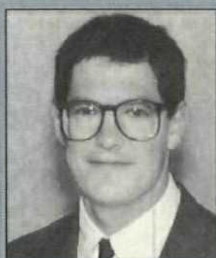
A Catholic Healthcare Advocacy Agenda for 1998

BY FELICIEN "FISH" BROWN

Every year in late winter, Washington, DC, experiences a vicious snowstorm that briefly shuts down the federal government. A week later all is back to normal as the wheels of the legislative and executive branch machines roll on. This year the capital was spared the cold, white stuff, but it was bombarded by a February flood of activity. President Clinton announced the good news on the economy and rolled out his budget with numerous proposed legislative changes that—if taken up this year—would keep Congress busy for all of 1998. But what actually will be accomplished in Washington in 1998 and how can Catholic healthcare play an important role? Before answering those questions, let's look at the economic, healthcare, and political contexts in which decisions will be made this year.



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Economic Context

Economically, the country is doing swimmingly at the moment. Inflation is down to just over 2 percent, a level not seen since the 1960s. And unemployment has fallen to a 24-year low of just over 5 percent, well below the rate in most western European countries. Probably most surprising is that the federal budget deficit, which was $300 billion just seven years ago, has been eliminated. With a big grin on his face, President Clinton presented a budget that not only is balanced for the first time in 30 years but also runs a combined surplus of more than $200 billion over the next five years. But economic estimates are tricky, and lurking in the background are the prospect for war in the Persian Gulf, the inevitable cyclic downturn in the economy, and millions of baby boomers waiting for their Social Security and Medicare benefits to kick in, beginning in 2010.

Healthcare Context

Regarding healthcare, the message is mixed as well. National health spending, adjusted for inflation, rose just 1.9 percent in 1996—an all-time low. (Katherine Levit et al., "National Health Spending Trends in 1996," *Health Affairs*, January/February 1998, pp. 35-51). Yet nearly one-seventh of the U.S. economy goes toward healthcare; spending exceeded $1 trillion for the first time in 1996. Moreover, although health insurance premiums edged up just 0.2 percent last year, they are expected to surge approximately 8 percent in 1998, according to a recent survey of nearly 4,000 employers conducted by William M. Mercer, Inc.

A force keeping costs down has been the rise of managed care, but there is growing evidence of a backlash by consumers and providers against health maintenance organizations. And financial analysts are starting to hedge their bets on the future profitability of managed care.

Closer to home for many healthcare advocates is the discouraging statistic that 41.6 million Americans, including 10 million children, still do not have health insurance. And ethical issues are popping up all over—from late-term abortions to assisted suicide to human cloning.

Political Context

This is an election year. Congressional leaders want to complete work in Washington by early October to allow enough time for campaigning. The big fiscal debate this year centers around what to do with a budget surplus—spend it, bank it, or lower Americans' taxes. Regardless of how this issue plays out, there are the 13 annual appropriations bills that Congress must pass. In addition, Congress and the president will discuss and may act on a federal tobacco settlement and standards for managed care. It is unlikely that Congress will reopen the Medicare and Medicaid provisions of the Balanced Budget Act of 1997, but legislators will oversee the Health Care Financing Administration (HCFA) as it implements hundreds of changes enacted last year. Wild cards this year are foreign policy crises and ongoing legal investigations involving the president.

CHA's Advocacy Priorities

Catholic healthcare has an excellent reputation in communities across the country and among policymakers in Washington, DC. CHA benefits from that goodwill when we ask Congress and the administration to support or oppose specific legislation. However, we need to draw on that goodwill wisely. CHA's advocacy priorities for 1998 are diverse but fall into four major themes.

Theme 1: Responsibility for the poor and vulnerable calls for a particular commitment to those without access to healthcare. *CHA will advocate expanding coverage and access for the uninsured.* Comprehensive federal efforts to achieve universal coverage failed in 1994 and will not be revisited in the near future. However, in an effort to expand access incrementally, Congress enacted new rules for private insurance in 1996 and in 1997 created the State Childrens Health Insurance Program (CHIP), which is expected to expand coverage to 2 million children. About 15 states have already sought federal approval for their children's health plan and a few states have received the go-ahead. CHA will continue to monitor the debates in state capitols over how CHIP programs should be designed.

In the coming months, debate will center around the president's proposal to allow 55- to 64-year-olds to "buy into" Medicare by paying $300 per month until age 65 and then paying a supplemental Medicare premium therafter. Congressional Democrats are largely united behind this approach but most Republicans and some prominent Democrats are wary. CHA is reviewing the proposals and may suggest changes such as subsidies for lower-income populations. We are also exploring political support for expanding coverage for other groups, including immigrants.

Another important CHA advocacy initiative is support for efforts to enroll eligible children in the Medicaid program. In 1994, one-fifth of all poor and near-poor children under age 11 who were eligible for Medicaid—nearly 2.7 million—were neither enrolled in Medicaid nor covered by any other health insurance. The president has proposed expanding the entities that can determine Medicaid presumptive eligibility and increasing federal funding for Medicaid outreach.

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CHA strongly supports these legislative efforts and community-based initiatives. Recently the Daughters of Charity National Health System and Carondolet Health System joined with Catholic Charities USA to launch "Children's Health Matters," which aims to identify, educate, and enroll eligible children in Medicaid.

Theme 2: Religiously sponsored healthcare must be allowed to operate in a manner consistent with religious beliefs. *CHA will help maintain an environment that respects the values and contributions of religiously sponsored healthcare.* As Congress considers enacting federal standards for managed care, Catholic healthcare needs protections against mandates that it cover objectionable services. CHA is already working with Congress on a "conscience clause" provision in the proposed legislation. In addition, we will seek to ensure that Medicare+Choice plans are not required to cover abortions.

CHA will also continue to oppose physician-assisted suicide at federal and state levels. In a new twist, the federal Drug Enforcement Administration (DEA), stated that "delivering, dispensing or prescribing a controlled substance with the intent of assisting a suicide would not be under any current definition 'a legitimate medical purpose.'" As a result, the prescribing of a controlled substance in order to assist a suicide would be a violation of the Controlled Substances Act and could lead to the DEA's revocation of a physician's registration to dispense controlled substances. In February CHA sent a letter to President Clinton urging him to support the DEA decision.

Theme 3: Payment system changes designed to promote cost efficiency must also maintain quality. Ensuring access, accountability, and quality in managed care plans is critical as well. *CHA will argue for appropriate managed care standards that keep providers at the heart of patient care and protect consumers. We will also work to ensure that new Medicare and Medicaid rules and payment systems for providers and plans are responsible and fair.*

Low healthcare inflation over the past few years has led consumers and policymakers to focus increasingly on quality issues rather than costs. A

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even though no abortion procedures are being performed on the premises of the hospital. However, a Catholic facility faced with this type of situation must tread carefully before considering termination of the physician's staff privileges in order not to give the physician a viable, federal cause of action.

If the individual is so notorious in the community that his or her activities give rise to scandal, as that term is used in the *Directives*, then perhaps the healthcare provider can argue that its constitutional right to the free exercise of religion supersedes the statutory protection provided to the physician. However, winning this kind of case would be extremely difficult, time-consuming, and expensive. Close scrutiny of the facts of the situation by counsel is strongly encouraged to minimize the negative legal ramifications of any decision. □

NOTES

1. National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*. U.S. Catholic Conference, Washington, DC, 1995, Directive 45.
2. Statutory law is distinguished from constitutional analysis. See note 3, below, and the article's final paragraph.
3. See Rice, Charles E., "Catholic Hospitals and Abortionists," *The Wanderer*, January 8, 1998, arguing that Catholic hospitals should challenge the constitutionality of laws that require them not to discriminate against a physician based on the physician's performance of abortions.
4. 369 F. Supp. 948 (D. Mont. 1973).
5. 42 U.S.C. 300a-7.
6. 42 U.S.C. 300a-7(c)(2).
7. 42 U.S.C. 300a-7(e).
8. 42 U.S.C. 300a-7(b).
9. 42 U.S.C. 300a-7(c).
10. 42 U.S.C. 300a-7(c) (italics added).
11. 42 U.S.C. 300a-7(d)(e).
12. 364 F. Supp. 799 (D. C. Idaho 1973), *aff'd* 529 F.2d 894 (9th Cir. 1975).
13. *Watkins v. Mercy Medical Center*, 520 F.2d 894 (9th Cir. 1975).
14. Edwin F. Healy, *Moral Guidance*, Loyola University Press, Chicago, 1960, p. 112.

ADVOCACY AGENDA

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fundamental question is whether there should be broad federal legislation governing managed care or whether states alone should retain this authority. CHA, along with other provider-based advocacy groups, took a leadership role on managed care legislation by issuing "Principles for Accountable Managed Care" in 1997. In consultation with Catholic providers and health plans, we are now reviewing several legislative proposals on managed care and determining what provisions to support or oppose.

Last year's Balanced Budget Act enacted major changes in Medicare's managed care program, establishing Medicare+Choice, which includes a new option for provider-sponsored organizations (PSOs). In April, HCFA will publish rules for PSOs and in June will roll out Medicare+Choice contracting standards. CHA has assisted HCFA in developing solvency and other requirements for PSOs, with a focus on assuring opportunities for Catholic and other not-for-profit healthcare organizations.

The Balanced Budget Act also revised Medicare payments to managed care plans. It reduced geographic inequity and required that funds for graduate medical education be paid directly to the hospitals. CHA supported these changes but more needs to be done to ensure fairness. CHA will support legislative efforts to channel disproportionate-share hospital funds directly to hospitals and to further reduce the variation in Medicare managed care payments across geographic areas.

CHA will also seek to scale back the Balanced Budget Act's Medicare "transfer" provisions, which expanded the definition of "transfers" to include patients sent from hospitals to a rehabilitation facility, skilled nursing facility, or home health agency. The transfer provision is estimated to cost hospitals $1.3 billion over the next four years.

Successful coordinated care increasingly relies on adequate long-term care. CHA will focus its long-term care advocacy on the following:

- HCFA rules on managed care that account for the unique needs of "dual eligibles," that is, persons eligible for both Medicare and Medicaid
- A Chronic Care Act to establish a national chronic care policy and streamline Medicare and Medicaid requirements for care of chronically ill persons
- Senior housing as part of the continuum of care

Congress and the president will continue to compete to see who is tougher on healthcare fraud and abuse. CHA provided input to the Health and Human Services department's Inspector General for the development of the Model Corporate Compliance Program for hospitals, and we will strongly encourage Catholic hospitals to adopt compliance measures. At the same time, CHA will support legislative and regulatory efforts to prohibit inappropriate use of the False Claims Act by the federal government.

Theme 4: Healthcare is a public good that is best delivered in a not-for-profit setting. *CHA will support measures that strengthen not-for-profit healthcare and enhance its mission to provide high-quality care and serve the community's needs.* Over the past few years, many states have more closely scrutinized the distinction between for-profit and not-for-profit organizations. Therefore it is imperative that Catholic healthcare providers be able to clearly justify their not-for-profit, tax-exempt status. CHA will continue to promote the significance of the community benefits not-for-profits provide and will serve as a clearinghouse for Catholic organizations' community benefits policies. We will use this information for advocacy on behalf of the Catholic healthcare ministry at both state and federal levels. We will also pursue clarification of federal policy on tax-exempt bonds and tax questions regarding integrated delivery networks. □