

# REFORM UPDATE

## CLINTON PLAN MEANS OPPORTUNITY FOR THE CATHOLIC HEALTHCARE MINISTRY

**F**or the Catholic Health Association (CHA), White House events launching President Bill Clinton's healthcare reform plan were more than a celebration. According to CHA President Jack Curley, they represented a "kairos" moment, a crucial point in time that marks a beginning for CHA and its members. The Catholic healthcare ministry, through CHA, now has a critical opportunity to contribute as the nation shapes a new healthcare system. "The ministry can have an enormous impact on the healthcare debate and turn its compassion and commitment into advocacy for public policy that serves the needs of all the nation's people," Curley said.

He was among 100 leaders on healthcare reform invited to a White House reception September 22, the evening on which President Clinton laid out his plan in an address to Congress. The next day Curley and Sr. Maryanna Coyle, SC, CHA's chairperson, represented the association at a rally to kick off the campaign for healthcare reform.

### Beginning the Debate

The White House events were not an opportunity for CHA to celebrate a victory, but to assist in beginning the process of formulating what could be "the most significant social legislation in this half-century," Curley said in an interview with *Health Progress*.

Noting that the president's plan represented the coming to fruition of 10 years of CHA effort, Curley said, "It is clear our nation is now going to have the public policy debate our people deserve." CHA is approaching the debate, he said, "with hope and anticipation for what could be the outcome if we in Catholic healthcare can make our wishes known for how best to care for

people. That is our expertise." First Lady Hillary Rodham Clinton, in remarks at the rally, made the point that the healthcare crisis is a uniquely American problem and it deserves a uniquely American solution, Curley recalled. The debate on healthcare reform, he said, "should be as intense, widely based, and fully representative of the diversity of our country as possible; that is the only way to get a uniquely American response."

In private remarks to Curley, Mrs. Clinton praised the quality of CHA's reform proposal and acknowledged the guidance that CHA and its Leadership Task Force on National Health Policy Reform provided to the administration (see **Box**). She said she appreciated the input—both positive and negative—that CHA has provided.

In a September 15 letter, Curley told President Clinton that CHA supports many aspects of his plan—universal coverage, a substantive uniform benefit package for all persons, protections for needy populations, and expenditure control. However, during the legislative process CHA will pursue modifications that are faithful to the ethical values of the Catholic healthcare ministry. In addition, the plan's reliance on reductions in Medicare and Medicaid to achieve savings is troubling. CHA fears that attempting to save \$238 billion in the programs over only two or three years will impede access and services. Another problem is that Medicare remains separate from the rest of the reformed system, and thus does not operate under the same incentives for efficient healthcare delivery.

The association is also concerned that the plan's national budget-setting process uses a formula-driven rate of increase that fails to take into account changing health needs, system efficien-

cies, and the public's views on "trade-offs between healthcare and other important social goods," the letter said.

### Responsibility for Debate Continues

Curley believes that if the administration's effort to systematically address the healthcare needs of the American people fails, it will be generations before another attempt. This places a great responsibility on organizations and individuals. "Everyone who has a constructive role to play in the debate must become as fully engaged in that debate as possible," Curley said.

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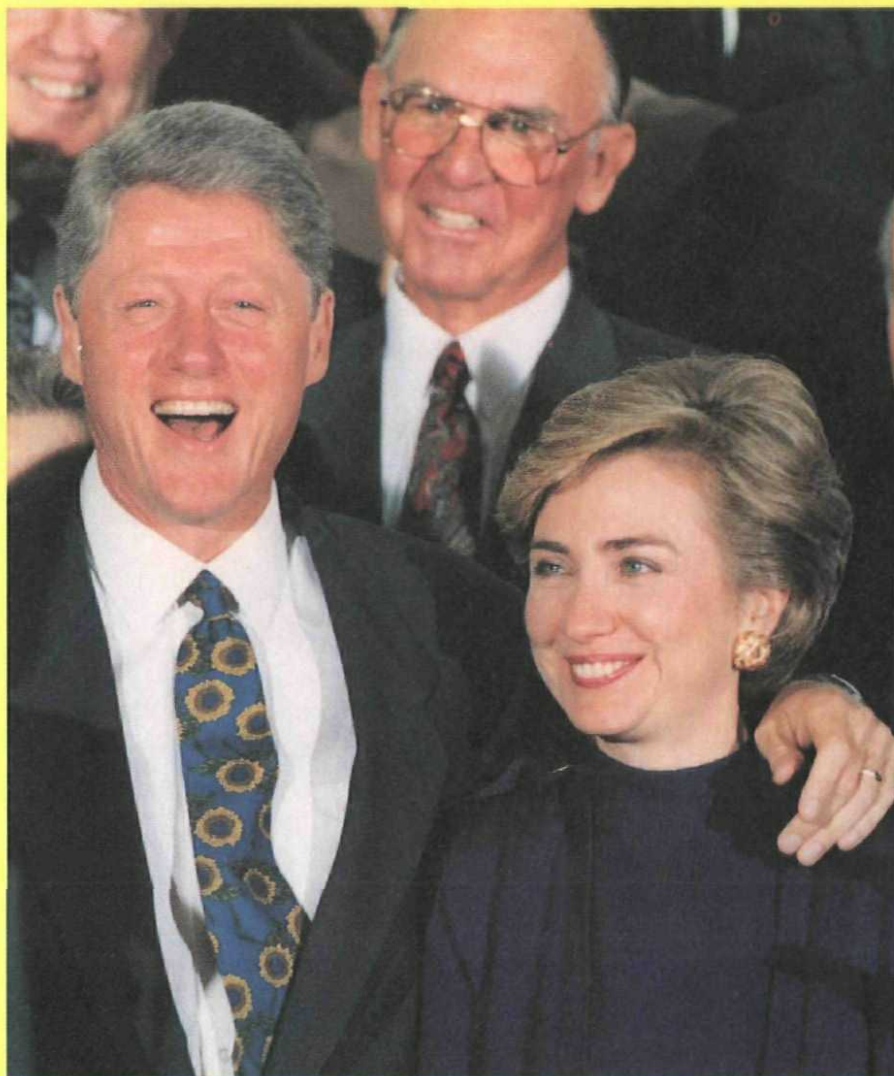
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CHA's efforts to explain the need for healthcare reform began in the 1980s with a public policy advertising campaign to raise consciousness about the plight of the underserved. Two reports, in 1986 and 1988, made more explicit CHA's commitment to engage issues affecting vulnerable populations, he noted. *No Room in the Marketplace*, a report of CHA's Task Force on Health Care of the Poor, and *A Time to Be Old, a Time to Flourish*, by the Task Force on Long Term Care Policy, called for responses to the needs of the poor and the frail elderly.

The 1991 document *With Justice for All? The Ethics of Healthcare Rationing* provided guidance on evaluating rationing proposals from an ethical perspective. Education about the need for reform continued with articles in CHA's regular publications and a series of regional legislative field meetings for members over the past four years. CHA's 1992 and 1993 annual assemblies focused on healthcare reform.

For almost two years, CHA's Task Force on National Health Policy Reform, chaired by Sr. Bernice Coreil, DC, has worked on CHA's proposal, *Setting Relationships Right: A Proposal for Systemic Healthcare Reform*, which was distributed the day before President Clinton's address. The task force's earlier "working" proposal had also been widely distributed in Washington and among various groups, as well as to CHA members.

Curley said CHA efforts will continue. "We look forward to being engaged with our own members as we bring the richness of our value tradition to the content of this debate." —Judy Cassidy



CHA President Jack Curley was among leaders who stood on stage with President Bill Clinton and First Lady Hillary Rodham Clinton at a kickoff rally September 23. About 1,200 people cheered the gathering on the south lawn of the White House.

## CHA AND CLINTON PROPOSALS EMBODY SIMILAR VALUES

The values in President Clinton's plan and CHA's *Setting Relationships Right: A Proposal for Systemic Healthcare Reform* encompass many of the same concepts. Here is a thumbnail comparison.

### CLINTON PLAN

- Security—Every American will be guaranteed benefits.
- Simplicity—One standard insurance form and simpler rules and regulations will streamline the system.
- Savings—Plans that deliver healthcare will compete on the basis of price and quality.
- Choice—People will

choose among plans, join a health maintenance organization, or choose their own doctor (fee-for-service).

- Quality—"Report cards" on health plans will enable people to choose the highest-quality providers, and quality indicators will help physicians make treatment decisions.
- Responsibility—Insurance reform, monitoring of fraud and abuse and cost of prescription drugs, as well as personal and societal responsibility for changing conditions that contribute to poor health, are encompassed in a plan that requires every

American to take responsibility for health.

### CHA PROPOSAL

- Healthcare is a service—Care of the ill and dying is an essential good, a service to persons in need, and should never be reduced to a mere commodity exchanged for profit.
- Every person is the subject of human dignity—All persons have a right to basic and comprehensive healthcare.
- Public policy must serve the common good—The healthcare system must not serve only the self-interest of a few but also the best interest of our nation

and communities.

- The needs of the poor have a special priority—The wealthy and the well should care for the poor and the sick.
- There must be responsible stewardship of resources—Economic discipline and credible expenditure controls must be part of the system.
- Tasks should be performed at appropriate levels of organization—The system must use federal authority to create a national healthcare community, respond to local diversity through state involvement, preserve pluralism in delivery, and protect a range of choice.

## SR. COYLE PRESENTS CHA'S POSITION ON PRESIDENT'S HEALTHCARE REFORM PROPOSAL

*Sr. Maryanna Coyle, SC, chairperson of the Catholic Health Association's Board of Trustees and president, Sisters of Charity of Cincinnati, testified before the Senate Committee on Labor and Human Resources on October 5, 1993. Here are her remarks, slightly condensed.*

**T**wo years ago the Catholic Health Association (CHA) developed its own proposal for healthcare reform. This comprehensive plan describes our vision for a healthy America. We were pleased to hear Mrs. Clinton cite our plan as a model for the administration's own reform proposal in her testimony before this and other committees last week.

Like the president, we believe healthcare reform is essentially a debate about values. CHA is encouraged by the fact that President Clinton's reform proposal is based on a similar set of principles (see **Box**, p. 7). As the president's reform proposal notes, these values "reflect fundamental national beliefs about community, equality, justice and liberty," and they anchor healthcare reform in our nation's "shared moral traditions."

### The Need for Reform

Today, millions of working Americans, their families, and others cannot afford or otherwise obtain health insurance. National healthcare expenditures are consuming increasing portions of the nation's wealth. These problems have been exacerbated by the abandonment of community rating in private health insurance and employers' growing resistance to cost shifting. These developments are undermining our nation's voluntary social safety net in healthcare and making it more difficult for not-for-profit healthcare institutions to meet their

historic missions of community service.

Meanwhile, the healthcare delivery system is fragmented. It is increasingly burdened by a broad range of private and public rules on prices, volume, and methods of treatment. One thing is certain: If Congress fails to act forcefully, comprehensively, and soon, things will only get worse. The underlying problems are systemic and, as the president has recognized, can only be addressed through comprehensive change.

### Critical Components

CHA calls on Congress to *hold fast* to several critical components of the president's approach to reform.

**Universal Coverage** Anything less than universal coverage creates a vicious circle whereby the uninsured are more likely to receive care in costly settings and for conditions that have grown more severe with time. The high cost of this care is then shifted to employers who in turn find insurance coverage for their workers increasingly unaffordable.

**Guaranteed National Benefit Package** The best strategy to defend the interests of the poor is to create a system that ties their fate to that of the average person. Such a system has the powerful potential of drawing our society together rather than dividing it along economic or class lines.

**Protections for Low-Income Populations** Most important is the incorporation of Medicaid funds into Health Alliances along with most other forms of financing. No longer would the poor be treated as a separate class of citizens, because premium payments to plans for former Medicaid recipients, other low-income populations, and everybody else in Health Alliances will be indistinguishable. This will end the cost shift from Medicaid to the private sector, reduce

the exposure of Medicaid financing as an easy target for budget cutting, and eliminate many of the financial disincentives to serve the poor.

**Continuous, Uninterrupted Coverage** As in CHA's proposal, Clinton has largely ended the link between employment and health insurance coverage. Both the employed and the unemployed can select from among any certified health plan in their community. This is important both because it is the humane thing to do and because a continuous, uninterrupted relationship with one's physician is critical to the goal of keeping people healthy.

**Consumer Choice** In the president's plan the link between employment and healthcare coverage has been severed. Even without the fee-for-service option, a family could select any certified plan in the community, including the plan that has their family physician.

**Overall Expenditure Control** CHA has long been in favor of a global budget. Morally, this is a question of responsible stewardship. Pragmatically, the rate of increase in healthcare spending is unsustainable, and there is no guarantee that managed competition will work without an expenditure "backstop."

**More Equitable Financing** Everyone is asked to share in the burden in this plan. The employer mandate ends the destabilizing cost shift from one employer to the next and reinforces the notion that we are all in this together.

**The High Cutoff for Firms That Must Use a Health Alliance** All firms with fewer than 5,000 employees would pay standardized premiums to the Health Alliance, which would then negotiate with health plans on behalf of all workers. To lower this threshold and allow substantial numbers of employers to continue negotiating separately with health plans would be a serious mistake.

### Strengthening the Proposal

CHA believes the Clinton proposal must be strengthened in five ways.

**Delivery Reform** The president's proposal



Sr. Coyle calls on Congress to hold fast to several critical components of the Clinton plan.

says little about how the healthcare delivery system should be reoriented to achieve *both* lower costs and clinically effective healthcare.

CHA's healthcare reform proposal starts with delivery reform. At the heart of our plan is the person-centered, community-based integrated delivery network (IDN). An IDN is a set of providers organized to assume financial risk for a full continuum of healthcare services. The kind of delivery reform embodied in these networks is *essential* for true, long-term cost control. The incentives in a capitated network encourage primary and preventive care, less unnecessary care, better coordinated care, services in less costly settings, more appropriate capacity levels, and a more rational use of high-technology services. *Without* delivery reform, insurers will rely on à la carte discounting, rate setting, formula-driven utilization controls, and micromanagement of providers in order to live within premium caps. Some of these devices may be appropriate. But to rely on them solely will be a mistake. We believe that the insurance function should be *merged* with the delivery function in the form of integrated networks and that the focus should be on more efficient methods of organizing care, not simply clamping down on payments and utilization.

Several elements of the Clinton proposal will impede delivery reform. First, the proposal encourages reliance on insurance companies to form and administer plans. This is not a problem as long as insurers act as *partners* with providers to create integrated community-based networks. It becomes a problem, however, if insurers act as distant regulators who seek savings through discounts and

formula-driven utilization controls, as many do today. This kind of arrangement will *not* result in more coordinated or efficient care. Nor will it ensure accountability to local communities.

Another impediment to delivery reform is that Medicare is left outside the new financing arrangements. While the Health Alliances may encourage more integrated of care through annual per-person payments, Medicare will perpetuate the opposite incentive by paying providers on a procedure-by-procedure basis. Thus providers will face the mixed and counterproductive financial incentives that plague our current system.

We support the president in his expansion of long-term care services, but sustainable cost savings will occur only if integrated networks can manage the full continuum of healthcare services, thereby allowing them to make patient-specific decisions about the most appropriate, most humane, and least costly patient care settings.

Finally, expenditures in the Clinton proposal are compressed unevenly and unrealistically. CHA supports the need to bring private and public healthcare costs under control through a global budget. However, a faster compression for Medicare and Medicaid will result in greater cost shifting between the public and private sector and could lead to severe access problems for the elderly.

More important, total spending is brought down at an implausibly rapid rate that may encourage "quick-and-easy" payment and utilization controls, but will not allow time for the development of efficient, community-based healthcare networks.

**Process for Setting the Global Budget** CHA's second recommendation is to employ a more effective, realistic process for setting the global budget. CHA's reform proposal calls for a "top down-bottom up" national budget-setting process that incorporates critical information on population needs and local system efficiencies. Our plan outlines checks and balances to ensure accountability to voters

for each year's global budget.

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 opportunity to make healthcare expenditures not only more predictable and reasonable, but also more consistent with changing needs, system capacity, and the public's own view with regard to the trade-offs between healthcare and other important social goals.

**Abortion** CHA strongly opposes, on both moral and political grounds, the inclusion of abortion in the guaranteed national benefit package. While abortion is currently legal, it is strongly opposed by millions of employers and taxpayers. *This government should not compel them to pay for abortions.* We are hopeful that when Congress decides this issue, it will come down in favor of keeping healthcare reform and legal abortion separate and distinct issues.

**Conscience Clauses** CHA firmly supports a strong conscience clause provision for individuals, institutions, and employers. The president has stated his intention to include conscience clauses in his legisla-

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tion. CHA will be working with the White House and Congress to ensure that the protection is adequate.

**Maintaining the Professional Ethos in American Medicine** Most politically viable healthcare reform plans (including the president's) rely on market forces to control healthcare costs and improve the quality of care. Such plans would accomplish this by shifting most of the financial risk from the purchasers of care (government and employers) to those providing the

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care (hospitals and doctors). The latter would be organized into accountable health plans that compete with one another on price and quality.

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 professional ethos in American medicine, threatening patient care and undermining the long-term stability of a community's healthcare resources. At least two questions need to be addressed:

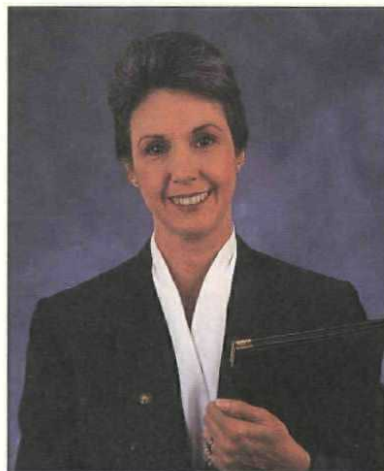
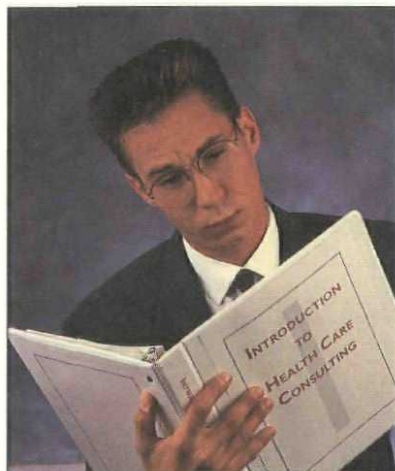
- How will patients fare when the treatment they need could make their provider less competitive, less profitable, or even bankrupt?
- Will accountable health plans owned by commercial interests abandon communities when their profits are squeezed and a higher return on investment can be achieved elsewhere?

### **The Measure of Success**

We conclude our testimony by returning to the point at which President Clinton opened this historic healthcare debate: a clear focus on values. Values are the beacons that guide us. But values also provide us with the standards by which we can measure our progress. How should we measure it in this debate? By the availability of persons throughout America's future healthcare system who are motivated to help others.

Successful healthcare reform will come down to people caring for people. When we are sick and in need, we ask, Is someone there when I call? Do they make me feel like a human person? Can I maintain my dignity and self-respect? These are the issues by which future generations of Americans will judge the success of what we are beginning today. They are the issues we must keep in front of us throughout this debate. It is what the American people expect of us and what we owe to them.

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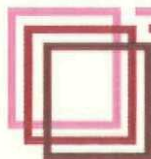
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