you can get off the Web, are they really genuine offers to sell? So if a high-risk person actually

goes through the process, how much underwriting might exist? And to that question, I am not really sure.

Another vehicle is obviously to move to a publicly-provided system. In some sense, I consider myself an analyst and do not really have a preference one way or the other. But I think there is legitimate economic arguments that can be made for public provision of certain things. I do not know if that is a popular statement to make here. But I guess, at the end of the day, there are all sorts of different alternatives out there, and it depends on, I guess in some sense, your preference for equity versus efficiency, and reasonable people differ.

MR. MILLER: Brad, in pushing against that kind of tradeoff, where we are currently in the possible tradeoffs or crowd-outs between charitable care, free care, safety net care and trying to stimulate greater private health insurance, are we at the point where one substitutes for the other, or can you do a little bit of both, or where are the offsets given the elasticities that you found in your work?

DR. HERRING: That is a good question. I should say that the results I found as far as this crowd-out effect of obtaining private coverage, as a function of how much charitable care is available, they are significant but they are somewhat small. So you can look at that two different ways.

One way is if we actually do a fair amount of work in strengthening the safety net, perhaps looking at which communities are doing a good job and which are not, sure, that might increase the number of uninsured. But at the end of the day I would guess that that increased amount of care that we provided to the uninsured is greater than the costs that we have incurred by increasing the number of uninsured.

And somewhat the corollary of that is if your idea is to say, well, we are going to just increase the number of people obtaining coverage by pulling out the rug of charitable care, my results would indicate that that is not a good idea, and the number of people who are currently uninsured that will be induced to buy insurance, based on that hardcore policy, would be small.

MR. MILLER: The flip side of that, though, would be which is the better buy? Do you get more health care by targeting resources to an enhanced safety net, or is it extremely expensive to try to subsidize greater insurance coverage levels without delivering presumably more health care?

DR. HERRING: I think that is still somewhat unanswered -- how much good does insurance do for people and how much good does it do for the healthy people who are probably skimping on preventive care versus how much it might do for the high-risk people who perhaps are receiving care right now? I think that is just an unanswered question.

MR. MILLER: Well, I will be working on that in a few weeks for Bob Helms over at AEI.

DR. HERRING: Well, send me a copy.

MR. MILLER: Another question from the audience? Ed?

QUESTION: Mr. Bovbjerg, in talking about the changes that occurred in the pools and the deregulation and the new sources of funding, one of the things that you touched on -- and it is in slide 9, new funding sources -- was the New York ERISA precedent. For the benefit of those of us who are not familiar with it, could you maybe elaborate on that and what the precedent was and the implications for funding sources?

MR. BOVBJERG: The ERISA case was the so-called Travelers case in New York that grew out of an argument I believe by HMO's -- David may know this more than I do -- that to put an assessment on their hospitals that they then had to pay as payers was an action that affected an ERISA plan, an employee health benefit plan and, therefore, invalidated it; that the federal law, ERISA, preempts State law that impacts health benefit plans. What the Supreme Court ended up saying was, wait a minute, they could not possibly have really meant that. That sweeps everything. That means traffic tickets that are imposed on the street in front of the building could not be given, that quality of care requirements could not be imposed.

So they loosened the previously fairly hard line that courts had taken about what was preempted by ERISA. Previously, I think the basic principle of ERISA interpretation was, if you are a State, you lose. After that, it became, yes, if this is part of a general scheme and it is not specifically targeted, and so forth and so on. I am by no means adept in ERISA interpretation. You have to pay quite a lot per hour for quite a few hours to get the chapter and verse on this; although, David is clearly willing to speak for free.

MR. MILLER: That is a PPO discount that Cato has negotiated.

DR. HYMAN: Not necessarily on ERISA. I think there was nothing you just heard that I would really disagree with. I would just expand on it slightly by saying that after New York won the right to impose these surcharges, about a year later, they folded their rate-setting program. And once they had done that, there were not any surcharges anymore. Maryland is the only State that is still doing that.

MR. BOVBJERG: There are. There are still payer assessments, and they have to pay them straight to the State. That is how they fund the pool.

DR. HYMAN: Oh, for the pool. Fair enough.

MR. BOVBJERG: Yes, for the pool.

DR. HYMAN: But very few States are, shall we say, aggressively pursuing their new-found authority under Travelers to create pools of this sort. I think they are using it for a variety of other things. But the money is not 50 States all going after it simultaneously. They have consumer protection fish that they are using ERISA to fry.

MR. MILLER: Yes, another question.

MR. CANTWELL: Hi, I am Jim Cantwell from the House Budget Committee.

I have a question about the bright line that some try to draw between the uninsured and the insured. In fact, it is probably a fuzzy line in that some of the uninsured have availability of health care through community health centers. They may be Medicaid-eligible but not enrolled. Could you simply discuss what that 38.5 million uninsured really does mean?

MR. BOVBJERG: I guess you have two people who may answer that. I thought you were going to say, well, people are not uninsured forever and, in general, there are patterns to uninsurance. Some people are uninsured for part of the year, some are longer-term spells. These are different types of people. It is more serious for some people than others.

I think what you are saying is that the safety net can operate something like insurance -- which is just what Brad points out -- and even without explicitly trying to make it more

like insurance of the types of things that I was talking about. And that is certainly true, and it does tend to be catastrophic, partly because of EMTALA but more because of medical culture; that the more needy you are, the more likely you are to get charity. I mean, doctors don't want to see you die on their doorstep; they are much more willing to see you go without preventive care.

MR. MILLER: With the limitations of not just-in-time delivery.

MR. BOVBJERG: Right. Just-in-time delivery is probably not economically efficient.

MR. MILLER: We have time for another question.

MR. GREENE: John Greene from the National Association of Health Underwriters.

If Medicaid take-up is about 50 percent, David, I was wondering if hospitals are moving to try to sign them up as they come through the door if they are being assessed for eligibility for public programs.

DR. HYMAN: I am not sure I quite understand the question. I think a lot of institutional providers have been trying to set up their own networks to contract with Medicaid as their own sort of managed care organizations. I can certainly remember walking down the streets of Chicago and seeing signs on the side of buses saying, "Covered by Medicaid? We would like

you." And certainly that was not the historical treatment of Medicaid patients by hospitals in the City of Chicago, or much of anywhere else for that matter. But when you start doing selective contracting, you see people doing that.

Even with that, though, the Medicaid utilization rates of emergency departments are substantially higher than any other population, including the uninsured. That is where they go to get care. That is historically where they have gone. And I think hospitals have had fairly limited success in moving it out of the emergency department to a variety of other possible settings.

MR. MILLER: If there are no further questions, we will wrap things up. First, let's thank all of our speakers for this excellent presentation.

(Applause.)

MR. MILLER: When we go upstairs for lunch, you can see your own vision of the health care safety net in the various foods arrayed out there. Is it Swiss cheese full of holes, bland American cheese, cheese that just stinks, or just enough nourishment to get you by for another day?

Thank you very much.

(Whereupon, the Cato Institute Policy Forum concluded.)