REFORM
UPDATE

REFORMS MUST RESTRUCTURE CARE DELIVERY, HEALTHCARE EXPERTS INSIST

As Congress debates national healthcare reform, the need to restructure the delivery of healthcare has been overshadowed by furious battles over finance and coverage issues, Bill Cox, the Catholic Health Association's vice president of Government Services, told more than 270 congressional aides and journalists at a daylong briefing in Washington, DC.

At the July meeting, which was co-sponsored by CHA, the American Hospital Association, and the Alliance for Health Reform, Cox and more than 20 other representatives of organizations involved in delivery reform described the current "revolution" in healthcare delivery occurring as delivery is moving from fee-for-service care, in which providers and payers focus on isolated incidents of care and disease, to managed care, in which plans assume the financial risk for the health of a defined population.


Cox

Managed Care Opportunities

Managed care plans paid by capitation offer the opportunity to improve quality while also controlling costs, said Paul Starr, Princeton University professor of sociology and author of the Pulitzer Prize–winning book *The Social Transformation of American Medicine.* Capitated plans have a more comprehensive view of treatment options than do traditional fee-for-service plans that attempt to control costs by imposing arbitrary payment limitations, he noted. With their ability to use information on performance and outcomes, plans can reengineer inefficient processes of care delivery and demand accountability from physicians, he said.


Starr

Complete Overhaul Needed

Today's "nonsystem" of healthcare delivery needs complete reorganization, agreed William L. Dowling, vice president for planning and policy development, Sisters of Providence Health System, Seattle. The time has come for vertically integrated delivery systems that offer a broad range of acute and long-term services under one umbrella, Dowling said.

Such systems are the only way healthcare organizations can assume the financial risk for the


Dowling

PHYSICIAN SUPPLY IN A RESTRUCTURED DELIVERY SYSTEM

The evolution from fee-for-service medicine to managed care has profound implications for the number of physicians and the number of specialists the United States will need in coming years. "We need more primary care physicians, and we need to get them into some of the 2,500 areas in the country—particularly in inner cities and in rural areas—where there is a health professional shortage," said Sen. Jay Rockefeller, D-VA, at the July conference on delivery reform.

He cited findings by Jonathan Weiner, reported in the July 20, 1994, *Journal of the American Medical Association*, that by the year 2000, the nation will have a surplus of 165,000 physicians and a 60 percent oversupply of specialists. "Only one American physician in three has a primary care practice, and only one American medical student in seven even plans to have one in the future," Rockefeller said. "Congress needs to make the graduate medical education system more responsive to national needs," he insisted.

David Altman, associate vice president for education policy, Association of American Medical Colleges, Washington, DC, said current legislative proposals do not address the surplus. This may be partly due to complexity of the issue. Altman listed questions challenging graduate medical education programs, including, How many physicians will be needed? How much will it cost to change physician training? Who will train physicians in the future? Are medical schools adequate to train physicians to work in settings outside the hospital? Can specialists be trained to deliver primary care?

The issue has been framed as a simple dichotomy—primary care versus specialists, added Michael E. Whitcomb, director of the American Medical Association's Division of Graduate Medical Education. This approach, he said, fails to address a major issue: *which* specialties to downsize. "We don't want a policy that adversely affects a certain specialty we need," he cautioned.

health of the people they serve—a risk public and private payers are shifting to them with increasing rapidity.

In the Providence system, he said, facilities are putting together integrated delivery networks community by community in each of the system's regions (see article on p. 18 for an example). The system is building formal collaborative relationships with physicians who manage care within fixed dollar limits. A network of primary care clinics will provide access to care throughout the areas the system serves. Information systems that report quality, outcomes, and cost effectiveness will enable the system to allocate resources appropriately without external regulations, he said.

Dangerous Proposals

Dowling fears minimal reform proposals that would hinder the restructuring of delivery and perpetuate the fee-for-service delivery system—a system that reinforces fragmentation and duplication, diverts attention from the health status of communities, and "forfeits opportunities for cross-provider efficiencies," he said.

With the question, "Why are some in Congress trying to put us out of business?" Anthony Watson expressed similar concerns. Legislative proposals that allow members of a managed care plan to use providers outside the plan's network and "any willing provider" laws that prevent plans from excluding physicians would destroy the plans by making it impossible for them to control costs, he said. Watson, who is president of the Health Insurance Plan of Greater New York, which provides managed care to 77,000 Medicaid recipients, acknowledged some access problems for the poor but opposed the proposals' "meat axe approach" to solve them.

Watson

Universal coverage and insurance market reforms are crucial in healthcare reform legislation, CHA's Cox said. Without reforms such as community rating, risk-adjusted premiums, and consumer choice, plans will continue to compete on the basis of avoiding the uninsured and high-cost enrollees rather than on quality and price, he said.

To protect the quality of care, consumers must have a choice of plans, Cox added. In the current system, employers and insurance companies are making more and more healthcare choices for people, and they will always choose the lowest-unit-cost plans, he said. "It is important to delink employer sponsorship of health plans from employer payment. This is how the very successful Federal Employee Health Benefit Program (FEHBP) operates. Federal employees choose their health plans on the basis of cost, quality, and convenience. Their employer helps them pay for their plan but doesn't make the choice for them. If people have a choice of capitated plans, the plans will be very consumer oriented because they won't want to lose a significant portion of their enrollees from year to year."

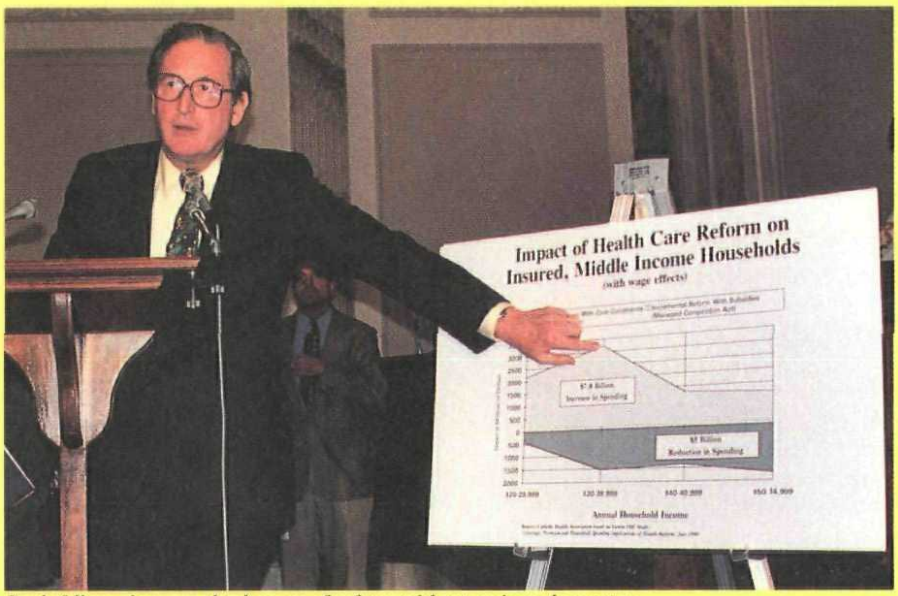
"It is important to note that the FEHBP does a superb job of controlling costs and being administratively efficient," Cox said. "The FEHBP should be the model for healthcare reform."

—Judy Cassidy

CHA STUDY SHOWS THAT INCREMENTAL REFORMS ARE COSTLY, DANGEROUS

Health insurance reforms linked to subsidies, but without universal coverage, would significantly increase healthcare costs for families earning between $20,000 and $75,000 a year (nearly 60 percent of American families), reports a Lewin-VHI study commissioned by CHA. The study measured the impact of several healthcare reform plans on household spending for healthcare at various income levels.

"Any senator who advocates an incremental approach will now have to explain why he or she is backing a plan that forces middle-class families to pay more for healthcare without giving them any additional health security," Sen. Jay Rockefeller, D-WV, said during the July 18 press conference at which the study's findings were unveiled.



Rockefeller points out the dangers of reform without universal coverage.

"Incremental reform would force healthcare spending [by the middle class] to increase by almost $8 billion in the first year," Sen. Patty Murray, D-WA, pointed out at the press conference. On the other hand, universal healthcare coverage, linked to cost controls and employer contributions, would lower spending on healthcare for insured families earning less than $100,000 a year. Murray added, "The 'go slow' idea on healthcare reform is the equivalent of

putting a 10 mph speed limit on ambulances—it's costly and it's dangerous."

To drive home her point about the costs of incremental reform, Murray noted that a family earning between $30,000 and $40,000 a year would spend $344 a year more after taxes and wage adjustments. Murray said, "$344 may not sound like a lot of money to some people in Washington, but to a family making $30,000, it's a lot of money, particularly since these people expect and deserve to have their spending on healthcare reduced, not increased."

Another "surprising result" of incremental reform, Murray noted, is that families earning between $75,000 and $100,00 a year would get a break. She explained that this "is at least partially due to the fact that people in higher incomes have more of their insurance premiums paid by employers, one of the key elements of reform that we are trying to extend down to people in middle-income households."

A Vicious Cycle

Without universal access, many young and healthy persons—who use fewer services—would forgo healthcare coverage. Their absence from insurance pools would result in high health insurance premiums because persons who typically consume more healthcare services—the elderly and those with preexisting conditions—are covered, explained William J. Cox, CHA's vice president, government services. This results in a "vicious cycle of upwardly spiraling health insurance premium costs" as more small businesses and young people drop their insurance coverage each year, he added.

States' Experience

Cox pointed out that health insurance premiums shot up 18 percent in New York during the first year of the state's insurance reforms, which did not include universal coverage. Rockefeller reported that some insurers increased rates by as much as 35 percent.

During a July 19 *Good Morning America* interview, Hillary Rodham Clinton also mentioned New York's healthcare system woes. "If you say to insurance companies, 'You have to take everybody, you have to guarantee they have portability'—which means they can move their policy—they will increase costs without universal coverage," said Clinton. "That's what happened [in New York] and in every state that tried it. That means, as the Catholic Health Association said yesterday, the costs for middle-income working Americans who currently have insurance will increase because insurance companies will have to insure people who are sick and have preexisting conditions and [insurance companies] will make up the difference by increasing the costs on the rest of us."

To demonstrate that universal coverage can work, Rockefeller pointed to Hawaii, a state that has come very close to universal coverage through employer mandates. Health insurance premiums in Hawaii are nearly 30 percent lower than on the mainland, he said. Hawaii has had its employer mandate program in place for 20 years, Sen. Daniel J. Inouye, D-HI, pointed out. "We have demonstrated what this report has shown: Universal coverage works."

CHA Responds as Debate Heats Up

The CHA-Lewin report has been received positively in Washington, DC, and across the country. But as the debate in the U.S. Congress becomes more focused, CHA is intensifying its efforts to help secure comprehensive healthcare reform.

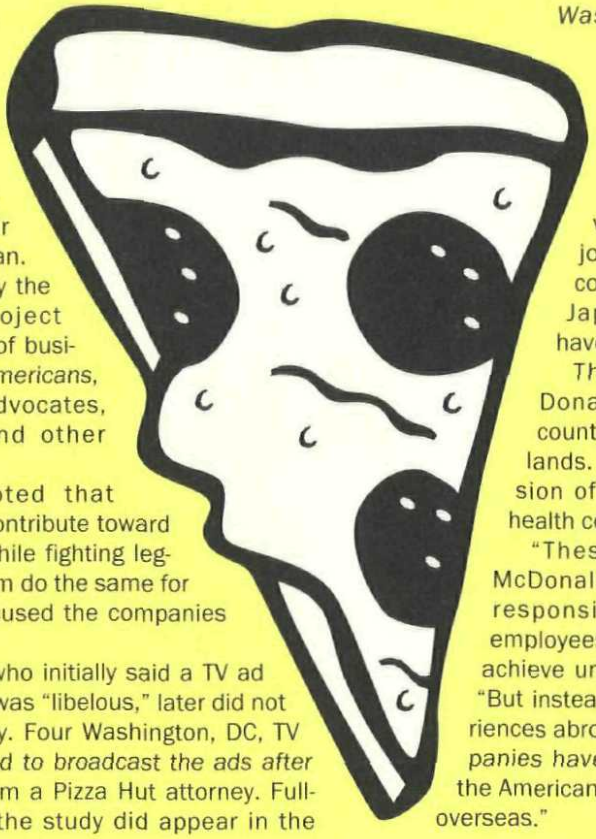
CHA has increased the frequency of its communications with association members and policymakers. In August a letter from CHA President and CEO Jack Curley to CHA members expressed support for Mitchell's and Gephardt's bills, which strive for universal coverage, but argued for the need to exclude abortion coverage. A daily faxed reform briefing and more frequent Action Alerts are keeping members apprised of the process during House and Senate floor debates.

FINDINGS AT A GLANCE

CHA commissioned Lewin-VHI to compare healthcare reform that includes universal coverage with reform that achieves only partial coverage through insurance market regulation and subsidies. The study concludes:

- Middle-class Americans who now have health insurance will pay significantly more for healthcare if reform does not include universal coverage.
- Middle-class Americans who now have health insurance will spend less on healthcare if reform with universal coverage includes costs constraints and requires all employers to contribute to their employees' premiums.
- High premium costs are averted through universal coverage because insurance pools would include all persons—healthy persons, who use few services, as well as persons with preexisting conditions and the elderly, who tend to use more services. Risk is thus spread evenly across insurance pools, and cost shifting is eliminated.
- Without universal coverage, resulting high premium costs will drive young, healthy persons out of risk pools, and premium rates will escalate. If healthy persons remain uninsured, cost shifting increases.
- Many employers who now provide their employees health insurance may reduce coverage or drop it entirely if, in the absence of universal coverage, subsidies are provided to low-income persons.

HCRP ACCUSES EMPLOYER-MANDATE OPPONENTS OF HYPOCRISY



The healthcare reform battle heated up July 15 when it was revealed that two U.S.-based fast-food giants provide insurance coverage for only a minority of their domestic employees but fully cover most of their workers in Germany and Japan.

The study was released by the Health Care Reform Project (HCRP), a national coalition of businesses, consumers, older Americans, labor unions, children's advocates, healthcare providers, and other groups, including CHA.

The HCRP's study noted that McDonald's and Pizza Hut contribute toward workers' coverage abroad while fighting legislation that would make them do the same for U.S. workers. The HCRP accused the companies of hypocrisy.

A Pizza Hut spokesman, who initially said a TV ad based on the HCRP's report was "libelous," later did not dispute the study's accuracy. Four Washington, DC, TV stations nevertheless refused to broadcast the ads after receiving warning letters from a Pizza Hut attorney. Full-page HCRP ads based on the study did appear in the *Washington Post* and the *New York Times*.

Pizza Hut, a subsidiary of Pepsico, was the target of the TV ad. The HCRP report said that although Pepsico officials have claimed U.S. employer mandates would force companies to reduce job opportunities, Pizza Hut stores continue to blossom in Germany and Japan, where employer mandates have long been in force.

The HCRP study notes that McDonald's is also expanding in those countries, plus Belgium and the Netherlands. All four countries have some version of shared responsibility to pay for health coverage.

"These companies [Pizza Hut and McDonald's] are living proof that shared responsibility works for employers and employees, and as a means for a nation to achieve universal coverage," the report says. "But instead of applying their successful experiences abroad to the United States, these companies have effectively said to Congress and the American people: Do as we say, not as we do overseas."

PROVIDERS SPEAK OUT FOR UNIVERSAL COVERAGE

Hundreds of healthcare providers from around the nation gathered on Capitol Hill August 2 to demonstrate their unwavering support for universal coverage. If Congress fails to pass it, we will see "a vicious cycle of upwardly spiraling health insurance costs and more uninsured Americans," warned Sr. Laura Wolf, OSF, president of Franciscan Sisters of Christian Charity HealthCare Ministry, Manitowoc, WI.

Wolf

Other speakers at the rally included Hillary Rodham Clinton; Sens. Paul Wellstone, D-MN, Paul Simon, D-IL, and Jay Rockefeller, D-WV; House Majority Leader Richard Gephardt, D-MO; and House Majority Whip David Bonior, D-MI.

"Healthcare reform without universal coverage simply will not work," insisted Sr. Wolf, who was speaking at the Capitol Hill rally on behalf of CHA and other participating hospital groups. "Insurance reforms, which extend coverage to sick and high users of care, will surely drive up average premiums for presently insured middle-income working families. Because of these higher premiums, some healthy individuals and firms will drop their health coverage. Consequently, the shrinking insurance pool will have higher average costs for the less healthy who remain."

COMMUNITY CARE PROJECT GETS GRANT

The American Hospital Association's Hospital Research and Educational Trust (HRET) has been awarded a $6 million grant to build community care networks. CHA and the Voluntary Hospitals of America, Inc., are collaborators in the project.

The grant, from the W. K. Kellogg Foundation, will allow HRET to develop 20 fully operational community care networks in inner cities and rural communities across the country. The networks bring together hospitals, family care centers, clinics, nursing homes, schools, social services, and local governments to provide care for the community.

The 20 sites chosen for grants to develop the networks will be studied over the next four years to design guidelines and tools for others interested in implementing community care networks.

As a collaborator in the project, CHA will name a steering committee member; identify participants for various conferences; and cosponsor and help plan summits, forums, and other meetings.