Fight Under Way for Universal, Non-HMO Insurance in Pennsylvania

Steven B. Larchuk is a Pennsylvania attorney who is chairman of the Pennsylvania HealthCare Solutions Coalition and an expert on proposed legislation for universal health care in Pennsylvania. He was interviewed by Patricia Salisbury by phone, at a June 7 press conference in the state capital of Harrisburg, which was announcing the introduction of the legislation into the Pennsylvania House by State Rep. Linda Bebko-Jones (D).

EIR: Today, June 7, there are many events around the country supporting the idea of universal single-payer health care. Could you fill us in on what is occurring in Harrisburg, and its significance for the state and the nation?

Larchuk: I will be happy to. I'm in the Capitol Building in Harrisburg, where just about an hour and a half ago Rep. Linda Bebko-Jones, who is a Democrat from the city of Erie, announced that she is introducing House Bill 2722, which legislates a universal single-payer health-care reform package for Pennsylvania. What makes this particularly exciting, is that it matches a bill that has also been offered in the Pennsylvania Senate by Sen. Jim Ferlo from the Pittsburgh area, and so we have a single-payer bill that is now pending in both houses. This would be significant from a national perspective, because it isn't a plan to just increase business for insurance companies, but rather it essentially hands the insurance companies their hats and says, "Thank you very much for your service, but we will take it from here."

EIR: Can you tell us a little more on how the legislation would work? While Pennsylvania is by no means leading the nation in uninsured—I believe the figure is about 14% or about 1.5 million (I think the dubious honor of leading the uninsured goes to President Bush's home state of Texas, with something like 27%)—it is still obviously an extremely distressing figure. So how would the legislation deal with this crisis?

Larchuk: The problem is every bit as large as you describe, and even worse than that, because when you say that someone has insurance, rarely do you ask what the quality of that insurance is. A person can have a very minimal kind of coverage policy and still be declared by the government to be "covered." Yet, when when they need to get service, they find that the coverage is really inadequate. But we don't measure the inadequate insurance; we just say you either have it or you don't.

If you really measured people who have no insurance or have inadequate insurance for some portion of the year—and I'm talking about people who are *not* on Medicare—it approaches 50% or more of Americans who are not on Medicare, every year, who suffer some level of health insecurity.

How does this bill solve that? This particular bill is actually what I call a health reform cocktail; meaning you mix in several different reforms, because the health-care crisis has many different parts. The first thing we do is adopt a universal health-care plan that covers every Pennsylvanian. It doesn't matter who you work for, you can change jobs, you can be unemployed, you can be a student who is just graduating: You will be covered. We don't go through all sorts of gymnastics to qualify or disqualify people; everybody is covered. That is number one.

Number two, it is a single-payer plan, meaning that instead of a whole bunch of private or semi-private insurance companies spending a fortune to compete with each other, and then spending more money denying claims, it is a single payer that is really owned by the people; it is a trust, so that all the money that we collect to pay for health care goes into this trust, and we end up saving 15-20% of the money that is currently being wasted because of the private health insurance business. So right off the bat, we are able to fund universal health care with the money we save by just squeezing out the waste that we see from the private health-care system.

In terms of the "cocktail" aspect, this bill completely solves the medical malpractice crisis that we have in Pennsylvania, by adopting a "no fault" approach to medical errors, meaning we don't ask whose fault it was or any of that sort of thing; we just ask, "Were you injured by your caregiver?" If the answer is yes, all your medical bills are already covered because you have a universal health-care plan. And with respect to the non-medical damages, like pain, suffering, inconvenience, wage loss, those are covered through this administrative system, where you can very easily qualify for a settlement that carries you through your recovery period and beyond, if that is appropriate, without having to go through all sorts of lawsuits, hiring lawyers, waiting years hiring experts, and then when it's all over, if you are one of the relatively few

Philipsburg Area Hospital in Centre County, Pennsylvania, was closed in April 2006—one of the most recent facilities to fall victim to the "managed care" destruction of health services.

who succeed, then giving half of it to your lawyer for attorney fees and court costs. So we solve the medical malpractice crisis from the patients' side that way, and we also solve it from the doctors' side by making the funding for it part of the overall trust obligation, so that we don't ask the doctors or hospitals to write these $100,000 malpractice insurance premium checks, which are driving a lot of doctors out of Pennsylvania and toward states that limit the right of people to be reimbursed for malpractice.

And there is much more to this particular package. For example, an emphasis on a curriculum of wellness in our schools, going to a system where we treat the health and wellness aspects of education as being just as important as math or anything else, because your child's health is the most valuable asset they have or ever will have. We need to invest in that from the earliest days, and we need to finance that part of their education by providing the schools with the resources they need. In Pennsylvania, we estimate that we will have to hire 10,000 educators just to handle the challenge of teaching our kids how to take better care of themselves. Frankly, you can shrink the need, and therefore shrink the cost of health care, by creating a new generation of Pennsylvanians who understand how to take care of themselves.

EIR: Maybe some of those administrators who might be losing their jobs under this program will end up in the schools, teaching the wellness curriculum.

Larchuk: We expect exactly that to happen. It is not just the teaching part of it, but when you take a million to a million and a half Pennsylvanians who have no insurance at all, and you suddenly give them a card that says, "Okay, go get what you need," you will have a tremendous demand for health-care service that will translate into many, many high-paying jobs in the health-care industry. So you are going to take somebody who maybe spends their day looking at a computer screen all day in an insurance office to deny claims, and you can say, "Your job is no longer needed, because frankly your company has been outsourced to a trust. But don't worry, you are not unemployed." The bill provides within it the funds to transition people who are displaced by the legislation into new careers and particularly health-care careers. So you can take that person and maybe they'll transition into health education, or maybe you transition them into becoming a counsellor for a substance-abuse clinic, which is something that would be fully funded for the first time. Maybe they decide to go to nursing school. We have a college I know in Pittsburgh, for example, where if you have just about any kind of a four-year degree, with an additional one year,you can qualify for a nursing degree. So there are tremendous opportunities for people to go from basically clerical, "no future" kinds of jobs, to actually helping people, to being part of a solution instead of part of a problem. And we fund it so that no one should miss a meal because they have been misplaced as part of the adoption of a single-payer system.

EIR: I've noticed that the issue is raised in the legislation of the incapacity and lack of flexibility in the current health-care system, in responding to man-made or natural disasters, which clearly is something on everyone's mind these days. How would the legislation increase that capability and flexibility?

Larchuk: Let's take Hurricane Katrina as an example. The health-care infrastructure, meaning the hospitals and the doctors' offices and the records, were all literally washed away. You have a situation where the people who were unemployed, and who were counting on employment for their health insurance, have no health insurance. You have no funding source, because there are fewer people to theoreti-

cally use the service, and then pay for it. This showed the vulnerability in a natural disaster situation, where private health insurance, the illusion that the employers provide the coverage, is not working, and it can't work, because the whole system has been knocked on its ear. If you were to change that and fund it with a tax-based system, with a tax dedicated to health care—nothing else, not to be raided by the legislature for roads or God knows what, as Congress has raided the Medicare trust fund for so many years—if you have a large-scale disaster like Katrina, the rest of the state can easily be called up to contribute a little bit more, just by racheting up the tax from 10% to 11% to 12%, to help get up over the funding crisis, and then as things get better, you can reduce it. It is very flexible, like the handle on a faucet: When you need a lot you open it, and when you need less you turn it to a lesser degree: That is how a dedicated funding taxing approach can be manipulated to generate the cash you need. And then if you have a sudden emergency, like Katrina or a nuclear terrorism attack somewhere in California, we could very quickly adjust the funding source. We need to have a funding mechanism for health care that can be turned up or down depending on the urgency of the situation.

EIR: This magazine has editorially endorsed, for a long time, the idea of a return to Hill Burton standards, a Federal mandate for required per-capita health-care infrastructure, county by county, in the nation. And we have documented the decline of this infrastructure in every aspect: community hospitals, public hospitals, health-care personnel, and so on. We have some fairly dramatic graphics that show, for example, that when Hill Burton was instituted in 1946, the number of hospitals in the country began to increase; and then when HMO legislation came in around 1973-75, you can see a sharp, sharp decline in the number of hospitals and other aspects of health-care infrastructure (see **Figures 1-3**). I notice that the legislation has a fairly lengthy section on the infrastructure question. Can you comment on this issue of infrastructure, and what you expect or desire on the infrastructure front?

Larchuk: One of the many problems with the health-care systems that we have in place nationally, is that we encourage an over-concentration of high-tech equipment in cities and don't really have it available in the more rural counties.

States Scramble As Health Care Collapses

On June 7, hundreds of citizens throughout the country rallied to dramatize the collapsed state of health care in the United States and to support Federal legislation establishing national single-payer universal health care legislation, HR 676, initiated by Rep. John Conyers (D-Mich.). (For a roundup of activities, see last week's *EIR.*)

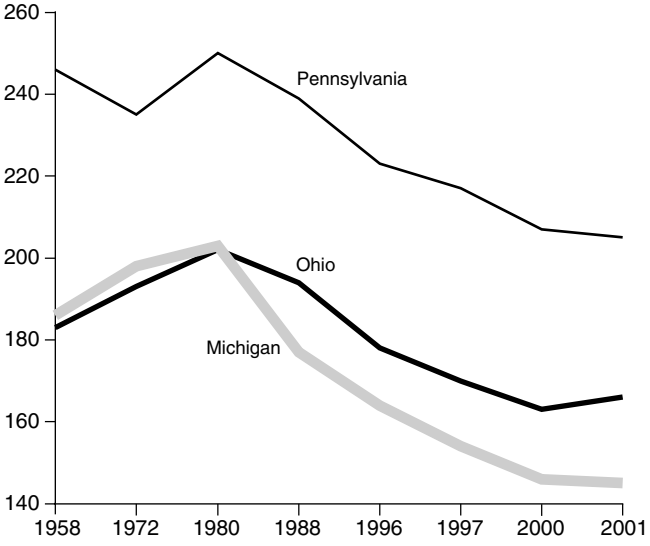
Reports are coming in from around the country on the accelerated collapse, including desperate attempts by local officials and health-care professionals to provide care to the 46 million uninsured and millions more underinsured. All kinds of arrangements are being made—donated time from physicians, health departments, etc.—as thousands more people daily are losing any form of health insurance. There are about 2,000 free clinics in the United States, according to the National Association of Free Clinics. Its director, Bonnie Beavers, told the *Syracuse Post-Standard,* "I'm sorry to say, we are definitely a growth industry. As more and more people join the ranks of the uninsured, more and more free clinics are springing up in communities where people are not content to sit by and watch their neighbors fall through the growing hole in the health-care safety net." Even in one of the wealthiest and fastest-growing counties in the nation, Loudoun County, Virginia, the local press is reporting 1,500 uninsured in the county—a very low estimate—and that two free clinics will be in place by Fall, one run by donations and the other by the County Health Department. The Loudoun County Health Department Director, Dr. David Goodfriend, described the situation in an understatement: "As our county grows and continues to increase its underclass, both, I think, will be essential."

As local officials scramble, some state governments, urged on by the Bush Administration, are moving to cut back already inadequate services provided to Medicaid recipients. As reported by the *Washington Post* on June 12, starting on July 1, West Virginia will require that Medicaid patients sign a "member agreement" promising, among other things, not to overuse emergency rooms, facing the threat of a cut in benefits if they refuse to sign or to follow the rules. Kentucky is dividing its Medicaid patients into four categories, depending on their health and age, with different benefits for each group. Florida will privatize parts of its Medicaid system in two counties in a pilot project expected to be enforced eventually for the entire state. The health of Medicaid recipients in Jacksonville and Broward Counties will be rated by Florida health officials, and the two communities will pay for only as much care as officials predict they should need.—*Patricia Salisbury*

FIGURE 1

Gain/Loss in Community Hospitals, 1958-2001

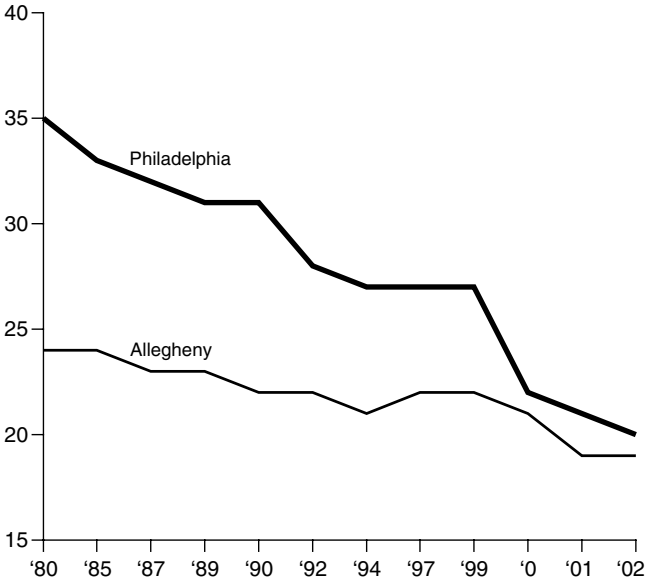
(Number of Hospitals)



Sources: U.S. Statistical Abstracts; *EIR.*

FIGURE 2

Loss of Hospitals, Allegheny and Philadelphia Counties, 1970-2002



Sources: Pennsylvania Counties, Health Profiles, Commonwealth of Pennsylvania Dept. of Health, State Center for Health Statistics and Research; *EIR.*

We had a similar problem with electricity before the TVA development. Part of the New Deal was the Tennessee Valley Authority, to bring electricity to a part of the country that was underserved. Now, if you just ask yourself, "Was that efficient to do that?" the answer is, "No, of course not." It was costing a tremendous amount to bring electricity out to these farms in the Tennessee Valley; but the objective was that availability of electricity was a human right at that point; that without it you couldn't move into the 20th Century, you couldn't really develop the communities. We have a similar phenomenon in health care, and Hill Burton was really the Tennessee Valley Authority Act for health care. It was the support to bring health care to everyone, not just in the cities.

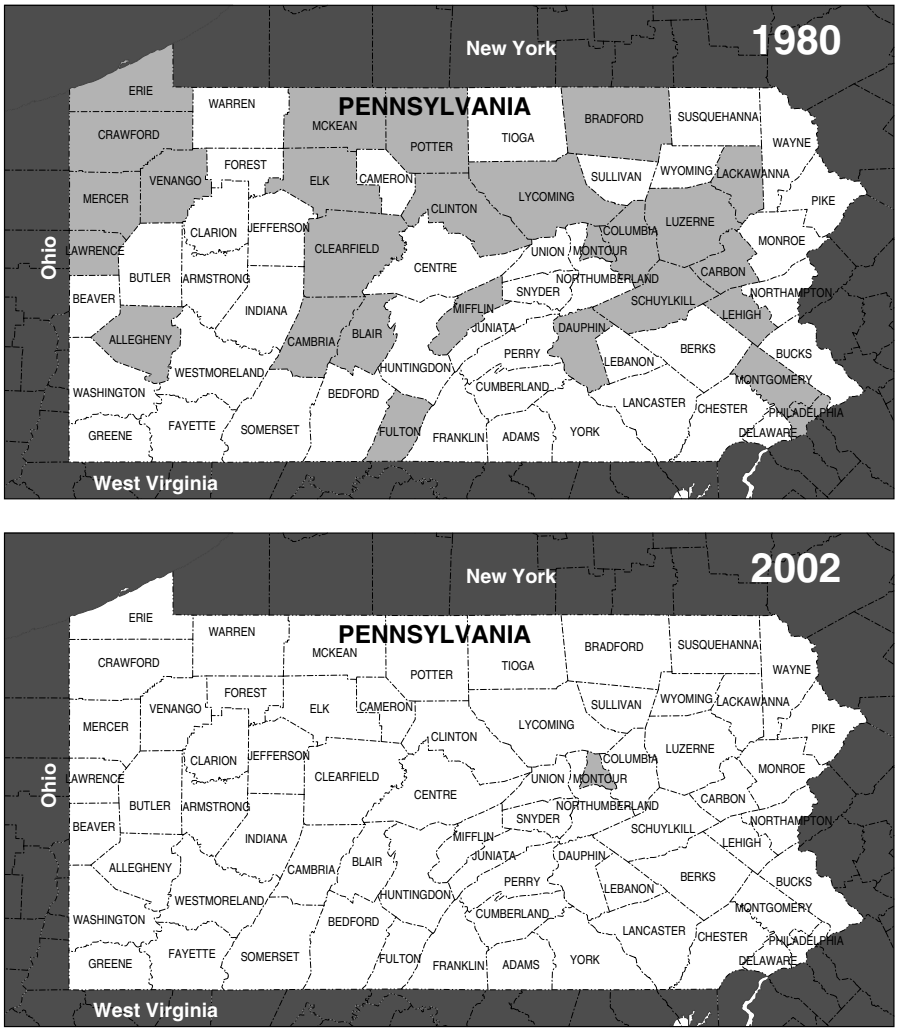
But we have gotten away from that, because money has become the controlling mantra for the health-care industry. So they are reluctant to build another MRI or CT machine out in the sticks, where maybe one would be useful, and instead they put another one in the city, so they can compete with the big hospital down the block. And since you need to fill up all those MRI time-slots to pay for those machines, maybe you have people ordering tests that they don't really need, to deal with the overhead cost of those machines. So, the way to deal with that is to reinstate certificates of need: In other words, if some hospital wants to invest a million dollars in a new piece of equipment, they need to prove that the community actually needs it. Otherwise, the answer is no; we are not going to authorize you to build a redundant machine that only puts a financial stress on both of the facilities, to try to justify their existence and possibly order tests just to support a cash flow.

The other thing is, we support the establishment of these facilities in places that are underserved, which is typically the rural areas and the poorer areas. And part of the certificate of need protection is, "Mr. Entrepreneur, we are going to fund putting your MRI machine in the middle of the sticks, and you can be comfortable that no one is going to put another one right next door to you. So we are going to help you build it and you will have a monopoly, so to speak, on that area, so that you will be comfortable that your investment is a good one." So with that, we begin to get back to the sort of effort we had after World War II, which was to recognize health care, and electricity, and other similar things, as part of the fabric of the society, and not just something for the lucky few or those who happen to live in the big cities.

EIR: Now turning for a moment to the political picture surrounding the legislation: I know from looking at HR 676 [see box], that there is substantial support from union layers. It seems the United Steelworkers are very much involved, and not surprisingly, given what has happened to their retirees, when companies were bankrupted and were taken over by financier types, and so on. Where is the support, and where is

FIGURE 3

Pennsylvania—Drop in Counties Meeting Hill-Burton Standard of 4.5 Beds per 1,000 Residents, 1980 to 2002



Source: Pennsylvania Department of Health.

In Pennsylvania in 1980, the statewide average ratio of licensed hospital beds per 1,000 residents was 4.8. This compared favorably with the range recommended by the 1946 Hospital Survey and Reconstruction Act (known as "Hill Burton," after its bipartisan sponsors, Senators Lister Hill [D-Ala.] and Harold Burton [R-Ohio]). The intent of the nine-page law was to see that rural and urban residents anywhere in the 3,069 counties of the nation had access to modern medical care. In 1980, 27 of Pennsylvania's 67 counties met or far exceeded the ratio of 4.5 beds per 1,000 population, so that most citizens had reasonable access to care. The major metropolitan areas especially had a base of medical infrastructure—Philadelphia, Pittsburgh, Erie, Harrisburg, and so on. Then this was all dismantled over the past 25 years of the HMO-era, with its looting practices of underpayment to hospitals, and deregulated, for-profit hospital takeovers and insurance plans.

Dozens of hospitals have closed down. In 1996, the state had 201 general hospitals, but this number fell to 176 by 2004, according to the Hospital and Healthsystem Association of Pennsylvania. The most recent of the 13 hospitals closed was in Philipsburg, in Centre County, in April 2006. The beds-per-thousand resident ratio has fallen in every county. Now, only Montour County is at the Hill Burton standard. This reflects the fact that it is a rural county, which fortunately is home to the Geisinger Clinic, a 400+bed first-class facility, founded with an industrialist family endowment, which now serves the entire mid-state region.

the opposition to the legislation, and what are they up to?

Larchuk: Well, the opposition is lying very low. They feel that they are in command and have got our money to fight us with, through the premiums they have collected over the years. They invested heavily in supporting candidates who support their positions, and also those private insurers have managed to get their hooks into a lot of organizations that sell health insurance to their own groups. For example, we have something called the Pennsylvania Farm Bureau, which one would think would be all for a universal health-care plan, which would help farmers more than anyone; yet they are against the universal single-payer plan, because they actually sell private health insurance, and about the last thing they want to do is put themselves out of business, whether it is good for farmers or not. And that sort of phenomenon exists all over the country. You have got a lot of hidden objectors to any sort of reform, because various people have found a way to make money from the inefficient system we have.

Now in terms of the politics in Pennsylvania, Representative Bebko-Jones' bill, I believe, has a dozen or so co-sponsors, one of whom is a Republican, so it is bipartisan. It is just starting today, and in an election year, when people are very reluctant to do anything controversial, so we are very encouraged by that sort of support. Plus, with Massachusetts having just adopted their bill, which I call a "big insurance bill," because it mandates everybody to buy a private insurance product—which I think is nuts; I can't think of any similar situation in the history of the United States, where a state ordered everybody to buy a private product. But the other thing is that Vermont just passed a similar type of bill, a little less oriented toward the insurance companies, but still dependent upon the theory that the insurance

companies will somehow come up with a way to make this all work.

Our bill in Pennsylvania rejects that; we are a single-payer system that doesn't use the insurance companies. Still, I think with the example of two other states passing legislation, I think that those who might have thought that this required a Federal solution or nothing, now have to ask themselves, is this really the truth?

EIR: It would seem to me that your legislation parallels the efforts on the Federal level, Congressman Conyers' bill. Is that the case?

Larchuk: There are many similarities, in the sense that it is a single-payer universal system. I think that the major difference, is that the Conyers bill contemplates having the Federal government buy the private hospitals and convert them into non-profits. Our bill in Pennsylvania does not do that; we believe that if we can just change the way we collect the money, and allocate the money and find a lot more efficiencies, we can permit the private sector to function the way that it should, with the theory that if you have a better mouse trap, the people will come to you. Let that system continue to work, and we think it can work. But with that said, there is a lot that is similar as well.

EIR: Are you finding constituency support, from unions and other bodies like city councils and so on?

Larchuk: This particular proposal has already been endorsed by the city councils of Philadelphia, Pittsburgh, and Erie—the three largest cities in Pennsylvania, and they are in three different corners of the state. And yet all of them voted it up without objection, not one person on any of those city councils voted against it. We have a long list of other endorser groups, like the American Medical Students Association and District 10 of the United Steelworkers union. Many groups have stepped up and endorsed this bill as not just a good idea, but a great idea, and one that deserves to be debated and voted on by the legislature.

EIR: And to sum it up?

Larchuk: I would encourage every state to stop wringing their hands and pretending like the problem is too big to solve, We can solve it, we must solve it. You have to have the courage to start with a blank sheet of paper and to put something down and not be embarrassed that someone will think ill of you for it.

That is what we have done here in Pennsylvania, and every state is going to have to do it sooner or later—so the sooner the better.