REFORM
UPDATE

CONGRESSIONAL STAFF RETREAT UNDERLINES THE NEED FOR UNIVERSAL COVERAGE

Successfully reforming the healthcare system will require a unique combination of collaboration and compromise among lawmakers of all political persuasions. With that in mind, in January the Alliance for Health Reform and the Catholic Health Association held a bipartisan health policy retreat for senior congressional healthcare staff, supported in part by a grant from the Robert Wood Johnson Foundation.

The retreat, held in Annapolis, MD, encouraged a bipartisan exchange of ideas about critical components of healthcare reform that Congress will be deliberating next year. The January meeting built on the success of two previous retreats sponsored by CHA and the Alliance for Health Reform, which is a nonpartisan organization that educates opinion leaders, including media, corporate leadership, and members of Congress and their staff, about the urgency of pursuing health and long-term care reform.

At the retreat, 130 attendees sorted through the tough questions that must be answered before healthcare reform can become a reality. Speakers included Henry J. Aaron of the Brookings Institution; Stuart H. Altman of Brandeis University; Douglas L. Bailey of the American Political Network, which publishes American Health Line; *Karen Davis of the Commonwealth Fund; Judith Feder of the Department of Health and Human Services; Robert Graham of the American Academy of Family Physicians; Uwe E. Reinhardt of Princeton University; Thomas Scully, a partner in a Washington, DC, law firm, formerly of the Office of Management and Budget during the Bush administration; Reed Tuckson of the Charles R. Drew University of Medicine and Science; and Walter A. Zelman, a senior policy adviser to President Clinton for healthcare.*

To encourage a frank exchange of views, speakers and participants were assured they would not have statements at the retreat attributed to their name. What follows is a thumbnail sketch of the key points discussed, reflecting the diverse—and often contrary—views of the various speakers.

Universal Coverage Is Central

The most significant tension in the health reform debate is that between the desire for universal coverage and the desire to avoid taxation and mandates. Universal coverage is central to reform for three reasons:

- More than 38 million uninsured people pose an obvious moral and economic problem for the nation.
- Universal coverage plays an important role in controlling costs. Health plans cannot compete effectively if they are held back by the cost burden of providing indigent care.
- If reform passes without universal coverage, lawmakers can prepare for a political backlash from the public.
- Insuring 38.5 million people puts a lot of pressure on the delivery system. Without universal coverage, cost shifting will not only worsen, quality of care will diminish.

Controlling Costs

The ability to control health spending is critical to solving many of the health system's woes. Already market forces are beginning to slow cost escalation. Some policy experts recommend allowing market forces to continue—but under closer public scrutiny. Managed competition can work with global budgets, but there must be coordination between the two. Without that, the stronger component will overwhelm the weaker one.

Overall, policymakers must make some effort to relieve the anxiety of the insurance industry. Three suggestions to do so are:

- Empathizing with insurance industry fears about the threat that taking on 65 million new enrollees (not only the uninsured but Medicaid beneficiaries, veterans, and native Americans) presents to the fiscal integrity of private plans. Thus, a plan using both competitive and global budget forces must create enough flexibility to adjust global budgets if targets are not met.
- Changing premium adjustment rules so plans can adapt to the average weighted premium without threatening fiscal stability.
- Enforcing annual budgets only after the third year of the transition period to full reform.

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Vulnerable Populations

The moral force driving health reform is the desire to extend health coverage to vulnerable populations. Current estimates indicate that about 45 million people fall under this rubric.

To create a stable financing mecha-

nism for healthcare for poor communities, reformers should consider the following policies:

- Earmark development funds to underserved areas and replace private capital with public capital.
- Provide underwriting subsidies or operating support to providers.
- Consider such protections as designing an appropriately sized purchasing pool that is large enough to prevent isolation of vulnerable populations, regulating how plans can market to prevent "redlining" of these populations, and constructing rules to prevent plans from redlining providers that treat these populations.

While issues important to minorities are addressed in reform proposals (preventive and primary care, for example), there is no infrastructure to support the delivery of such care to vulnerable populations. Therefore, community health centers may play an important role.

Healthcare Work Force

The short supply of generalist practitioners threatens the potential success of reform. Many policymakers and physicians believe that promoting a primary care agenda for consumers while controlling costs requires close to a 50-50 mix between generalists and specialists. A better mix, however, will not address the nation's primary care needs unless the new generalists practice in currently underserved areas, where some 45 million Americans live.

Should this shift of physicians' locations be forced by regulation or encouraged by marketplace demands? Because of the problems of relying on market forces and the urgency for comprehensive reform to control costs, a consensus has emerged supporting some regulation. It is the level of regulation, however, that is subject to debate.

To control costs, more physician assistants and other providers need to be able to compete with their physician counterparts. Expanding the role of nonphysician providers, however, must not be done carelessly. Although nonphysician providers may be less expensive per unit of service, their inclusion may add substantially to the healthcare tab as more services are provided.

Employer or Individual Mandates

If lawmakers decide to achieve universal coverage by maintaining the current private insurance market, they will likely debate two distinct approaches: an employer mandate or an individual mandate. The first makes employers responsible for providing coverage to workers; the second puts the responsibility to purchase insurance on the shoulders of the individual. The individual mandate proposal sponsored by Rep. Bill Thomas, R-CA, and Sen. John Chafee, R-RI, for example, provides premium subsidies paid on a sliding scale for those earning up to 240 percent of poverty.

The notion of health purchasing alliances as a new, fundamental structure to realign the system stands at once as both the darling and the devil in the debate.

Employer Mandate The advantages of employer mandate include:

- Limits cost to federal budget and, thus, broad-based taxes
- Builds on current system, minimizing disruption and distribution impacts of reforming the system
- Offers economics of group coverage
- Levels the playing field across firms in the same industry

The disadvantages include:

- May lead to adverse employment effect on low-wage workers
- May cause financial failure of some small businesses

Individual Mandate The advantages of individual mandate include:

- Breaks the link between employment status and health insurance coverage
- Does not pose a burden on businesses, minimizing adverse employment effects of expanding coverage to the uninsured

The disadvantages include:

- Requires substantial federal subsidies to make insurance affordable to the uninsured
- Provides incentives for employers to drop current coverage of low-wage workers
- Is difficult to enforce

Either type of mandate could leave an enormous segment of the population uninsured, particularly the 10 million individuals who do not file income tax returns and those who are undocumented aliens. In the long run, individual mandates may pose less of a financial burden on the federal budget because subsidy payments could more accurately target those with the greatest financial need. In the short run, however, employer mandates are more politically feasible because they hide the direct cost of healthcare, whereas individual mandates make payments explicit to voters.

Health Purchasing Alliances

The notion of health purchasing alliances as a new, fundamental structure to realign the system stands at once as both the darling and the devil in the debate. While there are many disagreements on whether healthcare purchasing alliances should be used and how they should be structured, their goals are clear:

- To spread risk and cost more broadly
- To foster competition based on efficiency, not risk selection
- To increase efficiency and decrease

Continued on page 11

CORPORATE ETHICS COMMITTEES

The articles in "The Changing Face of Ethics Committees: A Dialogue in Evolution" (November 1993) were, indeed, special. Sr. Patricia A. Sullivan, RSM, and Sr. Maureen Egan, RSM, are to be commended for their article, "A Measure of Growth" (pp.44-47, 52), and for their vision and the comprehensive nature of the corporate ethics committee evaluation survey. I believe the article acknowledges the strides already made, while it outlines a direction for the future of ethics committees, both within individual institutions and at the multi-institutional system's corporate level. This assessment is a key, if not critical, component of the work to be done. Too often it seems as though ethics committees get off to a good start, but are left to wither and barely survive. The three-step evaluative process is a puissant and realistic remedy for nurturing and encouraging committee viability at all levels of the system.

A modest caveat bears repeating in relation to the widening scope of healthcare ethics. Although the concerns definitely overlap, committee members must be aware of the administrative, legal, and ethical subissues of specific problems. The focus of the group's work should—must—be on the ethical dimension. On occasion committee members must be educated regarding the dangers of overlap (administrative, legal, ethical) and the folly of pursuing other than the real problem.

Once again, Sr. Sullivan and Sr. Egan are to be congratulated for their important and insightful guidance.

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REFORM
UPDATE

Continued from page 7

Alliances could offer plans with the best possible choice of provider and quality care.

health plan costs
- To reduce administrative costs
- To improve consumer choice of plans
- To improve continuity of coverage and care

Whether to make alliances voluntary or compulsory is central to the structure of reform and particularly contentious.

Voluntary Alliances Under a voluntary design, as proposed by Chafee, firms of a certain size that decide to offer (though not necessarily to pay for) coverage would have the option to do so through an alliance.

Proponents of this approach argue that it maintains provider choice and plan diversity, avoids the risk of permanently establishing an untested alliance structure, supports free market incentives as the best way to ensure consumer choice and cost-effective allocation of resources, and minimizes government control of the system.

Opponents of the voluntary alliance approach argue that it does not guarantee portability of an individual's health plan, continues some current market incentives to compete for low-risk populations, may increase consumer confusion, and is more costly and administratively complex than a compulsory system.

Mandatory Alliances Under a mandatory design, employers under a certain size—in the case of Clinton's plan, those with 5,000 workers—as well as individuals, must purchase insurance through an alliance that negotiates with various plans for the most cost-effective package of comparable benefits.

Supporters of this approach argue that it stops discrimination against small firms and individuals by creating a pool with the broadest possible risk sharing, could offer plans with the best possible choice of provider and quality care, creates a common marketplace that can effectively control costs through competition among plans, makes it easier to impose a premium price cap as a backup, and is simple and easy for consumers to understand.

Opponents argue that making alliances mandatory would create a bureaucratic giant to administer the health system, put too much power in the hands of government, and create highly politicized entities because of strong government involvement.

Bold Steps Needed

Despite disputes on the best way to achieve healthcare reform, participants at the forum agreed that bold steps are needed to address the problems in the current healthcare system. An indicator of progress toward reform may well be the acceptance by lawmakers of the need to create a new political entity—whether an alliance or something else—capable of administering universal coverage and realizing cost control. □