REFORM
UPDATE

ADVOCACY FOCUSES ON UNIVERSAL COVERAGE, EMPLOYER FINANCING, ABORTION EXCLUSION

On a national day of mourning for former President Richard Nixon, Catholic Health Association (CHA) members attending CHA's Federal Health Policy Institute were reminded that Nixon introduced a healthcare reform bill more than 20 years ago. The financing mechanism in that legislation was employer-based coverage.

Today, employer-based insurance coverage is again being proposed as the most logical way to finance a healthcare system for everyone in the United States. As House and Senate committees are engaged in drafting various legislative proposals for reform, CHA and its members are focusing their advocacy efforts on principles essential to a reformed system's success: universal coverage, employer-based financing, and exclusion of abortion in the mandated benefit package.

Bill Cox, CHA's vice president for government services, insisted that universal coverage is "a practical necessity" for CHA members. Without it, he warned, not-for-profit providers could find themselves unable to provide charity and uncompensated care as the rapid expansion of managed care inevitably eliminates their ability to subsidize this care by shifting some of the costs to private payers.


Cox

"Universal coverage," Cox added, "is critical because costs cannot be contained unless providers' incentives are aligned under a system that pays for everybody—young and old, sick and healthy—according to the same rules."

The employer mandate is still the most likely mechanism for financing universal coverage.

Tax Exemption Issue Heats Up

The prospect of universal coverage is rekindling questions at the local, state, and national levels about the tax-exempt status of not-for-profit healthcare organizations (see **Box**, p. 9). Critics are asking how the exemption, which has been based in part on these organizations' providing charity care, can be justified once everyone is covered.


Feder

"We're facing the most serious threat to tax exemption we've ever faced," Cox warned. He noted that a growing chorus of policymakers, for-profit organizations, and academicians is challenging the value of the exemption. Others are insisting that tax-exempt hospitals be held to a strict numerical standard in terms of meeting their community benefit requirement. "If we hope to retain our exemption or, more likely, fend off demands that we meet specific formula-driven standards for retaining tax exemption, then we need to be prepared to draw a clear, 'bright line' distinction between for-profit and not-for-profit providers. Thus CHA has a new proposal for retaining tax exemption."

He said one aspect of the proposal is "enhanced community benefit standards" that require tax-exempt healthcare organizations to:

- Provide programs to address their community's health needs
- Provide health professional training and education or conduct research
- Address the needs of the medically underserved where appropriate
- Dedicate revenues to delivering healthcare service, improving facilities or equipment, developing and maintaining integrated delivery networks, training and research, and providing other community benefits
- Provide emergency services to any individual, insured or not
- Provide an annual statement describing the organization's charitable purpose, populations served, and commitment to responding to community health needs; its activities to address

CHA'S POSITION ON MEDICARE/MEDICAID CUTS

Realizing that Congress will continue to cut provider Medicare and Medicaid payments as it seeks to reduce the national budget deficit, CHA believes it would be counterproductive for the association to take a hard stance opposing any and all cuts. CHA believes the large federal deficit will continue to make some Medicare and Medicaid cuts inevitable. Instead of opposing all cuts without reservation, CHA is advocating comprehensive reform that gives providers the tools to live with the inevitable cuts.

CHA's messages to Congress:

- Delivery reform that moves everyone into the same system is vital. Without it, providers cannot control costs and achieve savings that would make the cuts acceptable.
- Comprehensive delivery reform should include incentives for capitated plans.
- Savings are unachievable if the cuts are too deep and too quick, before comprehensive reform occurs.

those needs; a projection of health needs and its plan to respond; and a procedure for community members to comment on the organization's annual report and community benefit plan

A second aspect of the new rationale is support for "intermediate sanctions," which the Internal Revenue Service could use to enforce the federal tax code's prohibition against anyone inordinately benefiting from the activities of a tax-exempt healthcare organization.

In CHA's view, tax exemption for healthcare networks and facilities is also critical for the well-being of patients and communities. Cox noted that for-profit enterprises, driven by their responsibility to stockholders, have an added incentive to underserve patients. Undertreatment could become a serious problem once most healthcare financing is capitated. In such a setting it is imperative that most of the providers be tax exempt and thus prohibited from engaging in private inurement or private benefit.

"To retain our exemption . . . we need to be prepared to draw a clear, 'bright line' distinction between for-profit and not-for-profit providers," Cox said.

Catholic healthcare must aggressively counter proposals that would require providers to meet a national numerical community benefit standard, Cox said. A numerical standard could not be sensitive to local community needs and could be detrimental in areas where providers could meet the standard and yet still not meet many needs.

Opposition to Abortion Coverage

Cox stressed it is critical that advocacy efforts continue to oppose abortion coverage and support conscience clauses in congressional legislative proposals. CHA has consistently made known its moral argument against abortion coverage, but Cox put forth another, pragmatic argument: Including abortion would evoke such strong opposition from a large number of employers that it would jeopardize passage of reform legislation. Legislators should be persuaded not to allow the abortion issue to delay the achievement of universal coverage, he said.

Cox noted that Catholic providers would find it virtually impossible to participate in networks that made abortion services available. Also, he said the majority of Americans do not want abortion coverage to be included in a benefit package. In fact, in a *New York Times*/CBS poll on the "basic benefits," only 23 percent of respondents said the package should cover abortion, while 72 percent said abortion costs should be paid directly by the women who have abortions.

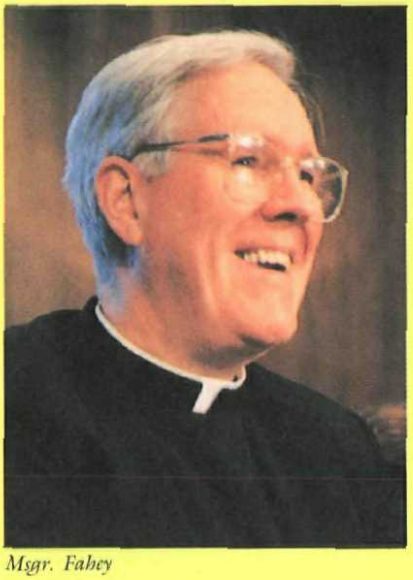
Legislation on the Fall Horizon

Insiders in the reform debate predicted that Congress will pass some kind of reform bill by next October. Although the process has been slow, the Clinton administration believes it is constructive, according to Judith Feder, PhD, principal deputy assistant secretary for planning and evaluation at the U.S. Department of Health and Human Services. She said the administration is optimistic that its objectives will be reached—a bill that guarantees universal coverage and health insurance with a comprehensive set of benefits for every employed person.

—Judy Cassidy

MSGR. FAHEY TESTIFIES BEFORE SENATE ON TAX EXEMPTION

On behalf of the Catholic Health Association, Msgr. Charles J. Fahey testified before the Senate Finance Committee at the end of April regarding the continued need for tax exemption for not-for-profit healthcare facilities.



Msgr. Fahey

"Universal health insurance coverage, as important as it is, will not fully solve the access problems in this country," stated Msgr. Fahey, who is senior associate, Fordham University's Third Age Center, Bronx, NY, and a member of CHA's Leadership Task Force on National Health Policy Reform. He pointed out that not-for-profit hospitals will continue to have a role in serving the poor and disadvantaged, both in inner cities and rural America.

"But our role as tax-exempt, charitable organizations is much broader than service to the poor," he testified. "It includes leadership in improving the overall health in the community, educating health professionals, and being the vehicle for volunteer efforts and philanthropy."

He warned, however, that the not-for-profits' mission to watch for and fill unmet needs is being threatened by the increasingly commercial environment and competitive forces, which are reinforced by reform proposals under consideration.

"Tax exemption, with its requirements for community benefit and prohibitions against private inurement and private benefit, is one safeguard against commercial values overtaking the professional and service orientation of individual not-for-profit facilities and the healthcare system as a whole," he said.

He added that healthcare reform should strengthen the enforcement of prohibitions against private inurement, grant tax exemption for not-for-profit healthcare plans that meet enhanced community benefit standards, and require all tax-exempt healthcare providers to meet an effective community benefit standard.

While praising the community benefit standards in the president's legislative proposal, Msgr. Fahey suggested that they focus more on implementation and accountability. "We want to ensure that providers are striving not only to assess—but also to meet—the needs of their community," he said. He cautioned against the use of numerical standards that would "limit the flexibility of these institutions to meet the differing needs of their different communities."

WASHINGTON STATE MANDATES LONG-TERM CARE IN ITS HEALTHCARE REFORM PLAN

Washington State's 1993 healthcare reform law (Health Services Act) has set up a plan (see **Figure**) that is "almost a mirror image of the Clinton plan," said Ken Cameron, at the American Society on Aging conference in March. But this plan goes farther. By 1999, when the state's reform legislation will be completely phased in, the full continuum of preventive, acute, chronic, and social services—including long-term care for the elderly and disabled—must be included in the state's uniform benefit package.


Cameron

The state's Health Services Commission has appointed a Long-Term Care Advisory Committee to prepare a plan for integrating long-term care into Washington's new healthcare system, in which certified health plans (CHPs) will receive capitated financing to organize a network of services. Cameron is technical adviser on the long-term care aspects of the state's reform plan and serves as executive policy coordinator in the Aging and Adult Services Administration of the state's Department of Social and Health Services. He said the committee's plan will include the scope of services to be offered, projected costs, and financing mechanisms. The Washington reform law emphasizes home and community-based care for the elderly.

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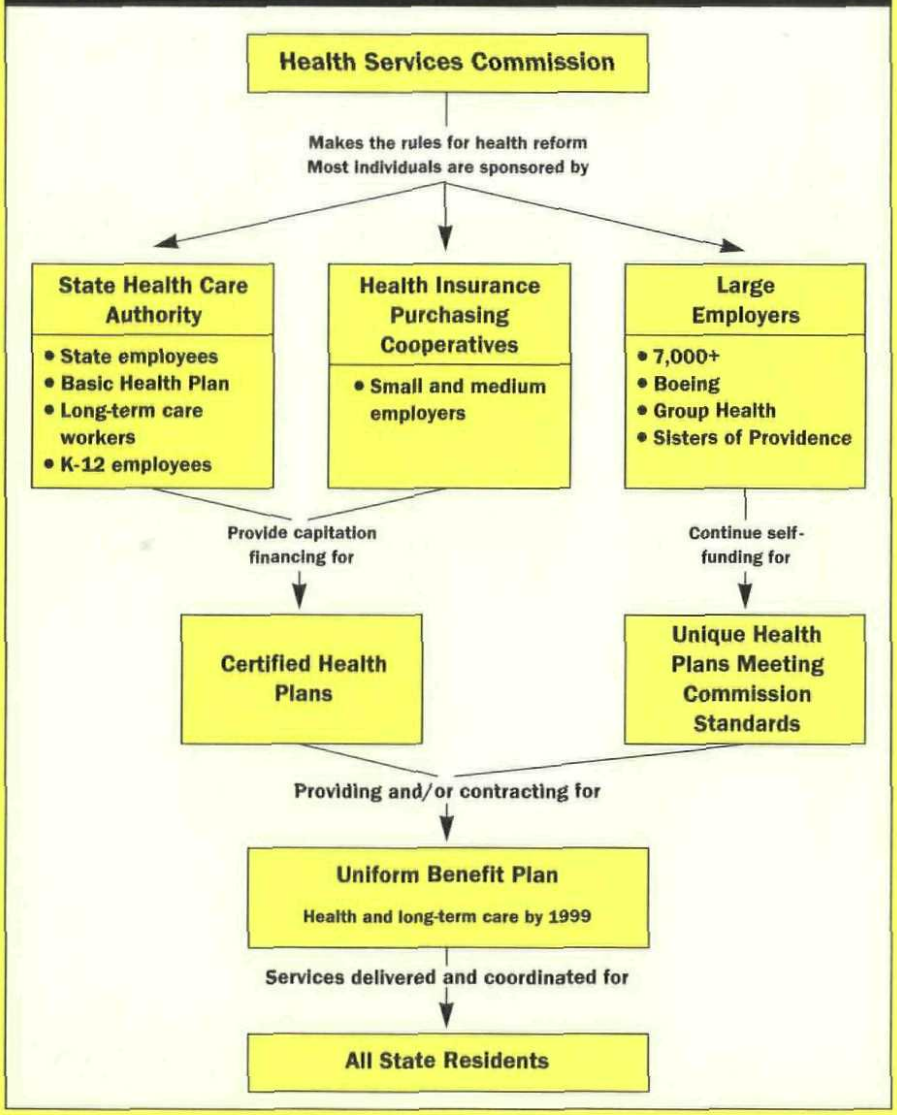
The commission will develop two pilot projects, called "life care projects," to model the principles regarding long-

WASHINGTON STATE'S HEALTH SERVICES ACT



term care services set down in the law (e.g., a uniform benefit package must be provided through plans that are qualified, efficient, and consumer oriented).

The life care projects will allow the state to prepare for the transition to statewide reform by seeing how the projects work with a representative smaller population, Cameron explained. These social health maintenance organizations (SHMOs) will provide a full range of medical and long-term care services and should be up and running by spring 1995, Cameron said.

The life care projects' benefit package will include case management, intake and assessment, nursing home care, home health and home health aide care, hospice, chore services, adult day care, respite care, and appropriate social services.

"A lot of people thought long-term care would fall off in a ditch," Cameron said, "but poll data indicate the middle class cares about long-term care now. They see it affecting their families. They know the social and financial risks. That's why the long-term care issue is so powerful and won't go away. There's no going back to the status quo."

—Judy Cassidy

CHA MEMBERS' GRASSROOTS EFFORTS STIR UP SUPPORT FOR REFORM

Throughout the country, at town meetings and press conferences, Catholic Health Association members are continuing to stir up grassroots support for reform, particularly in the congressional districts of key committee members. A sampling of recent activities:

• On May 17 a large group of Catholic healthcare leaders from targeted congressional districts participated in **"Hospital Constituency Day"** in Washington, DC. First, a White House briefing on healthcare reform was held for the CHA members, as well as representatives from the National Association of Public Hospitals, the National Association of Children's Hospitals and Related Institutions, and the Protestant Health Alliance. That afternoon the healthcare leaders visited their congressional representatives to present the Catholic healthcare ministry's vision of healthcare reform, including CHA's four advocacy positions.

• **James Wilson**, president/CEO, St. Agnes Medical Center, Philadelphia; CHA's chairperson elect **Daniel Russell**, president/CEO, Eastern Mercy Health System, Radnor, PA; and **Ron Aldrich**, president/CEO, Franciscan Health System, Aston, PA, joined other Pennsylvania providers in a White House meeting with Hillary Rodham Clinton.

• In addition, Wilson hosted a news conference at St. Agnes and co-signed a letter with physician and nurse groups to Rep. Marjorie Margolies-Mezvinsky, D-PA—a member of the Energy and Commerce Committee—asking her to support healthcare reform that ensures universal coverage via an employer mandate. The letter was written on behalf of the Health Care Reform Project (HCRP), a coalition of consumers and elderly, labor, business, physician, and hospital groups, including CHA.

On May 17 a large group of Catholic healthcare leaders participated in "Hospital Constituency Day."

• **Amie Thorton**, vice president of planning, Eastern Mercy Health System, appeared at a Norristown event with Mezvinsky.

• **Jan Haas**, vice president of corporate development and planning, Saint Mary Hospital, Langhorne, PA, spoke at a town meeting in Doylestown.

• **Christopher Carney**, CEO of St. Mary's Hospital, Richmond, VA, and **Kevin Conlin**, president/CEO of DePaul Medical Center, Norfolk, VA, joined other Virginia healthcare providers in a White House meeting with Mrs. Clinton and healthcare staff on the president's plan.

• **Sr. Loretto Marie Colwell, SCL**, president/CEO of St. Francis Hospital and Medical Center, Topeka, met with President Clinton and Rep. Jim Slattery, D-KS, to talk about healthcare reform at an HCRP news conference.

• **J. Douglas McBride**, senior vice president/CEO of Fitzgerald Mercy Hospital, Darby, PA, participated in an HCRP news conference unveiling Families USA's new study on the uninsured. The report documents that 2.25 million Americans lose their health insurance every month—two-thirds of them because of workplace changes.

Advocacy Handbook

A new CHA publication—*Healthcare Reform: Grassroots Advocacy for Catholic Healthcare Organizations*—helps providers present their message to legislators. The booklet offers guidelines and suggestions for developing an advocacy program, working with medical staff and trustees on reform, and writing and visiting legislators. To receive a free copy, call the CHA Washington office at 202-296-3993.