REFORM
UPDATE

CHA TASK FORCE ASSESSES STRENGTHS, NEEDED CHANGES IN CLINTON DRAFT PLAN

The Catholic Health Association (CHA) and its members must speak out for national healthcare policies that emphasize reform in the way care is delivered, a CHA task force insists. Meeting October 12 to analyze President Bill Clinton's draft reform plan, issued September 7, 1993, and compare it with CHA's own proposal, the Leadership Task Force on National Health Policy Reform supported many aspects of the president's plan, including universal coverage, overall spending control, and a substantial uniform benefit package (see **Box** below). However, the group found the plan does not adequately address clinical integration of care and reform of the delivery system. "The shortcoming of the Clinton plan is its emphasis on financing, rather than delivery," said CHA Chairperson Sr. Maryanna Coyle, SC, president, Sisters of Charity of Cincinnati, Mount St. Joseph, OH.

In CHA's *Setting Relationships Right: A Proposal for Healthcare Reform*, care is coordinated and managed through community-based integrated delivery networks that compete for patients on the basis of service and quality. The Clinton proposal (the American Health Security Act of 1993) delivers care through three types of health plans (ranging from an HMO-type to a more expensive fee-for-service plan) that are primarily differentiated on the basis of cost. The CHA task force maintains that the integrated delivery network concept, with its emphasis on quality and coordinated care, is needed to serve people better and lower the cost of healthcare.

The task force amplified concerns expressed in Sr. Bernice Coreil's congressional testimony (see **Box**, p. 7) that the president's plan may reinforce a separate insurance company layer that relies on discounts and externally imposed utilization controls as the sole paths to cost control.

Without adequate protection, the healthcare system could become commercialized and its professional ethos to serve people could be eroded.

Task force members would also like to see more clarity in the Clinton proposal on how plans would be held accountable to patients and communities. The group acknowledged that the plan intentionally limited government involvement in regulation of care delivery, but it is concerned that, without adequate protection, the healthcare system could become commercialized and its professional ethos to serve people could be eroded. "What happens to a community's healthcare resources if a plan pulls out because of insufficient profits?" asked Bill Cox, CHA's vice president for government services. "We must show congressional representatives why they need to pay attention to how systems of care are organized."

If health plans are sponsored by entities other than not-for-profit organizations (e.g., insurance companies, large physician groups), profits could be taken out of the community, rather than rein-

CHA ASSESSMENT OF DRAFT CLINTON PROPOSAL
(SEPTEMBER 7, 1993)

FEATURES SUPPORTED BY CHA

- Universal coverage achieved quickly
- Substantial uniform benefit package and Medicare expansion
- Continuous coverage; employment link ended for most persons
- Enhanced consumer choice
- Several protections for the poor
- Overall expenditure control
- Progress toward more equitable, stable financing

FEATURES THAT NEED TO BE ADDRESSED

- Inadequate emphasis on delivery reform
  - –Community-based, integrated networks underemphasized
  - –Insurer as distant discounter/regulator
  - –Medicare kept separate
  - –Long-term care not integrated with acute care
- Lack of "bottom up–top down" budget-setting process
- Expenditures compressed unevenly and unrealistically fast
  - –Too fast for effective delivery reform
  - –Public sector faster than private sector (i.e., cost shift)
  - –Impact on access
- Abortion
- Conscience clause protection
- Risk of commercialization and erosion of professional ethos

SR. COREIL CALLS FOR STRONGER DELIVERY COMPONENTS

Although the Catholic Health Association (CHA) supports many aspects of President Clinton's healthcare reform proposal, its leaders believe a number of components related to delivery reform need to be strengthened. On October 14, in testimony before the House Energy and Commerce Subcommittees on Health and the Environment and Commerce, Consumer Protection and Competitiveness, Sr. Bernice Coreil, DC, chair of CHA's Task Force on National Healthcare Reform, laid out areas of CHA's agreement and disagreement.

In answer to a question, Sr. Coreil, who is vice president for system integration, Daughters of Charity National Health System, St. Louis, said, "If we go into true integrated delivery networks, we take away price competition. We should compete on service and quality. It won't matter whether you are black or white, rich or poor, we will all have the same care."

In her testimony and a more comprehensive written statement, Sr. Coreil laid out CHA's position. Here is an excerpt.

CHA believes President Clinton's proposal is headed in essentially the right direction. Two years ago, CHA developed its own proposal for systemic healthcare reform. The two plans contain striking similarities. Primary among the plans' similar components is universal coverage, achieved in a timely fashion.

Now, let me turn to three recommendations CHA believes can and must strengthen the president's proposal. First, CHA believes that delivery system reform is necessary to achieve the fundamental reform needed to serve people better. This reform can be achieved by (a) merging the insurance and delivery functions in integrated networks that provide a coordinated continuum of care to enrolled populations; (b) incorporating Medicare into the overall reformed system through a scheduled transition process; (c) fully integrating long-term care with acute care under a specified time table; and (d) creating a more realistic time frame for reducing the rate of growth in both public and private healthcare spending.

Second, the president's plan needs to employ a more informed and realistic process for setting the global budget. CHA's reform proposal calls for a "bottom up–top down" national budget-setting process that would incorporate critical information on population needs and local system efficiencies over time. In contrast, the president's plan calls for a "top-down–only" approach to a national budget as defined by a formula-driven rate of increase. This approach misses an important opportunity to make healthcare expenditures not only more predictable and reasonable, but also more consistent with changing health needs, system capacity, and the public's own view with regard to the trade-offs between healthcare and other important social goals.

Third, the president's proposal may need to incorporate safeguards to preserve the professional ethos in healthcare and protect against an excessively commercialized system.The implications of shifting financial risk to providers *in the context of all-out price competition* have not been carefully examined. It is possible that intense competition in some healthcare markets will unleash commercial influences that will overwhelm the "patient-first" ethic in American medicine. At least two questions need to be addressed:

Sr. Coreil

- How will patients fare when the cost of the treatment they need could make their provider less competitive or less profitable?
- Will health plans owned by commercial interests beholden to distant shareholders abandon communities when their profits are squeezed?

These are critically important questions that have not received enough attention. We intend to examine the president's legislation on this issue to develop specific recommendations.

vested in the health plan to improve service, noted William Dowling, vice president for planning and policy development, Sisters of Providence Health System, Seattle. "How does capital stay in the system if it is insurance company or physician driven?" he asked.

Medicare Fold-in Urged

The task force also wants to alert Congress and the administration that keeping the current Medicare system could lead to problems for providers and for the elderly. Under the Clinton plan, when people turn 65, they may stay in their current health plan or move to a separate Medicare plan (unless their state decides not to retain a Medicare plan). Because Medicare is underfunded and largely fee-for-service, providers will have two different sets of incentives—one for the health plans and one for the Medicare plan—and they will lack new incentives for more efficient delivery of care to Medicare beneficiaries.

Having the elderly in the overall plan would help dispel perceptions of intergenerational differences and conflict, added Msgr. Charles J. Fahey, director, Third Age Center, Fordham University, Bronx, NY. It would also eliminate access problems caused by underfunding, the task force noted. Tim Eckels, CHA government liaison, said CHA will suggest a plan to the administration for phasing in Medicare, including the timing and cost implications.

Current Medicare underfunding will be exacerbated by the Clinton plan's reliance on large reductions in Medicare and Medicaid to pay for universal coverage. The task force fears that the president's proposal to limit Medicare increases to 4.1 percent by the year 2000 (as compared to 9 percent without reform) represents a dangerously rapid compression that could harm access.

"Bottom Up–Top Down" Budget Setting Needed

The task force's discussion also reflected objections to the Clinton plan's formula-driven, "top down" national budget-setting process. "There should be systematic information coming up through the state alliances to show how the health plans are doing at the community level to help the National Health Board decide each year's

percent of increase," Eckels said. Increases should be set according to community situations that affect spending needs, such as a large AIDS population, he said, and the budget-setting process should be visible so that people can evaluate spending decisions for the nation. CHA is preparing a brief to describe an alternative approach, he told the task force.

Long-Term Care: A Missing Piece

CHA will also address the need to incorporate long-term care coverage into overall reform. Joanne Elden Beale, CHA government liaison, described to the task force how the Clinton proposal adds important new long-term care benefits. "But the Clinton plan misses the opportunity to include long-term care in the uniform benefit package," she said, "which would encourage integration of the full continuum of care within health plans."

Noting that Clinton's plan appropriately deemphasizes institutional care, she said one of the reasons for not incorporating long-term care immediately is limited human resources in home and community-based care. CHA will prepare a transition plan for integrating long-term care into the nation's healthcare system within a specified timeframe.

Advocacy Role Outlined

Cox predicted that Congress will call on CHA and its members to contribute to the dialogue when legislation is being considered. "Our values are having an impact," he said. "Some questions are central to who we are, and if we don't give them attention, they won't get attention," he said.

CHA's advocacy efforts should focus on key uncompromisable tenets, added CHA President Jack Curley: Access must be universal, the needs of the poor must be addressed within the context of the whole population, and delivery reform must center around the patient, not the bottom line.

Sr. Coreil pointed to the critical role of CHA members: "All of us will be called on to be a voice in our areas for changing a system that is not adequate," she said.

—Judy Cassidy

EDITOR'S NOTE: *President Clinton's final proposal, issued as* Health Progress *was going to press, is likely to result in modifications in CHA's assessment. These will be covered in CHA's legislative field meetings (see p. 19 for dates and locations).*

SEMINAR FOR JOURNALISTS, CONGRESSIONAL STAFF URGES CONSENSUS ON REFORM

Progress on reforming healthcare is proceeding much faster than most people anticipated, according to Ira Magaziner. Some 260 House and Senate Republicans and Democrats have committed to some type of healthcare legislation, and a reform bill will pass next year, Magaziner told nearly 200 congressional staffers and journalists at a daylong briefing that explored various proposals for restructuring the healthcare system and the process of reaching consensus among them. The October 22 seminar in Washington, DC, was cosponsored by the Catholic Health Association; the Alliance for Health Reform, Washington, DC; and the Henry J. Kaiser Family Foundation, Menlo Park, CA.

Developing Consensus on Reform

Magaziner, chief White House staffer to the president's healthcare task force, said the administration's legislation (introduced as *Health Progress* went to press) will be committed to universal coverage and health security. He noted that in some proposals, universal coverage either is not immediate or is not affordable for all Americans. Cost control, he added, will also be an essential part of the legislation because "without it, universal coverage is doomed to fail.

"We'll lay a very detailed plan on the table" that will require lengthy discussion of the details, Magaziner continued. "I hope we can have that discussion over the coming months in as constructive a way as possible."

Ira Magaziner stressed the administration's openness to suggestions and ideas.

He proclaimed the administration's openness to suggestions and ideas: "We expect our proposal to change as it goes through Congress, and we hope our proposal will be improved."

Magaziner likened the passage of healthcare reform to that of the Social Security program, which passed despite widespread opposition. He said that just as we find it unthinkable today that the elderly once faced appalling impoverish-

ment, our children should be able to look back in a few years and find it inconceivable that people once lived in fear of losing their healthcare or of being bankrupted by having a sick child.

Republican Sen. John Danforth of Missouri, a member of the Senate Finance Committee, agreed that major healthcare legislation will pass next year but said a centrist position is building in Congress that calls for phasing in universal coverage as cost savings are obtained.

"Primary, preventive, and chronic care are as much a part of the quality equation as the medical miracles," Rockefeller said.

Sen. Jay Rockefeller, D-WV, said Danforth's comments indicated it will be "a very contentious year." But Rockefeller, who chairs the Senate Finance Subcommittee on Medicare and Long-Term Care and the Alliance for Health Reform, predicted that consensus will develop as the various proposals are scrutinized.

Common policy themes must include the principles in the Clinton proposal, he said. "First and foremost, everyone must qualify for coverage and no one must lose coverage." And costs, paperwork, and administrative regulations must be controlled, he said. "Rampant medical inflation sits at our national economic table like a hungry stranger, insatiably devouring wages, savings, capital, profits, the Treasury, national income."

Rockefeller is particularly interested in provisions of the Clinton plan and others that promote education of more primary care physicians. "Primary, preventive, and chronic care are as much a part of the quality equation as the medical miracles," he said.

Honest Analysis, Public Education Urged

Rockefeller warned that "proponents on all sides of certain issues" will be tempted to sow fears or exploit fantasies over the coming months. "To do either underestimates the intelligence of the American people," he said.

Uwe Reinhardt, PhD, a Princeton University economist, also called for honesty in discussing healthcare reform. Essentially he sees reform as rearranging the money flow from the well off to the poor. He said Americans do not share an ethos that healthcare should be distributed to everyone regardless of ability to pay. "A substantial block believe healthcare is like food"; the poor get a basic ration while the elite dine in fine restaurants.

Gail Wilensky, PhD, senior fellow at Project HOPE, Bethesda, MD, and former administrator of the Health Care Financing Administration, was equally forthright: "Right now the American public is being encouraged to look for something for nothing," she said. Reform proposals give the impression that the employed, unemployed, and uninsured can all have "Fortune 500 insurance," that people can retire at age 55 and have 80 percent of their insurance coverage paid for by the government, that the elderly can get new benefits, and that "the only people who will have to pay a little more are smokers and some young, healthy adults," she said.

"First and foremost, everyone must qualify for coverage," said Sen. Jay Rockefeller, D-WV.

Calling for extensive public education on reform issues, Wilensky cautioned that the public must examine the difficult questions about what benefits they are willing to pay more for or do without. The "worst outcome," she warned, would be a repeat of the 1989 experience with Medicare catastrophic insurance. The elderly forced repeal of the measure, which Congress believed they favored.

Reinhardt urged constructive discussion rather than all-or-nothing positions. "If we go into '94 without some vision that every American has the same kind of insurance, that will be tragic," he said.

—Judy Cassidy

CHA LAUDS OPPORTUNITY FOR DEBATE

"Healthcare reform will now be seriously debated in the public policy arena for the first time in more than a decade," said CHA President Jack Curley, who attended the U.S. Capitol ceremony where President Clinton and First Lady Hillary Rodham Clinton delivered the administration's legislative bill to congressional leaders on October 27, 1993.

"The president has presented an opportunity for this nation to achieve universal coverage; provide a comprehensive benefit package; establish continuous, uninterrupted coverage for consumers regardless of employment status; ensure consumers the ability to choose their providers; and ensure overall expenditure controls through global budgets and a financing mechanism of employer mandates," Curley noted.

He said the proposal builds on the strengths of American healthcare while addressing many of its weaknesses. "It is anchored in an explicit set of values which in large measure are consistent with our own values," Curley said. "The president's plan has incorporated most of the building blocks upon which CHA's proposal for systemic healthcare reform is founded."