REFORM UPDATE

CHA MEMBERS' ADVOCACY COORDINATORS TO EDUCATE KEY CONGRESSIONAL COMMITTEE MEMBERS

"Congress at work is Congress in committee," Woodrow Wilson wrote many years ago. Taking that advice, the Catholic Health Association's advocacy efforts on healthcare reform will concentrate on presenting CHA's advocacy positions to the key committees in Congress.

Spearheading these efforts will be advocacy coordinators appointed by facilities and sponsors in the Catholic healthcare ministry. "Almost all CHA members have appointed advocacy coordinators," said William Cox, vice president of government services. "We have a list of about 600 advocacy coordinators, and it's growing."

CHA's Advocacy Positions

CHA encouraged its members to appoint advocacy coordinators at the legislative field meetings held throughout the country from December through February. The field meetings were very well attended and received, Cox said. At the meetings, CHA staff described the Clinton plan in detail, touched on other reform proposals (for a comparison, see pp. 8-9), outlined CHA's four advocacy positions, provided an estimate of the political dynamics behind reform, and launched a grassroots advocacy campaign.

Cox noted that CHA has 360 members in districts of congressional representatives who are on key House and Senate committees. These committees will have primary responsibility for "marking up" President Clinton's reform proposal. To have any impact, he said, CHA members will have to present CHA's advocacy positions to these committee members. The four basic points are as follows (for more detail, see *Health Progress*, January-February 1994, pp. 6-8):

- Clinton's provisions for universal coverage must be maintained and enhanced.
- The uniform comprehensive benefit package must be one acceptable to most people.
- Delivery reform must be achieved via clinically and financially integrated networks.
- Reliable and fair expenditure control must be achieved.

CHA will also be working with the U.S. bishops and other groups to oppose the inclusion of abortion in the benefits package, Cox said.

The Growing Debate

CHA staff and members have already been participating in the growing debate across the country. CHA is a member of the Health Care Reform Project (HCRP), a coalition of 33 organizations including business, consumer, labor, hospital, and physician groups. HCRP has been holding press conferences, running advertisements, and trying to persuade key legislators to support the principles of Clinton's reform proposal.

The press conferences have included CHA members, such as CEO Jim Wilson of St. Agnes Hospital, Philadelphia, and CEO Kathryn McDonagh of St. Joseph's Hospital, Atlanta. CHA is encouraging its members to join coalitions with other groups sharing similar values to support comprehensive reform.

Cooper Bill Inadequate

Cox emphasized how critical it is for members to communicate their support for universal coverage. The cause may have suffered a setback in February when the Business Roundtable, a group of influential CEOs, voiced its support for the healthcare reform bill authored by Rep. Jim Cooper, D-TN. "Despite his protestations to the contrary, that bill does not provide universal coverage; it doesn't even come close," Cox said.

The Cooper bill would provide tax incentives to help people buy health insurance, as opposed to the Clinton plan's mandate for employers to provide coverage. The Cooper plan is favored by some because of its perceived gradualism and reliance on market forces rather than regulation. But CHA analysts point out that, by one estimate, it would require an uninsured working family of four making $30,000 a year to pay $5,000 a year for health insurance.

"Partial or incremental approaches to reform, and those that offer less than universal coverage, will not adequately address the problem," noted CHA President Jack Curley in response to President Clinton's State of the Union address. "Our nation cannot afford to miss this historic opportunity by allowing partisan or 'status quo' politics to thwart the reality of health security for every American."

—Susan K. Hume

REFORM UPDATE NEWSLETTER

To keep CHA members informed about efforts in Washington to reshape the healthcare system, the association's Washington office has introduced a biweekly newsletter, *Washington Reform Update*. These updates are being sent to CEOs, communicators, and advocacy coordinators of constituent members. To add your name to the mailing list, contact Jeanne Miller at 314-253-3456.

KEY PROVISIONS OF THE MAJOR HEALTHCARE BILLS

Plan Sponsor	Rep. Jim McDermott, D-WA; Sen. Paul Wellstone, D-MN	Rep. Pete Stark, D-CA	President Bill Clinton
Insurance coverage improvements	All Americans covered under tax-financed government insurance system.	Medicare for all. All Americans covered under an expanded Medicare program.	Requires all employers to pay for insurance for their workers. All others must obtain own insurance, which is purchased through newly created health insurance purchasing cooperatives (HIPCs), called "health alliances."
Financing	Payroll tax of about 7.9 percent on employers, 2 percent on employees; tobacco tax.	Expanded Medicare payroll tax.	Employer pays 80 percent of average cost health plan (but no more than 7.9 percent of payroll) offered through the health alliance; employee pays remaining amount . Government subsidies for small employers, low-income workers, and nonworking people—financed by Medicare-Medicaid cuts, cigarette tax, and 1% payroll tax on large employers (>5,000) that purchase outside the health alliance.
Benefits	Standard package for acute care (e.g., doctor and hospital) plus long-term nursing home and in-home care, prescription drugs. dental, mental health care.	Benefits would be identical to parts A and B of Medicare. Children and pregnant women would be fully covered with no deductible or copayments. Prescription drugs would be covered.	Standard acute care package plus prescription drugs, some dental and mental health benefits, and in-home care but no long-term nursing home benefits. Benefit package specified in the legislation.
Cost controls	Government sets annual budgets on how to spend for healthcare nationally; fee levels negotiated with doctors, hospitals, and others. Administrative savings.	National budget with rate setting and option for capitated health maintenance organizations.	Enhanced competition with national budget "backstop." Government sets limit on how much total insurance premiums can increase annually. Administrative savings. Malpractice reform.
Medicare-Medicaid	Abolished. Recipient covered under universal government plan.	Medicare is expanded to cover everyone.	Medicare remains as is unless a state opts to give recipients the general policies available through health alliances. Prescription benefit added. Medicaid retained for long-term nursing care, but for other care patients are shifted to subsidized private policies issued through alliances.
Insurance market changes (Limits denials or exclusions from coverage or excessive premiums because of health status.)	Not applicable.	Not applicable.	Yes.
Medisave option (Individuals and families can open tax-deductible "medical IRA" account to pay for routine care and insurance against "catastrophic" costs.)	Not applicable.	Not applicable.	Not applicable.

Prepared by the Catholic Health Association.

Rep. John Chafee, R-RI; Sen. Bob Dole, R-KS	Rep. Jim Cooper, D-TN; Rep. Fred Grandy, R-IA	House Minority Leader Robert Michel, R-IL	Sen. Phil Gramm, R-TX
All people required to obtain a policy if not provided by employers. Small employers, uncovered workers, or nonworking people could buy policies from HIPCs. Government subsidies for low-income persons if not eligible for Medicaid.	Small employers, employees, and nonworkers guaranteed right to buy insurance (with or without employer contribution) through HIPCs, with government subsidies for low-income people. Coverage not required.	Employers must offer (but not necessarily pay for) policies for their workers and may join health purchasing cooperatives to get lower rates from insurers. Government subsidies for low-income people. Coverage not required.	Government tax credits and subsidies to very low-income people to help them buy policies; tax deductions for some others. Coverage not required.
Limited tax deductions for premiums beyond a certain amount; cuts in Medicare and Medicaid.	Limited employer tax deductions for premiums beyond a certain amount; cuts in Medicare and Medicaid.	Shifts of funds from other government programs plus $5 billion over five years in cuts in various programs and higher premiums for high-income Medicare enrollees.	Cuts in Medicare and Medicaid.
Insurers must offer standard acute care benefit package; added tax deductions for long-term care insurance. Benefit package specified by national health board.	Standard acute care benefit package. Other benefits may be added later. Benefit package specified by national health board.	Standard acute care benefit package. A catastrophic plan and a Medisave plan must be offered. (Benefit package not specified in legislation.)	No standard package specified.
Enhanced competition among insurers and among healthcare providers. Administrative savings. Malpractice reform.	*Enhanced competition among* insurers and healthcare providers. Administrative savings. Malpractice reform.	*Enhanced competition.* Administrative savings. Malpractice reform.	*Enhanced competition.* Administrative savings. Malpractice reform.
Remain as is for immediate future.	Medicare remains as is. Medicaid acute care patients shifted to policies sold through cooperatives, with government paying; Medicaid long-term care cost gradually assumed by states.	Remain as is. States could enroll Medicaid patients in standard insurance plans.	Remain as is.
Yes.	Yes.	Yes.	Yes.
Yes; details to be worked out.	No.	Yes. Family could contribute up to $5,000 a year tax-deductible.	Yes. Family could contribute up to $4,800 a year tax-deductible.