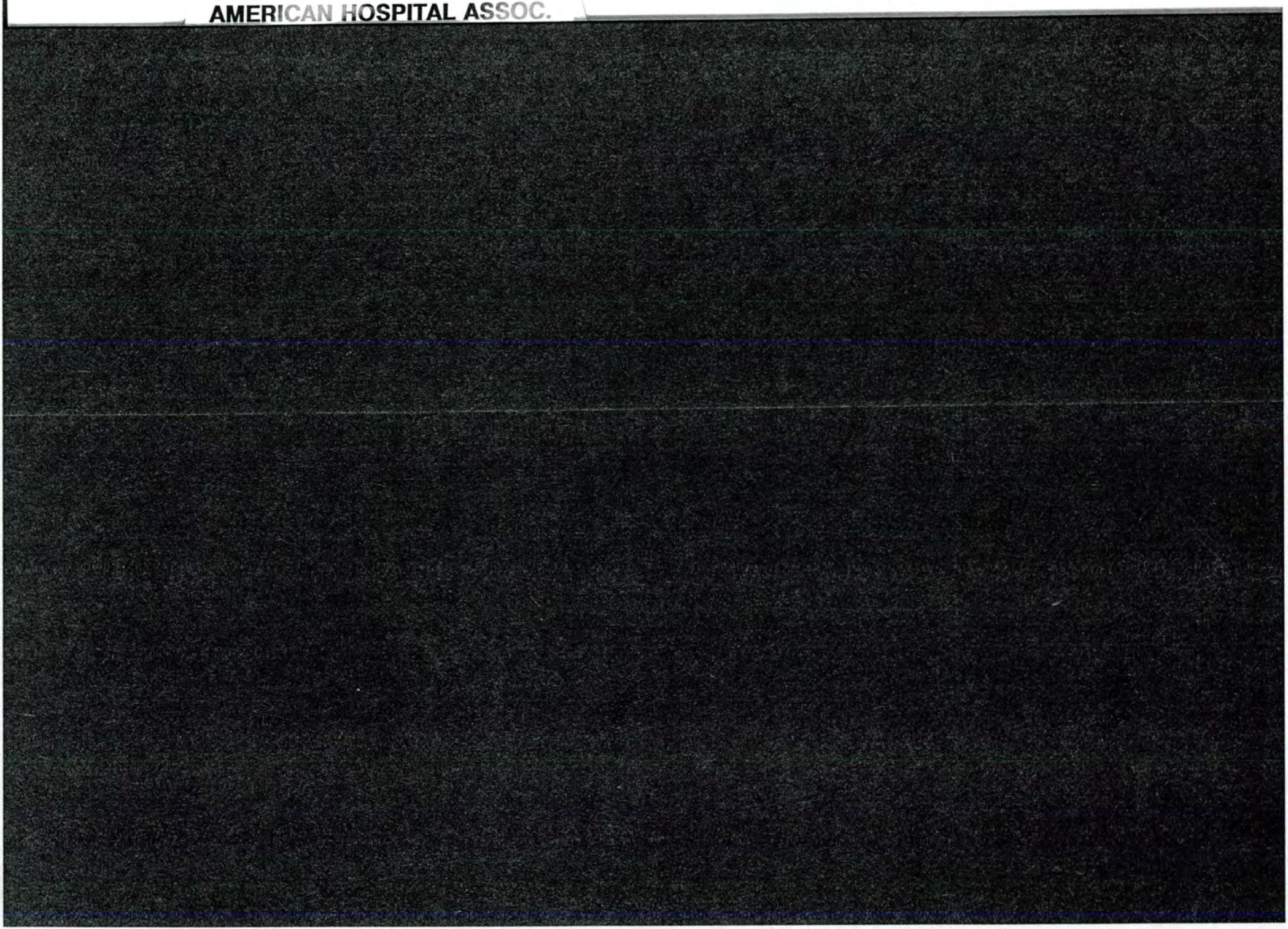

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American Hospital Association
(AHA)

file

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release February 1, 1994

REMARKS BY THE PRESIDENT
TO THE AMERICAN HOSPITAL ASSOCIATION

Washington Hilton
Washington, D.C.

10:18 A.M. EST

THE PRESIDENT: Thank you very much. Thank you, Dick; and thank you, Carolyn. And thank you also for bringing my tea out here. The Hospital Association is giving care to the President for his sick voice today. (Laughter.) I thank you.

I appreciate so much what both Dick and Carolyn said, and I want to begin by thanking all of you here who have ever had me in your hospitals -- (laughter) -- which is a large number of people. Especially all the people who represent my native state and who have done so much to help educate me on these issues over the years.

The time that I have spent in hospitals since I was a small boy has made a very big impression on me. I always learn something. I always leave with a sense of inspiration about the dedication of the people who work there. And I want to say a special word of thanks to this association for the work that you have done with our administration over the last year, in a very constructive way, in helping us to try to develop an approach which would solve the problems of the American health care system and protect and enhance what is good about it.

I know that there will still be some issues on which there will be disagreement as we go forward, but I think it's important that we clarify today, as Dick did so well in his introduction, that we agree on the most important issue: We have to preserve what is right; we have to fix what is wrong; we have to guarantee private insurance to every American so that everybody will be covered. That is the only way to stop cost shifting; the only way to be fair; the only way to solve this problem. (Applause.)

The problem with the health care system in this country did not just happen overnight. It happened because of the way this system is organized. Anybody who thinks there are no serious problems, no crisis in the health care system I would say go visit your local hospital. (Applause.)

Over the years, because of the insurance system we have in America, which is unlike any in the world and which, I will say, is irrelevant to the fact that we have the highest quality care in the world for the people who can afford it and access it, we have created a system which often makes it impossible for hospitals to do their jobs. While insurance companies have set up a system which enables them to slam the door on people who aren't healthy enough to get covered, hospitals open the door to everyone, whether they're covered or not.

We have created in this country, through the systems of hundreds of different insurance companies writing thousands of different policies, a giant bureaucracy which, on the insurance side, sorts the healthy from the sick, the old from the young, the geographically desirable from the undesirable. And as more and more

insurance companies sell more and more customized insurance policies to smaller and smaller groups, each of them has created its own set of forms and different sets of what would cover, spelled out in endless fine print. The result, as all of you know, has been a bureaucratic nightmare.

And what about the hospitals? You have had to create your own bureaucracy to deal with the insurance bureaucracy, and the government's as well -- to fight red tape, close loopholes and to try to get reimbursed somehow. And that only covers the patients who have good insurance. For those without insurance or with bare-bone coverage, you're forced to jump through a whole lot of other hoops. And you probably still often don't get any reimbursement.

Hospitals did not invent this system. You didn't choose a system which has resulted in hospitals hiring clerical workers at four times the rate of doctors being added to hospital staffs in the last 10 years. You did it because of the red tape of the present system -- the insurance red tape and the government program red tape.

Meanwhile, your missions didn't change -- it's still to treat the people who are sick who need to be in the hospital. Regardless of their age or medical history, of what may or may not be covered, you have to deal with the people that the insurance industry decides are not profitable. You can't ask whether an illness was a preexisting condition, it's still an illness.

So what are we left with today? A system where we're ruled by forms and have less time to make people healthy. A system that forces doctors and nurses and clerical workers in hospitals to write out the same information six times in six different ways just to satisfy some distant company or agency. It doesn't make sense, and you shouldn't have to put up with it anymore. (Applause.)

Just listen to Joan Brown, a registered nurse who works at a teaching hospital in Chapel Hill, North Carolina. She wrote to the First Lady that she spends -- and I quote -- "more time with paperwork than with any other aspect of health care." They've got a joke at her hospital, she said, "We'll do the patient care after we finish the paperwork, if we have time." It's not just a joke, it's a sign of a crisis, and one we've got to do something about.

I visited Children's Hospital here in Washington last year. The pediatrician, who is from this community and who is dedicated her life to the children of this community, told me she spends up to 25 hours a week filling out forms instead of tending sick children. "It's not what we trained all these years to do," she said. "Reducing paperwork would enable me to practice medicine again. It would free me," she said, "free me from the shackles and the burdens of the paperwork maze."

Let's be honest. In his wildest dreams, Rube Goldberg could never have designed a system more complex than the present health care system. (Applause.)

You in this room understand this better than anyone else in the world today. You see the crisis when people without insurance come to emergency rooms with serious injuries or illnesses. Many of those illnesses could have been prevented if only they had been covered and had access to a doctor, to primary and preventive care. The emergency room is the most expensive place to treat people. It should be reserved for emergencies. I know you believe that and you can make sure it happened if everybody had access to health care coverage.

You see the crisis when people come in who aren't fully insured and you become loaded up with what's called uncompensated care. The smallest estimate of that is $25 billion a year. It

either come out of your budgets, which hurts your ability to provide health care at a high quality, or you have to shift the cost on to the bills of those who can pay them.

A lot of people who complain about hospitals overcharging, about inflated bills, have no idea how much of this cost shifting occurs simply because of the insurance setup that we have in the United States. No other country in the world is burdened with it. And we should not tolerate it any longer. (Applause.)

You also see it because a lot of the people who come to you, either before they come or sometime during their treatment, deal with the problems of preexisting conditions or lifetime limits on insurance policies. Three out of four policies have such lifetime limits. I know a lot of times you wind up having to send a collection company after a patient that you know is not going to be able to pay the bill anyway because of these problems.

You see this crisis when a doctor prescribes prescription drugs, but then a person comes back to the hospital three or four weeks later because she couldn't afford to fill the prescription. So the illness got worse. One study says that problems related to the lack of appropriate medication lie at the root of up to 25 percent of all hospitalizations and cost over $21 billion a year. Our plan is the only one that takes account of this and covers prescription drugs along with other medical services.

You see it with the crisis of violence in the emergency room. We have to learn to treat violence as a public health problem. Billions of dollars a year again are loaded onto the health care system because we are the most violent country in the world. Many people in health care supported the Brady Bill, support our attempts to restrict assault weapons, to put more police officers on the street. That also will help alleviate the health care problem. So I hope you'll be out there after we deal with this the best we can also supporting what the administration is trying to do on crime. (Applause.)

I came here today once again to thank you for the work you have done with us and to appeal once again for your support, for the real battle is now being joined in Congress. And though we may disagree about the details, we all agree the time has come to do something. We have to do it now. And what we have to do includes providing guaranteed private insurance to every single American. That is what I need your help to do. (Applause.)

I implore you to go to Capitol Hill and tell your members of Congress again what is going on in your hospitals. Go home and talk to your friends and neighbors about it, and the people who come in to your hospitals. Talk to business leaders in your communities and local media people.

One of the biggest problems we have in this fight today is that this issue is so complex and people are naturally enough so concerned that they don't want to lose anything good that they have now, that it is easy to confuse people about what the real issues and the real facts are.

I love having a discussion with your representatives, even if there is some disagreement around the edges of policy. We come to the table with an accumulated knowledge of how the world really works. Our biggest problem in passing this is that there are too many people even in the Congress who have not had the opportunity to study this program in all of its complexity. This is a tough, tough issue.

And as I could tell from your applause, you know that the most complex system that could ever be designed is not the one

in the administration's bill, it's the one you're living with right now. (Applause.)

Our approach is not to tell you how to deliver health care, not to build barriers or bureaucracy. What we want to do is to establish a framework in which people are covered, provide the right incentives, help to remove the barriers to access, and get out of the way. We agree that local community care networks must be the center of any reform system. (Applause.) Groups of providers who see their mission as keeping people well, treating the sick when they are sick, and having the right incentives to do exactly that. We need to look no further that your own NOVA award winners for examples of providers who come together and make collaboration work.

One example, the Health Partners of Philadelphia, where six urban teaching hospitals came together and worked together to deal with violence and drugs and teen pregnancy in one community -- this is a very moving sort of thing. This can be done throughout America. And we could do more of it if we covered everybody. It would lower the cost to the overall health care system if we did it because we could practice prevention, we could give more primary care. The system as a whole would be less burdened, and we could have more networks like the one in Philadelphia you have honored.

I know that many of you are already finding incredibly creative ways to serve your community and are forming these networks. That approach will be quite consistent with the administration's approach. We helped to do that with clear incentives for people to join together in networks and guarantees that when they do there will be compensation there for the services that are provided. And we agree that reform must simplify the system for you by reducing the paperwork burden. There's no excuse for not having a single standard form to replace the thousands of forms that exist today. And we want to help you move forward with electronic billing, less regulation by the government, and other ways to help get rid of some of this paperwork hassle.

I am tired of trying to explain why we spend a dime on the dollar more on paperwork, regulation and premiums than any other country in the world and we still don't even cover everybody. It cannot by explained so it should be changed. (Applause.)

And I want you to help me do something else, too, when you go up to Congress. Ask every member of Congress, the next time somebody comes to them and says, what we really ought to do is tax the benefits, the health care benefits of middle class working people -- say, well, before you tax the benefits of working people whose wages have been stagnant for 20 years, why don't you ask how we can justify spending a dime on the dollar more on paperwork, regulation and insurance premiums than anybody else? That is waste. Why take something away from hardworking people before you squeeze the system and its unconscionable burdens on hospitals, doctors, nurses and the American people themselves? That is where we ought to start. (Applause.)

I also want to talk a little bit about the guarantee of private insurance. Most people, under our approach, would get insurance the same way they do today, through their employer. Each consumer -- not an employer, not a bureaucrat -- would have a choice of health care plans and doctors.

Let me point out something else on this choice. Today -- today, 55 percent of the companies who insure their employees and 40 percent of the total work force insured through their employer have no choice today in doctors or health plans. They take the plan the employer has chosen. Under our plan, everybody would have at least three choices of plans, including the right to simply pick a doctor and have fee-for-service medicine. That is more choice than

exists today, not less. Again, the rhetoric of people who have attacked change defies the reality of what people face and deal with in their daily lives in the health care system today.

Once someone has picked a plan, if they need to go to a doctor for a checkup or if they get sick, they'll simply take a health care security card, show it, and get the care they need. Then they'll fill out one standard form, and they're done. That way, we can go back to seeing hospitals as places of healing, not monuments to paperwork and bureaucracy.

I have heard so many stories in so many hospitals, I could keep you here all day laughing, but it would be like preaching to the saved. (Laughter.) The only thing I want you to do is to go tell the Congress about it, and that we can do better.

Last week when I spoke to Congress, I said that I would veto any legislation that did not cover every American with guaranteed insurance. (Applause.) Now, again I want to say that I did that because you know that unless we do that we can't have everybody playing by the same rules, using the same forms, ending the cost shifting and getting people the preventive and primary care they need so they don't simply wind up in the emergency room. That is, all the systematic problems that the Hospital Association brought to the administration when we began this discussion will continue unless we provide coverage to everyone.

Now, again, I know there are issues to work out. There are differences about what level of Medicaid savings can be achieved. I'll tell you this -- our plan is the only one that takes the Medicare savings and puts it back into the health care system, which is very, very important. But the biggest thing you need to do, I would argue, to get a good health care bill out of Congress is make sure that the people in the Congress understand how the system works today and what these various approaches would do if they were passed.

Yesterday, Families USA issued a very valuable document which I just received a copy of this morning which takes 10 different families, 10 different health situations and goes through in practical terms how they would be affected if each of the major plans now pending in the Congress were the law of the land. I would urge you to read it. But it won't surprise any of you because you know how the system works today.

Again, I implore you to take this debate to Congress, get beyond the rhetoric, get beyond the ideology, talk to people in the Congress about the American people and how the American health care system affects them. That is the only way we can work through the real problems as opposed to the imagined one.

One distinguished member of the House of Representatives who represents a district with a wonderful teaching hospital and who has been required by virtue of his membership -- his constituency -- to become an expert on health policy over the years, read our plan the other day and he said, "It's the only one that really takes account of so many different problems that most people don't even know about. But I have no idea how to get my colleagues in the Congress to take this issue seriously and spend all the time it would take to absorb it all."

You can do that. Every member of Congress has a lot of hospitals in his or her district. Every member of Congress basically cares a lot about health care. And you can come to this debate with a perspective that is not ideological, not partisan, has no axe to grind, doesn't care who wins except the American people and the American health care system. That's what you can bring to this debate.

So I would ask you, at a time when some say we just need a little tinkering and others say there are ideological barriers to changing it, I just want to say that Dick Davidson, your President, in my view, said it as well as it could be said last December. He said, "Comprehensive reform is what the American people are asking us to do. To do nothing -- or worse, to fall back on simplistic solutions -- only postpones and complicates our task." And that's the truth.

Let us stand together for the health care of the American people. We have a chance finally for the first time in decades to do this right. You know what needs to be done. I pledge to you an open door, a listening ear, a firm partnership. Let's go out there and solve this problem for the American people.

Thank you very much, and God bless you. (Applause.)

END 10:40 A.M. EST

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Statement
of the
American Hospital Association
before the
Subcommittee on Health and the Environment
of the
Energy and Commerce Committee
United States House of Representatives
on
Cost Containment in Health Care Reform

November 8, 1993

I am John G. King, President and Chief Executive Officer of Legacy Health System, Portland, Oregon. Legacy is a health system serving the Portland metropolitan area with four hospitals, a home health program, and a network of physicians and immediate and primary care clinics. I am here today, as a former member of American Hospital Association Board of Trustees, representing the American Hospital Association and its 5,000 member hospitals and health care organizations nationwide.

Members of this subcommittee and the full committee have worked for many years in the effort to extend and improve health care coverage for the nation. I know you share the American Hospital Association's excitement about the real opportunity before us for achieving that goal.

Blueprint for Real Health Care Reform

For more than two years, America's hospitals have worked to shape our own blueprint for health care reform. As we see it, real reform must achieve at least six objectives, and we will evaluate every proposal based on its success in meeting them. They include:

- universal access in a reasonable time period financed in a pluralistic manner;
- redeveloping health care delivery into an integrated and coordinated system able to address the needs of the population;
- economic discipline based on clear incentives -- such as paying providers a fixed amount of money to serve a defined population -- rather than micromanagement;
- balancing promised benefits with adequate financing;
- public accountability for the clinical effectiveness and economic efficiency of health plans; and
- antitrust and medical liability reform.

In our view, these goals are interrelated. Achieving one at the expense of another could place reform at risk. For example, expanding access without 1) controlling the cost of care, and 2), providing for adequate financing, would make the new benefits vulnerable to attack for accelerating the growth of health care spending. AHA's third goal -- economic discipline -- recognizes that accelerating costs are unacceptable, and acknowledges that the nation has a right to expect care to be delivered more efficiently than in the past.

Society's Charge -- Containing Health Care Costs

Setting cost containment goals in a vacuum -- without considering what it costs to provide care and streamline operations -- could have equally serious consequences for reform, undermining both access to care and reform of the delivery system. If health plans are underfunded, a health security card will do little to ensure that enrollees receive the guaranteed national benefit package, nor will it afford much security. We need an appropriate level of resources to achieve fundamental reform. For example, reconfiguring hospitals and other provider services into more efficient cooperative arrangements takes both human and financial resources. We know from experience that laying out a solid plan for merging services between two hospitals, or between a hospital and physician group, can take a year or more. The infrastructure investments we all endorse in order to reduce administrative costs -- electronic billing, computerized patient

records, new information systems -- also require appropriate resources before they can be put into place.

Hospitals must have the resources to allow them to do this -- resources that could be freed up through the greater efficiencies and lower administrative costs that are possible with real reform. Managers in the system must have the tools and flexibility to manage. They cannot reallocate all resources at once. The payoff in terms of cost containment for the emphasis on primary and preventive care comes long after the initial investment of resources to provide such services. For example, greater use of medically appropriate mammography would, over time, improve detection of breast cancer at an earlier stage, when it can be more successfully treated, and at a lower cost as well. But in the short term, there would be an <u>increase</u> in costs, as we pay for a greater number of screening mammograms. If the financial environment is too constrained at the outset, however, reform of the delivery system -- including shifting our emphasis to early detection of disease -- may never get off the ground.

Legacy Health System's Story

Let me turn the subcommittee's attention to the story of Legacy Health System. At the outset, I said that Legacy Health System was a four-hospital system with a network of physicians and immediate and primary care clinics. It is Legacy's mission to

enhance the quality of life and improve the health status of the community we serve. To accomplish these goals, we are developing an integrated health care system designed to provide high quality cost effective care by managing the care of the patients we serve. Containing the cost of medical care requires innovation, cooperation, and forging new partnerships. And we are succeeding at Legacy. From fiscal year 1991 through fiscal Year 1993, our cost per adjusted hospital admission rose only 4 percent. *And for fiscal year 1993 our cost per admission rose only six-tenths of one per cent.* Our financial plan released in April, 1993, listed no price increases for hospital services. We expect our financial plan for spring of 1994 will also have *no* price increases. At Legacy, our cost containment effort is driven by four strategies: managed care, continuous quality improvement (called CQI Legacy), administrative consolidation, and integration of clinical services.

Managed Care

For Legacy, managed care is more than Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). For Legacy, managed care is the management of medical treatment and health care based on delivering medically appropriate care that works in a cost-effective manner. The various health plans that Legacy serves save our patients between 5 and 30 percent of their historical health care costs. Our success in managing care requires that the physicians, nurses, laboratory clinicians and

hospital administrators work in partnership to contain cost while providing quality care.

CQI Legacy

Legacy's Continuous Quality Improvement Program (CQI Legacy) is one of our principal levers in balancing quality and cost. CQI Legacy ensures that the people who do the work have the power to make positive changes. Because they know the most about their jobs, they are best able to identify and remove problems and improve productivity, make decisions and improve the quality of care. Our efforts to maintain and improve the quality of the care we deliver rely on research into the clinical outcomes of procedures. To monitor and coordinate future outcomes research throughout Legacy, we created a council for outcomes research.

Administrative Consolidation

Our first steps toward consolidation began with merging the three downtown Portland hospitals -- Emanuel, Good Samaritan, and Holladay Park. We merged administratively into one hospital operating on three sites. We then merged the medical staffs of the three hospitals into a single medical staff. And we went on to merge other functions, such as purchasing and material services, Legacy Health Plans management, and planning and resource allocation.

We were then faced with the hard fact that the Portland area has far more hospital capacity than needed to serve both its current and projected populations. This fact, added to the nationwide shift from inpatient surgery to outpatient procedures, led us to announce the closing of one of our three hospitals, Holladay Park Medical Center. Our previous integration of its services into the larger whole meant that Holladay Park's closure could be handled with minimal disruption to patients. Legacy now leads the region in reducing duplication of services and integration of health care delivery.

Integration of Clinical Services

In addition to the consolidation of the medical staffs of Portland's downtown hospitals, we are integrating the clinical services of other hospitals and providers. Legacy's partnership with primary care and specialty physicians in the Portland area assures that our community has access to primary, secondary, and tertiary health services. Mount Hood Medical Center and Meridian Park Hospital offer primary and secondary services to the growing populations east and south of Portland. A network of physicians' office buildings, immediate care clinics, occupational medical clinics and residency-based primary care clinics weave the system together.

Partnership with employers is also key to the success of Legacy. We have forged an agreement with Portland's Precision Castparts Corporation that will use highly innovative approaches to contain the cost of health care while improving the health status of the company's employees. For example, we're conducting a health status survey of all employees, and then monitoring the improvement we expect to see after intensive preventive and wellness programs are implemented.

It is important to note that the Portland area is a mature managed care environment with a high penetration of Health Maintenance Organizations and Preferred Provider Organizations. Providers serving the Portland area have learned to provide health care within a fixed budget system through some form of capitation in a highly competitive market. This is a direct example of marketplace incentives at work. By integrating health care delivery and restructuring internal operations, we have been able to maintain high quality care while containing cost to the patient and the system.

Cost Containment Strategies

As it considers how best to contain costs, this subcommittee will be forced to choose between two fundamentally different approaches. The first involves writing some sort of arbitrary limit (or limits) on health care spending into the law, based on some notion of the appropriate rate of growth for this sector of

the economy or on the need to generate sufficient savings to offset any new Federal budget costs generated by reform. A limit of this sort could be imposed on insurance premiums or on payments for health care services, but both approaches would be driven by a formula based on factors having little to do with the actual delivery of care. Their rigid application may seriously penalize those providers who have made conscious and appropriate efforts to reduce costs.

The second approach involves achieving some economic discipline immediately by reforming the way health services are paid for and provided, while simultaneously establishing a process -- not a formula -- under which an independent national commission evaluates the level of payments in light of the benefits to be provided.

This latter approach, which AHA favors, would achieve cost containment by giving providers the economic incentive to work together in health plans or community care networks℠ -- cooperating groups of local providers paid on a capitated, or per-person, basis -- to eliminate expensive duplication of services and technology and establish a seamless system of care that works better for patients. In our view, health plans would then be working under incentives to manage <u>care</u>, rather than managing providers and patients.

Let me use the Portland area as a case in point. Nearly 41% of the Portland area population under age 65 is enrolled in HMOs. Another 44% is enrolled in PPOs. Of those over age 65, close to 56% are enrolled in an HMO Medicare plan. This managed care phenomenon results in significantly lower hospital utilization, which of course reduces health costs. Portland's inpatient days per 1,000 persons is 435, compared to the U.S. average of 890 days per 1,000. Average length of the hospital stay is 4.7 days, versus 7.3 days for the nation as a whole. We are convinced that properly constructed economic incentives that pay providers a fixed amount of money to serve a defined population work as a cost containment methodology.

And we're just as convinced that what doesn't work is the kind of government micromanagement or price controls that are likely to be the enforcement mechanism if we try to achieve cost containment through arbitrary federal limits on health care spending. As all price controls imposed in the last 25 years have shown, incentives for innovative programs and improved care would be sidetracked and replaced by strategies to survive and outsmart the regulators. Rate setting in health care would create underfunding, promote unbundling of services and therefore expand utilization, and would subject the well-being of patients to the political process.

A better approach is to establish a process for evaluating health care spending in light of benefits. This avoids the risk inherent in guessing -- far in advance -- what the appropriate level of health care spending should be for a particular year.

And it would enable policymakers to achieve a better balance between promised benefits and adequate funding by basing their decisions on better, more recent information on demographic changes, scientific and technological advances, developments in productivity and quality of care, and other relevant factors.

Cost Containment Strategies in Current Proposals

AHA has serious concerns about those health care reform plans now before Congress that would achieve cost containment with a formula-driven approach. Although some believe the President may have backed away from the explicit Medicare and Medicaid caps proposed in the September 7 draft version of his plan, there are nevertheless strong limits on spending in the President's bill. There is a limit on the amount employers can spend; there is a limit on the amount employees can spend; there is a limit on the federal government subsidy for low-income people and for small business. And, there are extraordinary reductions in Medicare and Medicaid payments to hospitals. The reform proposal of the Senate Republican Task Force on Health also suggests reductions in spending for both the Medicare and Medicaid programs. Sponsors of the bi-partisan Managed Competition Act of 1993,

introduced by Rep. Jim Cooper (D-TN) and Rep. Fred Grandy (R-IA), have also been active in advocating reductions in Medicare and Medicaid payments.

While the goal of these proposed Medicare reductions is to squeeze out waste, none of these plans propose applying to Medicare the same economic incentives that would promote efficiency in the rest of the health care system. Instead, these spending reductions are to be carried out through a series of arbitrary and technical changes. These changes are not intended to fix what's wrong with the Medicare program. Instead, their purpose is to fund the new federal costs associated with reform. While there may be merit to the new benefits funded by these cuts, we can't support underpaying hospitals in order to finance them.

A similar disconnect of actual needs from resources happens on the private side of the Clinton proposal, where spending growth is capped by tying it to the Consumer Price Index (CPI). But the CPI has no real link to the actual costs of providing health care; health care has its own set of input costs that aren't reflected in the CPI -- labor costs that are driven up by health personnel shortages and the steeply rising cost of new medical technology, for example. This is a particular problem in the early years of reform when the health care delivery system would have to adapt to massive changes.

Another example of the shortcomings of rigid spending limits is the proposed cap on Federal subsidies to low-income individuals and small, low-wage businesses under the Clinton plan. In an effort to provide fiscal certainty to the Federal government, the plan would strip away any sense of security these groups might have by requiring that the subsidies they were depending on be scaled back if demand proved greater than anticipated. This would apparently occur regardless of whether the pressure on subsidy funding was caused by a failure to control health premiums adequately, or by more individuals qualifying for a subsidy because of changing economic conditions, such as would happen with a higher unemployment rate.

We agree on the need to slow health spending growth. But who among us sitting here today could say with any certainty what health spending should be five or six years from now? To try to control spending through a rigid formula amounts to putting the system on cruise control, taking one's hands off the steering wheel, and hoping for the best. That is not a responsible way to navigate in the uncharted territory of health care reform. Why? Because it doesn't allow us to adjust course to accommodate unforeseen circumstances. The slowness of the economy in coming out of the recession, unanticipated crises such as the AIDS epidemic -- all caution that we keep our hands firmly on the steering wheel. And the way to do that is to match health needs with available resources in an on-going, open and public way.

In our view, that should be the job of an independent national commission.

Conclusion

To sum up, hospitals recognize that moderating growth in health care costs is a legitimate national need. Our long experience in health care delivery tells us, however, that significant cost containment will not be achieved by half-measures. Significant savings can only be achieved by bold strokes -- by realigning today's perverse financial incentives that send hospitals in one direction; physicians in another.

We believe that capitated payment to a community care network[sm] -- a per person fee paid to a cooperating group of health care providers -- does the best job of realigning those incentives. Our track record at Legacy Health System shows that provider integration and cooperation <u>can</u> result in significant savings.

We also understand your need to have a reasonable idea of the federal government's financial exposure when we restructure the one-seventh of the economy that is our health care system. We urge you to reject the simplistic notion of setting an arbitrary limit on health care spending. Such a limit does not allow for mid-course corrections when unexpected circumstances arise, and it does not preserve the very necessary link between spending and people's actual health needs.

Instead we strongly believe that putting in place the right incentives and allowing savings to flow from the grassroots up -- and Legacy Health System's cost containment record shows that this approach works -- allows us to achieve a very important goal: making sure that promised benefits have adequate financing. Without that balance, our shared vision of giving every American health security could become only a hollow promise.

file

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November 16, 1993

The Honorable Thomas S. Foley
U.S. House of Representatives
Washington, DC 20515-4705

Dear Representative Foley:

The House will soon be asked to consider an amendment to H.R. 3400, the "Reinventing Government" bill, to reduce spending in federal programs by $100 billion over the next five years. On behalf of the American Hospital Association's (AHA), nearly 5,300 institutional and 45,000 individual members, I am writing to express our strong opposition to this proposal and to urge you to vote against it.

At the outset, let me say that the AHA shares Congress' frustration with the government's inability to control the federal budget deficit and understands the pressures that are leading members to embrace various measures designed to reduce spending. However, it is our belief that the Penny-Kasich plan will do our nation more harm than good by seriously impeding our nation's efforts to slow health care spending through meaningful health care reform.

While the Penny-Kasich amendment proposes to reduce the federal budget deficit by enacting piecemeal changes in the Medicare program, those changes fail to address the underlying causes of health care inflation. Hospitals are concerned about the spiralling costs of health care, but recognize that the only way in which we can achieve sustained deficit reduction over time is through comprehensive health care delivery reform.

The Penny-Kasich amendment seeks an additional $50 billion in entitlement savings, including $37 billion from the Medicare program. The AHA believes these reductions to Medicare would be unwise policy, especially as we attempt to reform our health care delivery system. In addition, the effects of the reductions would be compounded by the $56 billion in Medicare savings already achieved in the last budget round under OBRA 1993 (P.L. 103-66) -- on top of

$43 billion included in the OBRA of 1990. Most of the reductions in OBRA 1993 will take effect in the out-years of 1996-1998. Stripping an additional $37 billion from Medicare, as provided in the Penny-Kasich amendment, will certainly compromise the ability of many facilities, including those that treat large numbers of low-income patients and teaching hospitals, to continue to provide services to expanding populations.

Moreover, the amendment would throttle rather than advance comprehensive health care reform. Under the amendment, the Medicare savings would be directed towards deficit reduction rather than reinvested in health care reform. And that will require Congress to look elsewhere in order to finance health care reform -- higher taxes, deeper Medicare cuts, or scaling back health care benefits.

America's hospitals believe that now is the time to reform the way we deliver health care. But, expanding the covered population, restructuring the health care system, reconfiguring hospitals and other services for the future, and investing in new technologies to meet the demands of the new system will require adequate resources. The AHA believes that if any savings are targeted from the Medicare program, they should be reinvested in health care reform, not targeted for deficit reduction as proposed by this amendment.

In closing, the AHA urges you to carefully consider the serious consequences of adopting the Penny-Kasich proposal as a means of reducing the federal budget deficit. We believe that any changes to the Medicare program should be considered within the context of achieving comprehensive health care reform.

Sincerely,

Rick Pollack

Rick Pollack
Executive Vice President
Federal Relations

American Hospital Association

AHA

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An advocacy strategy to help hospitals serve their communities.

MEDICARE REDUCTIONS

Oppose Penny-Kasich Amendment to the "Reinventing Government" Bill (H.R. 3400)

November 17, 1993

Special Attention: Swing Vote States
See Attached List

ISSUE

This Advocacy Action Plan requests assistance from allied hospital associations in opposing an amendment to use $37 billion in Medicare savings for deficit reduction. AHA is requesting that opposition be generated in response to proposals that would result in further Medicare savings.

BACKGROUND

During consideration of the budget reconciliation bill last August, President Clinton made a number of commitments to lawmakers to ensure its passage. Among these was a promise that lawmakers would be afforded another opportunity to reduce the deficit in exchange for their vote on the budget bill.

President Clinton kicked off the second round of budget action with his "Reinventing Government" proposal, introduced in the House as H.R. 3400. A bi-partisan group of conservative House members, led by Representatives Tim Penny (D-MN) and John Kasich (R-OH), will offer an amendment calling for $100 billion in additional spending reductions over the next five years when H.R. 3400 is considered on the House floor later this week.

The Penny/Kasich amendment seeks an additional $37 billion in Medicare savings, which would come on top of the $55.8 billion in savings approved last summer as part of the Omnibus Budget Reconciliation Act of 1993. With respect to Medicare, the Penny/Kasich proposal would:

* impose a 20 percent coinsurance requirement on clinical lab services;

* impose a 20 percent coinsurance requirement on home health services (exempting those below 150 percent of the federal poverty level);

* means-test the Part B premium for beneficiaries with an annual income of $75,000 (individuals) and $100,000 (couples); and

* means-test the Part A deductible for beneficiaries with an annual income of $75,000 (individuals) and $100,000 (couples).

At the same time, the Administration has included some of these savings as part of its health care reform proposal. Although hospitals would not be directly affected by these proposals, AHA believes that the Penny/Kasich amendment has serious implications for health care reform. If the amendment is passed, the savings would be earmarked for deficit reduction rather than health care reform, thus making comprehensive health care reform even more difficult to finance.

By using these savings for deficit reduction, Congress and the Administration will be left with very few options to find the additional resources necessary to pay for health care reform and be forced to consider even more troublesome options such as: imposing even deeper Medicare cuts than the $124 billion currently proposed; or retreating from the commitment to universal access. Moreover, as past experience reminds us, Congress and the Administration are only too willing to turn to the Medicare program--and providers, in particular--to find additional savings.

The House is scheduled to consider H.R. 3400 after the vote on the North American Free Trade Agreement. The vote could be as early as Friday (November 19) or Saturday (November 20).

WHAT YOU CAN DO TO HELP

Please work with your hospital grassroots contacts to urge your representatives to oppose the Penny-Kasich amendment to H.R. 3400. While it would be helpful if every House member in your state be advised of the hospital position on this issue, it is absolutely critical that those members who appear on the attached targeted list of potential "swing" votes receive priority attention. Attached is a list of talking points to assist in communicating the hospital position.

STAFF CONTACTS

Please refer questions and any feedback to your regional director or Washington-based regional liaison.

Thanks again for your assistance and quick response on this important issue. We recognize the many pressures you face and appreciate your efforts.

Rick Pollack
Executive Vice President
Federal Relations

Attachments

Talking Points in Opposition to the Penny-Kasich Amendment to H.R. 3400, the "Reinventing Government" Bill

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- ✓ Just last summer, Congress approved the Omnibus Budget Reconciliation Act of 1993 which reduces Medicare spending by $55.8 billion over the next five years. Those reductions come on top of the $43 billion in Medicare savings enacted as part of the 1990 budget agreement.

- ✓ The Penny/Kasich amendment would reduce the federal budget through piecemeal changes in Medicare--changes which fail to address such underlying causes of health care inflation as an aging population, increased utilization and intensity of services, and new, innovative technology that keeps our health care system on the cutting edge of scientific development.

- ✓ The Penny/Kasich amendment would impede efforts to achieve comprehensive health care reform. Channeling $37 million of Medicare savings into deficit reduction activities will make it more difficult to finance the changes that are needed to bring about reform. It would force Congress and the Administration to consider some undesirable financing options, including another round of Medicare reductions; or retreat from the commitment to universal access.

- ✓ The Medicare payment system is broken and continued tinkering won't fix it. It's time to move forward with comprehensive delivery system reform. Only by restructuring our health care delivery system can we pave the way to genuine health care cost-containment and deficit reduction.

- ✓ Historically, Medicare and Medicaid have seriously underpaid most of America's providers for the care they render. In 1991, according to the Prospective Payment Assessment Commission (ProPAC), nearly two-thirds of all hospitals lost money treating Medicare patients. Furthermore, average Medicare PPS operating margins in that year were -3.4 percent, and ProPAC estimates that those numbers will fall to -9.9 percent in 1993.

Potential "Swing Votes"
Penny/Kasich Amendment to H.R. 3400

Alabama

Browder
Cramer

Arizona

Coppersmith

Arkansas

Dickey
Lambert
Thornton

Florida

Brown
Deutsch
Hastings
Hutto
Meek
Thurman
Johnston
Young
Stearns
Shaw

California

Becerra
Beilenson
Condit
Dooley
Eschoo
Farr
Filner
Hamburg
Lehman
Roybal-Allard
Tucker

Georgia

Bishop
McKinney
Rowland

Illinois

Costello
Guiterrez
Lipinski
Poshard
Reynolds
Rush
Porter

Indiana

Hamilton
Long
Myers
Sharp

Kentucky

Baesler
Barlow
Mazzoli

Louisiana

Hayes
Tauzin

Massachusetts

Kennedy
Meehan

Michigan

Upton

Minnesota

Minge
Peterson

Missouri

Danner
Skelton
Volkmer

Nebraska

Hoagland

New Jersey

Andrews
Hughes
Klein
Menendez
Pallone
Roukema
Saxton

New York

Hinchey
Maloney
Nadler
Valazquez
Lazio
Paxon
Gilman
Boehlert
Houghton
Molinari

North Carolina

Lancaster
Valentine

North Dakota

Pomeroy

Ohio

Applegate
Mann
Strickland

Pennsylvania

Blackwell
Coyne
Holden
Kanjorski
McHale
Murphy
McDade
Goodling
Ridge
Greenwood

Texas

Chapman
de la Garza
Edwards
Geren
Green
Hall
Johnson
Laughlin
Ortiz
Pickle
Bonilla
Sarpalius
Tejeda
Wilson

Virginia

Payne
Pickett
Scott

Wisconsin

Barca
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California
Hawaii
Nevada
Oregon
Washington

File

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Statement by President of American Hospital Association on Clinton Health Care Reform Proposal

To: National Desk
Contact: Carol Pearson, 202-626-2342,
Alicia Nulty, 202-626-2339,
William Erwin, 202-626-2284,
all of the American Hospital Association

WASHINGTON, Oct. 27 /U.S. Newswire/ -- Following is a statement from American Hospital Association President Richard J. Davidson on President Clinton's Health Care Reform proposal:

The Clinton administration's health reform legislation holds out the promise of health security for all Americans. But in offering an unrealistic way to pay for it, it's a promise destined to be broken. In short, September's expectations have become October's disappointments. The president's legislation seems to take a step back from his earlier commitment to genuine health care delivery system reform. While President Clinton says that he's going to issue every one of us a health security card, what he hasn't told the American people is that the card won't be worth the plastic it's printed on if we can't pay those bills down the road.

Here's why:

-- The president's legislation overpromises Americans health security by underfunding Medicare and Medicaid and by capping the federal subsidies intended to help small businesses and low- income people buy insurance. Restraining projected Medicare spending by $124 bilion over the next five years is unacceptable. It punishes the growing number of elderly people and the hospitals that serve them. These cuts will especially hurt the most vulnerable hospitals -- those serving inner city and rural populations.

-- President Clinton's reform legislation would leave Medicare out of a reformed health system. Segregating Medicare would lock into place the inefficiencies, waste, and conflicting incentives that now pervade the program. As a result, older Americans could well see Medicare deteriorate into a substandard program paying only for bare bones care.

-- By stretching out the transition to universal coverage one year beyond his original goal, the president has signaled his willingness to negotiate, and possibly compromise, with his critics on this cornerstone issue of access to health coverage.

-- President Clinton has scuttled his original plan for an independent national health commission, which we had hoped could be the forum for matching health care needs with available resources in an on-going, open, and public way. Instead, the legislation would deminish the board's clout by turning it into an Administration ``steering committee'' reporting directly to the President. The public loses.

Hospitals will continue to play a constructive role in helping shape reform. We have our own firmly-grounded set of reform principles that serve as our guide:

-- universal access in a reasonable time period financed in a pluralistic manner;

-- redeveloping health care delivery into an integrated and coordinated system able to address the needs of the population;

-- economic discipline based on clear incentives rather than micromanagement, incentives such as paying providers a fixed amount of money to serve a defined population;

-- balancing promised benefits with adequate financing;

-- public accountability for the clinical effectiveness and economic efficiency of health plans;

-- antitrust and medical liability reform.

It is these principles that today lead us to conclude that the Clinton legislation is a step away from our goals. But hospitals' reform principles will also enable us to continue to take part in the legislative give-and-take

that will now begin in earnest. We continue our pledge to President and Mrs. Clinton to strongly support those parts of the proposal that we can, and work in a constructive manner to reach consensus where we disagree.

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Health Care Purchasing Alliances

AHA Position

AHA envisions a reformed health care system in which employers and individuals contract directly with community care networks℠ for the provision of health services. We favor the creation of insurance pools to make coverage more affordable for small businesses and the self-employed. Our reform proposal does not call for the creation of health care purchasing "alliances," as does the Administration's plan, and we have specific concerns about their scope. It is possible, however, that we could support the concept if changes are made to address our concerns.

Background

Many of the key "managed competition" proposals for health care reform now being considered by Congress rely on purchasing cooperatives (either mandatory or voluntary) as a mechanism for purchasing health coverage. These cooperatives are intended to pool risk and consumer purchasing power to make coverage more affordable. The extent to which these cooperatives play additional roles will be a defining issue of any reform plan. The debate will focus on placing the role of the cooperative somewhere along a continuum that ranges from a purely administrative function at one end to a planning and resource-allocation regulator at the other end.

The purchasing cooperatives outlined in the Administration's plan are called "regional alliances." States would have the option of creating alliances as either state agencies or independent non-profit corporations and of determining how many alliances will operate within their borders.

Some alliance activities — conducting an annual enrollment, collecting and disbursing funds, and risk-adjusting payments to health plans according to federal guidelines — are, for the most part, necessary functions in any reformed health system. The additional roles envisioned for the alliances under the Administration's plan, however, represent a more active intervention in the health delivery system. Under the Clinton plan (Mitchell-S.1757; Gephardt-H.R.3600) these roles include:

- Negotiating health plan premium bids
- Negotiating a maximum fee schedule for fee-for-service care
- Ensuring the availability of health plans in undeserved areas
- At state option, setting provider rates and limiting plan enrollment
- Enforcing global budgets

All these roles add up to an unreasonable level of responsibility for a brand new entity. And most Americans, except for Medicare beneficiaries and those employed by the largest firms, would have to use the alliances to purchase coverage.

In place of the Administration's "alliances," the Chafee/Dole (S.1770) proposal envisions voluntary cooperatives for individuals and small businesses with fewer than 100 employees. And, to handle the alliance function, the Cooper/Grandy bill (H.R.3222) creates mandatory purchasing cooperatives with exclusive geographic franchises for businesses with fewer than 100 employees. These cooperatives can be increased at state option to a size sufficient to enroll no more than half of all the employees in that state.

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AHA

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Health Care Purchasing Alliances

Recommendation

The size of health alliances should be limited to serve only small businesses and individuals. They should have a limited administrative role, rather than a regulatory role. Their scope should be limited to four basic functions:

- Serve as a risk pool for small businesses and individuals
- Offer an open enrollment period with the opportunity to join any of the qualified health plans
- Disseminate easily comparable data on quality, cost and enrollee satisfaction to the public about each plan
- Collect community-rated individual and small business premiums and distribute risk-adjusted premium amounts to the health plans

ANTITRUST

AHA POSITION

Antitrust policy should allow hospitals and their communities the flexibility to assess local health care needs and implement strategies to address those needs. Hospital goals include reducing expensive overcapacity and unnecessary duplication of services and technology to more efficiently provide health services. Changes and clarifications in the antitrust area can help implement AHA's reform vision of a restructured health care delivery system based on provider cooperation through "community care networks."[sm]

BACKGROUND

With the advent of health care reform, an increasing number of hospitals are exploring innovative ways to cooperate with one another in serving their communities. For example, hospitals may wish to share services and equipment or agree to emphasize different specialties as a way to avoid expensive duplication of technology and services. Some hospitals consider mergers as a way to reduce excess capacity. And most importantly, hospitals and other providers are seeking to form provider networks to offer comprehensive care, from preventive services through long-term care, in a seamless setting.

Many of these collaborative initiatives, however, may be challenged at the federal level by the Department of Justice (DOJ) and the Federal Trade Commission (FTC) on antitrust grounds. In addition, state enforcement agencies and private parties can challenge activity. In light of these risks, lack of adequate antitrust guidance specific to health care has "chilled" health care providers from pursuing many cooperative activities.

Both Democratic and Republican Members of Congress showed support last year for accommodating antitrust restrictions to the unique needs of health care providers. Various legislative proposals were introduced and congressional hearings held to explore the antitrust issue. And an early draft of the President's health care reform proposal called for the federal enforcement agencies to issue antitrust guidelines in a variety of areas.

On September 15, 1993, these agencies took a first step and jointly issued six "Policy Statements" on antitrust enforcement in the health care area. The statements address the following areas: hospital mergers; hospital joint ventures involving high-tech or expensive equipment; physicians' provision of information to purchasers of services; hospital participation in exchanges of price and cost information; joint purchasing arrangements among health care providers; and physician network joint ventures. Each Policy Statement carves out an "antitrust safety zone" describing conduct that the agencies will not challenge, absent extraordinary circumstances.

An important component of the statements is the expedited review process established to answer providers' questions about proposed activity. Generally, questions on issues addressed in the statements will be answered within 90 days; questions on non-merger activity not addressed in the statements will be answered within 120 days.

While these Policy Statements represent progress, some key issues are not addressed in them, most notably: how the enforcement agencies will view the antitrust issues inherent in forming provider networks. DOJ and FTC have agreed to continue working with AHA to develop additional guidelines in a timely fashion. In addition, we continue to monitor other efforts in Congress to address antitrust issues within the context of health care reform legislation.

RECOMMENDATION

If providers are going to work together to put the health care delivery system on a more rational foundation, additional detailed guidance from the federal enforcement agencies is necessary. Guidelines must adequately address all relevant issues and be consistent with the health care reform efforts underway. While the Policy Statements issued by DOJ and FTC represent a step in the right direction, various issues remain and much work lies ahead. Additionally, in order to remove the chilling effect that discourages some innovative arrangements, any federal guidance needs to prove effective for state and private party challenges. And policymakers need to be aware that reform proposals being developed often raise antitrust issues that will need to be reconciled in any final health care reform plan. These combined efforts will help to realize a more effective and efficient community-focused health system.

COMMUNITY CARE NETWORKS℠

AHA POSITION

AHA's health reform vision calls for restructuring the delivery system through "community care networks" — groups of local health care providers, social service agencies, community organizations, and others who work together to integrate their services and thereby provide a seamless system of care for consumers.

BACKGROUND

The AHA supports providing care in a more integrated and coordinated way so that patients can receive better, more cost-effective care and the nation can begin to slow the rate of growth in health care spending. All three of the reform proposals in the political center — Administration, Chafee, and Cooper — could accommodate our "community care network" approach to an integrated health care delivery system. In addition, all three bills contain incentives to move toward integrated care in their insurance reform provisions.

The Administration's bill proposes broadly-defined "Health Plans." While the bill does not preclude the formation of integrated delivery systems, it does not contain strong incentive to create them. The Chafee bill's "Qualified Health Plans" and the Cooper bill's "Accountable Health Plans" would also accommodate our vision of community care networks but do not contain strong incentives to create networks.

Insurance reforms in all three bills do, however, help reinforce movement toward integrated care. For example, the insurance reforms included in the President's proposal begin to change incentives and move the health care system in this direction. By prohibiting discriminatory insurance practices — the use of pre-existing condition clauses, for example — insurers are required to *manage* rather than avoid risk. In order to better manage risk, health plans will have to better manage care, and that means forming partnerships with local provider networks to give care in a more integrated way. The Chafee and Cooper proposals also prohibit discriminatory insurance practices and thus contain similar incentives for insurance market restructuring.

RECOMMENDATION

Any final reform proposal must contain more federal guidance for qualification as an integrated health plan. Specifically, health plan criteria should ensure that health plans have incentives to provide coordinated care, stimulate providers to work together, and encourage the use of capitated payment (setting a fixed, up-front fee for each enrollee). Criteria should also ensure that plans are held accountable to the enrollees they serve.

Global Spending Caps

AHA Position

The AHA is strongly opposed to global budget approaches that are arbitrary and have no relationship to patient needs.

The President and several influential leaders in Congress are calling for strict limits on the growth of health spending in public health programs and in the private sector as well through the establishment of a "global budget." That is, through setting a fixed, up-front amount that can be spent for the nation. While we recognize the need to moderate the growth in health spending, our own vision of health care reform calls for serious cost containment and economic self-discipline by changing provider and consumer incentives. These changes would be achieved by restructuring the delivery system and by paying networks of providers a fixed fee per enrollee, known as "capitated" payment.

Background

The President's plan (Mitchell-S.1757; Gephardt-H.R.3600) calls for limits on the growth of health spending in the private sector through the establishment of a global budget enforced by premium caps. Under the President's proposal, after a relatively short transition period, annual health insurance premium increases would be limited to the increase in general inflation as measured by the Consumer Price Index, or CPI.

While we understand the need to slow the growth in health care spending, we have serious concerns about the rigidity of the President's top-down, formula-driven global budget proposal. The CPI has no real link to the actual costs of providing care. Health care has its own set of input costs that aren't reflected in the CPI, including labor costs driven up by health care personnel shortages, and by the steeply rising cost of new medical technology.

Attempting to slow the growth in health spending through a rigid formula amounts to putting the system on cruise control, taking one's hands off the steering wheel, and hoping for the best. Such an approach will not allow us to adjust course to accommodate unforeseen circumstances, such as sudden downturns in the economy that swell the ranks of the uninsured; previously unknown crises such as the AIDS epidemic; and other factors causing health spending to increase that are beyond hospitals' control.

Recommendation

We believe that there must be a direct link between promised health benefits and the costs of providing those benefits, as well as flexibility to be able to respond to changing health spending needs.

Instead of acting as rigid caps on the rate of increase in private-sector health care premiums, global budget targets could serve as a measure of annual health spending increases for publicly subsidized health care expenditures — those directly subsidized by government appropriations, and those indirectly subsidized through the provision of tax-free benefits. Global budget targets should be flexible and take into account the health needs of the population, changes in demographics, technological advances, and other factors that an independent national health commission determines are appropriate.

If health spending increases exceed the global budget target in a given year, it would be the job of the independent commission to make the tough choices that will be necessary to balance public resources available for health care, and publicly funded and subsidized health services.

(For related arguments, please see "Independent National Commission")

Hospital Tax-Exempt Status

AHA Position

Tax exemption for community hospitals demonstrates society's commitment to providing everyone access to health services, and aligns tax policy with the larger goals of society.

Background

With President Clinton's proposal to provide universal health insurance coverage has come a call to reassess the standards for hospital tax exemption. Some have questioned the need for a tax subsidy in the form of exemption when the need to provide charity care is greatly diminished. President Clinton's health reform proposal (Mitchell-S.1757; Gephardt-H.R.3600) rightly preserves a broad community benefit standard for measuring hospital behavior in meriting tax exemption.

Tax exemption for hospitals is based on more than providing free care. Tax-exempt hospitals provide important benefits to their communities beyond the basic provision of acute care services. Today, a hospital is often the hub of a host of programs and services that reach out into the community: a home health agency; a long-term care facility; drug and alcohol treatment programs; adult day care for the elderly; outpatient and primary care centers, to name just a few. And many hospitals are also tackling the tough societal problems that contribute to illness and injury, from providing improved housing to helping stimulate local economic development.

Proponents of changing this broader community benefit standard, such as California Democratic Rep. Fortney "Pete" Stark in his proposal (H.R.200), say the standard should be replaced by a strict charity care standard. Exemption would then hinge on providing a minimum amount of free care to the uninsured. If charity care is no longer needed under a reformed health care system, goes the argument, then hospital tax exemption is no longer warranted.

The universal coverage and access to health care we seek under reform, however, is not an ironclad assurance that services will be available when and where needed, or that all who need health services will be reached. Hospitals are likely to remain a health care safety net. And hospitals' health education and outreach efforts are going to be even more important under reform.

In fact, the President's reform plan proposes a new statutory requirement that charitable health care organizations assess the health care needs of their community and develop plans to meet those needs. This change is consistent with AHA's vision of a reformed health care system and hospitals' role in that system.

Tax-exempt hospitals and other charitable health organizations are the core of our health care delivery system. Continuation of tax exemption for these institutions and organizations, based on the current community benefit standard, is consistent with, and complementary to, guaranteeing broader access to health care coverage.

Recommendation

The existing community benefit standard for tax-exempt status should be preserved. AHA will continue to work with Members of Congress to explain the advantages to communities of the present system.

Independent National Commission

AHA Position

An independent national commission should be established as part of a reformed health care system to determine, with the help of on-going public debate, the proper balance between promised health care benefits and funds available to pay for those benefits.

Background

In our current health care system, there is no mechanism to balance public program benefits with available federal financing. Rather, these difficult policy decisions are made as part of the political horse-trading that Congress engages in when developing the federal budget. Putting these difficult decisions in the hands of an independent national commission would have the dual benefit of removing them from the political and budgetary process — which too often bears no relationship to actual patient needs — and giving the public a more direct voice in the process.

We need to remember that reforming our health care system, one-seventh of our economy, is a massive job. It is not going to get done all at once, nor is it going to be perfect from the beginning. It will need careful adjustment and course correction along the way. A truly independent commission can do the best job of managing the on-going balancing act between promised benefits and realistic financing that is going to be such a necessary part of reform.

While the Administration's plan (Mitchell-S.1757; Gephardt-H.R.3600) does call for the establishment of a "National Health Board," it is not an independent entity, but merely an arm of the Executive Branch with "steering committee" status. We are disappointed that it is not given the responsibility to balance promised benefits with available resources. And, we oppose the broad range of implementation and regulatory functions it has been given.

Recommendation

An independent national commission should be divorced from political pressures generated by the deficit reduction process. It could be modeled on existing successful independent government bodies such as the Defense Base Closure and Realignment Commission, the Federal Reserve Board, or the Securities and Exchange Commission. While these model entities have different purposes and structures, they share the important quality of being insulated from deficit reduction pressures. Like them, an independent health reform commission should be made up of a relatively small number of individuals selected on the basis of their knowledge and integrity. They should be appointed by the President subject to U.S. Senate consent, and should serve for relatively long terms of roughly seven to ten years.

The independent commission should be focused on a few key roles. First, it should provide advice to Congress, giving Members the information needed to set an appropriate budget target for publicly subsidized health care expenditures. In doing so, the commission would ensure that adequate resources are available to provide a promised set of benefits. The information provided to Congress might include such factors as the estimated costs of various benefit levels, the adequacy of public program funding, and the adequacy of provider payments. Establishment of an independent commission also allows for the flexibility necessary to respond to changing health spending needs — an example is the unforeseen strain on current resources resulting from the AIDS epidemic.

While some observers question whether giving these roles to the commission is constitutional — taxing and spending authority is reserved to Congress by the Constitution — the question can be addressed by requiring that Congress approve the recommendations of the commission by an up or down vote. This is the mechanism successfully used by the (military) Base Closure Commission.

Continued on reverse side.

Independent National Commission

Finally, once Congress determines the aggregate funding level for publicly subsidized health care expenditures, the independent commission should determine the basic set of benefits to be covered under public programs, ensuring that benefits are adequately financed. This set of benefits should also serve as the benefit floor for coverage offered in the private sector.

The independent commission should not be given a broad range of regulatory functions such as setting standards for health plan grievance procedures and operating quality management systems, as are proposed in the Administration's plan. These functions are better left within the Department of Health and Human Services. The role of the independent commission should be narrowly defined, to free it to concentrate on the difficult choices that need to be made in balancing benefits against financing and on gathering public input into the process.

In summary, the viability of a network delivery system — which we believe must be the fundamental building block of reform — depends on the adequacy of the basic benefit package and on the adequacy and fairness of funding. It is important to create an independent commission to safeguard the integrity of the decision-making process that will define that critical balance.

(For related arguments, please see "Global Spending Caps")

MEDICARE INTEGRATION

AHA POSITION

AHA envisions reforming the health care system by changing the way in which care is delivered. Community care networks℠ — cooperating groups of local health care providers — would integrate their services to provide more cost-effective care. In order to achieve maximum savings and efficiencies, it is essential that the growing Medicare population be part of the same reformed system as other Americans.

BACKGROUND

Currently, the health care system is a tangle of conflicting incentives, both for patients and health care providers.

Patients who have health care coverage through traditional fee-for-service medicine — in which providers are paid for each episode of care — have no real incentives to seek the most cost-effective care. And the differing incentives for hospitals and physicians also do not provide the strongest incentives for provider cost-effectiveness. Providers in a reformed health care system who form collaborative groups, provide integrated care, and are paid a fixed, up-front fee for each enrolled patient *do* have much stronger incentives to provide cost-effective care, including emphasizing preventive services and health promotion. Patients in a reformed system will have the ability to make informed choices among plans, based on reports to the public on quality and cost-effectiveness.

Keeping Medicare beneficiaries (who account for an average 40 percent of hospital revenues) in traditional fee-for-service arrangements undermines the movement to a reformed health care system. Those hospitals who treat a disproportionate share of Medicare patients will see the effects of this double standard magnified. They will be disadvantaged in their efforts to become part of integrated care networks, whether that be in taking a leadership role to form a network, or assuming a role as a vendor of services to a network. Given Medicare's historic underpayment record, exacerbated by the proposed reductions in the Administration's and other reform plans, these facilities will be financially unattractive to potential network partners. They simply won't have the resources to do the reconfiguring and outreach that will be necessary as we move from today's flawed system to tomorrow's better one.

Our goal is to move Medicare beneficiaries into integrated delivery systems. And, we have identified a number of options that could increase enrollment in existing Medicare managed care arrangements. We see providing incentives for Medicare beneficiaries to choose managed care arrangements as a stepping stone to the restructuring of the health care delivery system into "health plans," as they're known in the Administration's plan (Mitchell-S.1757; Gephardt-H.R.3600), or the community care networks in our plan.

These options include: Make managed care arrangements less expensive than a fee-for-service option by waiving a current cost paid by Medicare beneficiaries — for example, deductibles, copayments, or a limit on inpatient days; offer benefits in a managed care arrangement that are currently excluded from Medicare coverage — such as prescription drugs, long-term care, or more preventive services; offer a point-of-service option in Medicare managed-care arrangements. Today, providers who treat Medicare patients can be paid either on a fee-for-service or a capitated basis. This option would allow an enrollee to "opt out" of the capitated payment arrangement at any time to see a provider of his or her choice — but at a higher cost to the beneficiary. This opens to Medicare beneficiaries the same care and payment options currently available to other Americans.

Any of these options must be linked to a vigorous effort to educate older Americans about the advantages of these plans and the satisfaction of those who use them. And, of course, such managed care plans must not sacrifice quality in delivering care at a lower price.

Continued on reverse side.

Medicare Integration

Recommendations

Restructuring the health care system for only part of the population — as would be the case if Medicare beneficiaries are not included in reform — undercuts efforts to achieve more cost-effective and efficient delivery of services. Medicare beneficiaries can be brought into a reformed system through these steps:

- Encourage the formation of community care networks.
- Educate Medicare beneficiaries about the benefits of these networks.
- Encourage Medicare beneficiaries, through incentives, to choose these plans, with existing managed care plans as a transitional step.

MEDICARE FINANCING

AHA POSITION

We agree that the growth in health care spending must be moderated. The way to achieve that end is to fundamentally restructure our health care system, through establishing cooperating groups of health care providers to eliminate expensive duplication of services and technology and stimulate both effectiveness and efficiency. Significant reductions in Medicare spending undermine our ability to transform the health care delivery system and threaten our ability to continue to deliver quality patient care, not just to Medicare patients, but to all patients.

BACKGROUND

As the Administration and lawmakers look for ways to finance an overhaul of the health care system, the Medicare program appears to be the cookie jar into which everyone wants to get their hands.

The President's reform plan (Mitchell-S.1757; Gephardt-H.R.3600) would reduce Medicare spending $124 billion by the year 2000. Of the reductions in provider payments, 70 percent would come as a result of lower payments to hospitals. The other plans in the political center, namely the Chafee/Dole and Cooper/Grandy proposals, also call for large reductions in Medicare spending as a means of financing their reform efforts.

Under the President's reform plan, $74 billion of the $124 billion in Medicare spending reductions would come through lower payments to hospitals. These reductions come on top of Medicare reductions sustained by hospitals last summer as part of OBRA 1993. Of the $56 billion in five-year Medicare reductions contained in OBRA 1993, $24 billion came from hospital care for the elderly. And these reductions are added to the $43 billion approved as part of the 1990 budget agreement.

While we support the added benefits for Medicare patients that the reductions the Administration proposes will help fund — prescription drugs and long-term care — we *cannot* support underpaying hospitals in order to pay for these benefits.

Such unprecedented reductions would be unwise policy at any time, but would be especially dangerous as we attempt to reform our health care delivery system. Providing universal coverage is not cost-free. Expanding the covered population, restructuring the health care system, reconfiguring hospitals and other services for the future, and investing in new technologies to meet the demands of the new system — all will need adequate resources. Infrastructure investments we all endorse, such as new information systems, electronic billing, and computerized patient records, will require an up-front investment. Unless we invest adequate resources now, the benefits of improved efficiencies will never materialize.

The reductions called for by the President are intended to limit the annual growth in Medicare spending to no more than the rate of general inflation, bringing the current annual growth rate of about 12 percent down to just over 4 percent by the year 2000. While we agree with the nation's need to slow health spending growth, we believe the ability of hospitals to continue to provide high quality, cutting-edge health care services would be seriously threatened by these massive reductions. In 1991, according to the Prospective Payment Assessment Commission (ProPAC), Medicare payments fell 12 percent short of meeting hospitals' costs for those patients. That is why two-thirds of the nation's hospitals must subsidize the cost of treating Medicare patients in fiscal year 1993.

The President argues that greater efficiencies can be achieved in hospital and physician settings. While it may be true that some efficiencies can be achieved, the Administration and Congress must be realistic in establishing their savings goal. Hospitals have and will continue to search for ways to improve efficiency. But ProPAC also reports that 60 percent of hospital cost increases from 1985 to 1989 were due to factors beyond hospitals' control, including inflation in the general economy and the increasing intensity and complexity of patient's health needs.

Continued on reverse side.

MEDICARE FINANCING

RECOMMENDATIONS

- Use the estimated $58 billion in savings and taxes now targeted for deficit reduction to help finance the health care reform effort.

- Increase taxes on alcohol, tobacco, and ammunition and devote the additional revenue to health care.

- Limit the employer/employee tax deductibility for health care coverage.

- Means-test the Administration's planned new entitlement subsidies for many individuals and small businesses that may be able to afford coverage on their own, including the proposed subsidy to early retirees.

- Postpone expanding Medicare benefits (for example, the Administration's proposal to add outpatient prescription drugs and more home care) until universal access is achieved for the non-Medicare population.

- Ask upper-income Medicare beneficiaries to contribute toward the cost of Medicare Part A coverage through premiums and to pay a larger portion than they do now of Part B coverage through premiums.

- Reform the way patients receive care by restructuring the health care delivery system to stimulate both effectiveness and efficiency.

Universal Access

AHA Position

Access to health coverage for all Americans — "universal access" — is AHA's first priority in the health care reform debate. Access to such care should be achieved within a reasonable period of time and provided through a pluralistic system of financing that combines private coverage with a new public program. Funding mechanisms undergirding universal access must provide adequate and fair financing to providers.

Background

There are currently 38.9 million uninsured individuals in the United States, 10 million of whom are children. Half of the uninsured live in families with incomes below the poverty threshold. Medicaid, a program originally designed to provide health insurance for the poor, now provides care for only about half of those living in poverty. Because of strained federal and state finances, those who do qualify for Medicaid face limitations on the services they receive. Even for the privately insured, coverage limitations are more commonplace today as many employers and insurers resort to benefit cutbacks to limit their rising costs. On the positive side, the current system of employer-based health coverage does provide coverage for 88 percent of the nonelderly, privately insured population and more than 85 percent of the uninsured are connected to the workplace — either as workers or living in a family headed by a worker. While the uninsured ultimately have access to care through hospital emergency rooms, it is often care received after an illness has become acute, and certainly not in the most cost-effective setting.

The three major health care reform proposals — Clinton Administration (Mitchell-S.1757; Gephardt-H.R.3600), Senate Republican Leadership (Chafee/Dole, S.1770) and that of Tennessee Democrat Jim Cooper and Iowa Republican Fred Grandy (Cooper/Grandy, H.R. 3222) approach the question of universal access differently.

The Clinton Administration's proposal, set out in "Health Security Act" legislation — achieves universal access on a relatively fast track. States enter the reformed health system on the basis of an approved state plan that ensures universal access for all citizens and legal aliens. States are required to have an approved plan by January, 1998. While emergency services are funded for undocumented aliens, these persons are specifically excluded from eligibility for the guaranteed national benefit package. Universal access is financed by requiring employers to provide coverage (known as an "employer mandate"). For the unemployed, subsidies are provided based on an income-related means test. Additional subsidies are available to small businesses and to those employing low-wage workers. The current acute-care Medicaid program would be absorbed into the reformed system.

The Senate Republican Leadership (Chafee-Dole) proposal, "Health Equity and Access Reform Today Act of 1993," approaches universal access more slowly through an *individual* mandate as opposed to an employer mandate. Low-income individuals would purchase coverage through a means-tested federal voucher program. The voucher program would be financed through reductions in the rate of growth in federal entitlement programs and would be phased in by 2005. The Medicare and Medicaid programs would continue to serve their present populations. All individuals would be required to pay for their own health care coverage by the year 2005, with the federal tax system as the enforcement mechanism.

A proposal by Congressman Jim Cooper (D-TN), "The Managed Competition Act of 1993," does not propose a mandate either employer or individual; it rather purports to expand access through a voluntary system that does not require individuals to have, or employers to pay for, coverage. The proposal folds in the current Medicaid program for acute-care services into a new public program and uses the subsequent savings to finance it. The new public program pays for health premiums for those below 100% of the poverty threshold. For those between 100% and 200%, premiums would be subsidized on a sliding scale.

Continued on reverse side.

UNIVERSAL ACCESS

RECOMMENDATIONS

Guaranteed universal access remains AHA's first priority in health care reform. It should be achieved within a reasonable period of time and through a pluralistic financing system. That pluralistic financing system should have as its base an employer mandate. An employer mandate is the most effective and practical road to universal access. It builds on the strength of current employer, employee, and insurer relations, and preserves these local ties. It is the strongest building block for universal access because it already provides health coverage for nearly 90 percent of the nonelderly, privately insured population.

Universal access can only be achieved by financially assisting citizens, particularly low-income citizens, to obtain health coverage. These subsidies involve some combination of employer-plus-government contributions. The Clinton Administration's proposal maximizes employer contributions via the mandate; the Chafee-Dole and Cooper proposals require larger individual and government contributions to achieve universal access.

AHA is concerned that without an employer mandate, subsidies would require large additional federal expenditures that may not be politically feasible — hence universal access may not be achievable using this route.

MEDICAL LIABILITY REFORM

AHA POSITION

The current medical liability system costs too much and works too slowly. It fails to provide access to the legal system or fair compensation for many injured patients, while providing exorbitant awards to others. It adds billions of dollars to the national health care bill by encouraging physicians to practice "defensive medicine" as a hedge against potential claims and lawsuits. The cumulative effect threatens access to health care, especially in certain high-risk services.

The AHA believes that comprehensive health care reform must include effective medical liability reform. Such liability system reform is an essential component of achieving access to care, containing costs, and ensuring quality of care — fundamental objectives of comprehensive health reform.

BACKGROUND

AHA, along with other health care groups, has long advocated reform of the medical liability system. Traditionally a state issue, a growing movement for reform at the federal level has developed in recent years. The national health care reform debate has brought a renewed interest in the issue.

Various legislative proposals to reform the medical liability system have been introduced in the past year. Elements of these proposals have been incorporated into comprehensive health care reform plans. The Administration's plan includes some medical liability reforms: alternative dispute resolution for health plans; limits on attorneys' fees to 1/3 of awards; periodic payments and modification of the collateral source rule; and pilot programs based on practice guidelines. In addition, the Administration's plan would establish demonstration projects to test the notion of "enterprise liability," under which health plans would carry liability risk rather than individual providers.

Both H.R. 3222 introduced by Representatives Jim Cooper (D-TN) and Fred Grandy (R-IA) and S. 1770 introduced by Senator John Chafee (D-RI), major health care reform proposals before Congress, include significant medical liability reform measures. Provisions include: alternative dispute resolution; a $250,000 cap on noneconomic damages; elimination of joint and several liability for noneconomic damages; periodic payments; limits on statutes of limitations; and use of practice guidelines. The Cooper/Grandy bill also limits attorneys' contingency fees on a sliding scale.

RECOMMENDATION

AHA recommends that medical liability reform be included in any health care reform proposal. The provisions supported by the National Medical Liability Reform Coalition (NMLRC), of which AHA is a member, will make positive contributions to our overall goal of health care reform. These include:

- Patient Safety Reform
- Alternative Dispute Resolution (federal support for state demonstration projects)
- Practice Parameters/Guidelines (federal support for state demonstration projects)
- Uniform Standards for Medical Liability Claims, including:
  - Periodic Payment
  - Cap on Noneconomic Damages
  - Mandatory Offsets for Collateral Sources
  - Attorneys' Fees Limited by Sliding Scale
  - Proportionate Liability (Elimination of Joint and Several Rule)
  - Limits on Statutes of Limitations and other provisions
- Federal preemption of state law, unless the corresponding state laws are more effective.

Medical liability reform is an essential component of comprehensive health system reform. AHA will continue to participate in the National Medical Liability Reform Coalition, a broad-based group of organizations promoting medical liability reform as a key element of health care reform.

In addition to the proposed changes to the Medicare and Medicaid programs included as part of the Clinton health reform plan, AHA believes the Clinton Administration may propose several changes to the Medicare and Medicaid programs during 1994 that have important implications for hospitals. These potential changes may affect Medicare payment to hospitals for both inpatient and outpatient services, as well as Medicaid disproportionate share hospital (DSH) payments and the ability of states to receive Medicaid waivers that are necessary to implement managed care programs.

Throughout 1994, AHA staff will continue to work with the Administration and Congress on these and any other proposed changes to the Medicare and Medicaid programs and periodically update you as important developments occur.

Medicare and Medicaid Update

PPS Wage Index

Both the Prospective Payment Assessment Commission (ProPAC) and the Health Care Financing Administration (HCFA) are working to develop alternative labor market area definitions for Medicare's inpatient prospective payment system (PPS). Currently, HCFA uses Metropolitan Statistical Area (MSA) definitions developed by the Office of Management and Budget to determine hospital labor market areas. HCFA determines a separate wage index value for hospitals in each MSA and, for each state, a statewide rural wage index for all hospitals outside MSAs.

AHA has opposed the use of MSAs to define hospital labor market areas since the inception of the PPS. Using MSAs often results in neighboring hospitals being assigned substantially different wage index values by HCFA and, subsequently, receiving vastly different payment amounts from Medicare simply because those hospitals are on different sides of an MSA boundary. At the same time, it also leads to HCFA assigning the same wage index value to hospitals within an MSA or rural area even though those hospitals may have very different wage levels.

The alternative labor market area definitions under consideration by ProPAC and HCFA are designed to smooth out differences in wage index values between neighboring hospitals and to ensure that the wage index more accurately reflects wage levels within areas. However, any change in hospital labor market areas is likely to significantly redistribute Medicare payments among hospitals.

AHA staff have met with both HCFA and ProPAC to discuss alternative labor market area definitions, but AHA has not endorsed any of the alternatives under consideration. Consistent with the PPS equity policy adopted by the AHA Board of Trustees in 1992, AHA will recommend that HCFA phase in any change in labor market area definitions that leads to a significant redistribution of Medicare payments to hospitals.

Outpatient PPS

AHA expects that sometime in 1994 the Secretary of Health and Human Services will submit a long-overdue report to Congress on a new Medicare prospective payment system for hospital outpatient services. Currently, Medicare uses a number of different methodologies to pay hospitals for outpatient services, including reasonable cost, fee schedules, and blended payment amounts.

Based on the latest information available to AHA, we believe the Secretary will recommend that Congress immediately implement a fully prospective payment system for ambulatory surgery and radiology services provided in the hospital outpatient setting and move to prospective payment for other outpatient services at some later date. Payment amounts under the PPS for ambulatory surgery and radiology services would be based on a blend of average hospital costs for those services and freestanding ambulatory surgery center payment rates or radiology fee schedule amounts.

The current mix of Medicare payment methodologies for hospitals' outpatient services imposes a substantial administrative and paperwork burden on hospitals. Consequently, AHA supports the implementation of a prospective procedure-based fee schedule based on hospital costs for Medicare outpatient services. Until such a procedure-based system can be implemented, AHA supports a reasonable cost limit system of payment for Medicare outpatient services.

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MEDICAID DSH PAYMENTS

The Omnibus Budget Reconciliation Act of 1993 contained a provision that limited the Medicaid DSH program in two ways. First, states will be prohibited from designating hospitals with less than a one percent Medicaid inpatient utilization rate as DSH hospitals. Second, the amount of DSH payment adjustments a state may pay to an individual hospital will be limited to no more than that hospital's Medicaid payment shortfall plus uncompensated care costs. (Medicaid payment shortfall is defined as the difference between the cost of care provided Medicaid recipients and the Medicaid non-DSH payments. Uncompensated care is defined as the difference between the cost of providing care to individuals with no health insurance and out-of-pocket payments and other third-party payments exclusive of state and local indigent care payments.) The facility-specific cap is phased in beginning with public hospitals in state fiscal year 1995. The cap for private hospitals would begin in the subsequent state fiscal year. The Secretary of HHS has some discretion in defining costs for purposes of implementing the facility-specific cap.

HCFA intends to publish implementing rules prior to July 1994. AHA staff have met with HCFA to discuss how hospital inpatient and outpatient Medicaid and uncompensated care costs should be defined. These discussions with HCFA staff will be ongoing and will include AHA's partners in the Medicaid hospital coalition (the Association of American Medical Colleges, the National Association of Public Hospitals, and the National Association of Children's Hospitals and Related Institutions).

MEDICAID WAIVERS

The Social Security Act grants the Secretary of HHS authority to waive statutory requirements for Medicaid to conduct demonstration projects. Section 1115 of the Social Security Act allows waiver of any provision of the Medicaid program for research and demonstration purposes. Section 1915 of the Act permits states to waive certain Medicaid provisions to allow states to develop cost-effective alternative methods of delivery and reimbursement. In recent years states have pursued statewide health care reform initiatives by seeking section 1115 waivers and have pursued Medicaid managed care programs through section 1915 waivers. Last year the National Governors' Association and HCFA negotiated a streamlined waiver process to make it easier for states to apply for these waivers. AHA has told HCFA that we believe any waiver process should include provider and beneficiary input. As the states' role in health care reform increases, a waiver process involving providers and beneficiaries becomes even more important. AHA will continue to work with its Medicaid hospital coalition partners and HCFA staff on an improved waiver process.

3/1 Hospital Kick off (lobbying kit) [ed /]

Ogilvie & Doris Shriver

① univ'l access + mandate

- move GOP toward Chafee

lot of people kill [leave] Clinton before do anything else

mar 4 / Waxman / Stark

get up momentum

nd consultants

to gin up membership

② defining a defineable health plan. AHA language not accepted. all plans linked to states.

AHA wanted it rooted in community (Mitchell [friend])

Chaffee picked up a little CHA there

③

medicare integration - provide incentives to move into new plan. (only get new bens if it stays out of medicare)

if high medicare provider + get only 90% of cost - you're in a lousy position of becoming a visible health plan)

1994 AHA Annual Membership Meeting

Confirmed speakers (as of 1/14/94)

Monday, January 31

Small or Rural Breakfast (7:00-8:15 a.m.)--Rep. Steve Gunderson (R-WI)
Metropolitan Hospitals Breakfast (7:00-8:15 a.m.)--Rep. Ron Wyden (D-OR)

Federal Relations Symposium (8:30 a.m.-3 p.m.)

9:45-10:45 a.m. Congressional Crossfire
moderator: *ABC News* correspondent Cokie Roberts
panelists: Sen. John Breaux (D-LA), Sen. John Chafee (R-RI) and Rep. Jim McDermott (D-WA)

1:00 p.m.-1:45 p.m. John Chancellor, former *NBC News* commentator

2:00 p.m.-2:30 p.m. HCFA Administrator Bruce Vladeck

2:30 p.m.-3:00 p.m. Sen. Ted Kennedy (D-MA)

Tuesday, February 1

Hospital Trustee Breakfast (7:00-8:30 a.m.)--William Archey, U.S. Chamber of Commerce

Wednesday, February 2

From the Nation to the Neighborhood: Turning Ideas Into Action (9:00-11:00 a.m.)

Ira Magaziner, White House senior adviser for policy development

Panelists: Paul Offner, Senate Finance
David Abernethy, House Ways and Means Committee's health panel
Sheila Burke, chief of staff, office of Senate Republican Leader Bob Dole

single page w/ bullets
① alleviate structure
⑤ medicare cuts - (back to budget res.) — legitimate issue on D54
⑥ global budget — target or goal, not formula with guidelines

ACCESS AND COVERAGE FOR ALL

PRINCIPLES/GOALS	McDermott/ Wellstone	Stark	Mitchell/Gephardt (Clinton)	Chafee/Dole	Cooper/Grandy	Michel	Nickles
	H.R.1200/S. 491	**H.R.200**	**S.1757/H.R.3600**	**S.1770**	**H.R.3222**	**H.R.3080**	**S. 1743**
EVERYONE COVERED BY FIXED DATE	**Yes,** by 1995 for citizens and legal aliens; others at national health board or state discretion.	**No.** Coverage not required.	**Yes,** by 1998, except undocumented aliens.	**Yes,** for full-time workers but not until 2005.	**No.** Employers must offer, not pay for coverage.	**No.** Employers must offer, not pay for coverage.	**No.**
SUBSIDIES FOR LOW-INCOME	**Yes.** Tax-based financing for all.	**Limited.** Medicaid expanded to those below 200% of poverty.	**Limited,** for those below 150% of poverty and $40,000 income. Subsidy dollars are capped.	**Limited.** For those below 240% of poverty. Funding depends on savings achieved.	**Limited.** For those below 200% of poverty. Funding depends on savings achieved.	**Limited.** For those below 200% of poverty.	**Limited.** Tax credit varies with income.
INSURANCE UNDERWRITING REFORMS	**Not applicable.** Private insurance eliminated for covered services.	**Yes.** Prohibits discriminatory practices.	**Yes.** Prohibits discriminatory practices.	**Yes.** Prohibits discriminatory practices.	**Yes.** Prohibits discriminatory practices.	**Yes.** Prohibits discriminatory practices, but only for employer-based plans.	**Limited.** Pre-existing conditions eliminated and guaranteed issuance for qualified health insurance plan.
INSURANCE MARKET RESTRUCTURING	**Not applicable.**	**Yes.** Creates voluntary purchasing cooperatives to facilitate the purchase of insurance.	**Yes.** Mandatory health alliances formed to facilitate the purchase of private insurance and Medicaid.	**Yes.** Voluntary purchasing cooperatives to facilitate the purchase of insurance.	**Yes.** Mandatory health plan purchasing cooperatives for employers of less than 100.	**Yes.** Guarantees access for small groups and creates state and multi-employer risk pools.	**No.**
UNIFORM BASIC BENEFIT PACKAGE	**Yes.**	**No.**	**Yes.**	**Yes,** both standard and catastrophic. Coverage details to be set by Benefits Commission.	**Yes.** Coverage details to be set by National Board.	**No.**	**Yes,** but qualified health plans required to cover acute care medical services only.
BROAD CONTINUUM OF CARE IN BASIC BENEFIT PACKAGE	**Yes.**	**Not applicable.**	**Yes,** but mental health and long-term care limited.	**Not clear.**	**Not clear.**	**No.**	**No.** Preventive care for low-income grant program. Long-term care through Medical Savings Account.

DELIVERY SYSTEM RESTRUCTURING

PRINCIPLES/GOALS	McDermott/ Wellstone	Stark	Mitchell/Gephardt (Clinton)	Chafee/Dole	Cooper/Grandy	Michel	Nickles
	H.R.1200/S.491	H.R.200	S.1757/H.R.3600	S.1770	H.R.3222	H.R.3080	S.1743
ENCOURAGES COMMUNITY-BASED, PUBLICLY ACCOUNTABLE PLANS	**Permits** community health service organizations but no incentives to choose them.	**No.** Incentives to form group- and staff-model HMOs only.	**No,** but does provide incentives for integrated delivery.	**No,** but qualified plans could accommodate networks.	**No,** but accountable health plan could accommodate networks.	**No,** but does not preclude them.	**No,** but does not preclude them.
ENCOURAGES ECONOMIC SELF-DISCIPLINE THROUGH CAPITATION	**No.** Uses global budgets and fee schedules to limit spending.	**No.** Uses Medicare payment methodologies and global budget to limit spending.	**Yes.** Promotes managed care through risk bearing health plans.	**Yes.** Promotes managed care through risk bearing health plans.	**Yes.** Promotes managed care through risk bearing health plans.	**Yes.** Promotes managed care through risk bearing health plans.	**No.**
REMOVES ANTITRUST AND OTHER BARRIERS TO PROVIDER COLLABORATION AND NETWORK FORMATION	**No.**	**No.**	**Limited.** Initial steps taken by agency guidelines. Does preempt certain state laws that would restrict networks.	**Yes.** Provides exemption from antitrust laws for certain activities and preempts certain state laws that would restrict networks.	**Limited.** Provides antitrust guidelines to facilitate plan development. Also preempts certain state laws that would restrict networks.	**Limited.** Ease anti-trust but not other barriers.	**Limited.** Guidelines for joint venture antitrust exemption. Preempts state laws: mandated benefits, anti-managed care, and mandated cost-sharing.
CONSISTENT INCENTIVES FOR MEDICARE	**Yes.**	**No.** Incentives under Medicare unchanged.	**No,** but state option to enroll Medicare beneficiaries through alliances.	**No.** Medicare remains unchanged but Congress to study possible phase-in to purchasing cooperatives.	**No.** Medicare remains unchanged.	**No.**	**No.** Study to assess Medicare voucher program.
FAVOR MEDICAL LIABILITY REFORM	**No.**	**No.** Asks for study on tort reforms and use of alternative dispute resolution mechanisms.	**Limited.** Does not include key reforms such as limiting non-economic awards.	**Yes.**	**Yes.**	**Yes.**	**Limited.** Limits noneconomic damages and calls for alternative dispute resolution process.

FAIR FINANCING

	McDermott/ Wellstone	Stark	Mitchell/Gephardt (Clinton)	Chafee/Dole	Cooper/Grandy	Michel	Nickles
	H.R.1200/S.491	H.R.200	S.1757/H.R.3600	S.1770	H.R.3222	H.R.3080	S.1743
MAINTAIN MIX OF PUBLIC AND PRIVATE FINANCING	**No.** Government is single source of financing and payment.	**Yes.**	**Yes.**	**Yes.**	**Yes.**	**Yes.**	**Yes.**
BROAD-BASED SOURCE OF FINANCING	**Yes.** Funded by payroll, income, and other taxes.	**Same as today.** Source of funds for added benefits not specified.	**Yes,** but much of new costs funded by Medicare and Medicaid cuts ($189 billion).	**Same as today.** Costs funded by large Medicare and Medicaid reductions.	**Same as today.** New costs funded from limiting employer deductibility of plan costs and $44 billion from Medicare cuts.	**Same as today.** New costs covered by $17 billion in reduced Medicare Part B subsidies for upper income beneficiaries and changed federal retirement rules.	**No.** Medicare cuts of $67 billion and Medicaid cuts of $72 billion over five years to offset tax credit revenue loss.
MECHANISM TO PUBLICLY BALANCE BENEFITS WITH FINANCING	**No.**	**No.**	**No.**	**Yes.** Independent Benefits Commission to publicly reconcile benefits provided with available funding.	**No.**	**No.**	**No.**
EXCLUDES FIXED, FORMULA-BASED SPENDING LIMITS	**No.** Uses formula-driven global budgets.	**No.** Relies on formula-driven global budgets for all services and by all payers.	**No.** Includes national spending limit tied to CPI.	**Yes.**	**Yes.**	**Yes.**	**Yes.**
ACTUARIALLY SOUND PREMIUM	**No.**	**No.**	**Unlikely.** Not for Medicare and Medicaid. Overall bases for various limits are unrelated to need/demand.	**Likely.**	**Likely.**	**Same as today.**	**No.**
INDIVIDUALS BEAR ECONOMIC IMPACT OF PLAN CHOICE	**Not applicable.** No plan choice.	**Yes,** depending on employer contribution.	**Yes,** but tax subsidy structure remains unchanged until 2003.	**Yes.** Tax deductibility limited.	**Yes.** Tax deductibility limited.	**Yes,** depending on employer contribution. Tax subsidy structure remains unlimited.	**Yes,** beyond level of tax credit.

BUILDING BLOCKS/STUMBLING BLOCKS

	McDermott/ Wellstone	Stark	Mitchell/Gephardt (Clinton)	Chafee/Dole	Cooper/Grandy	Michel	Nickles
	H.R.1200/S.491	**H.R.200**	**S.1757/H.R.3600**	**S.1770**	**H.R.3222**	**H.R.3080**	**S.1743**
BUILDING BLOCKS	+ Achieves universal access. + Uniform benefit package.	+ Requires community rating and guarantees renewability of coverage.	+ Significant progress on universal access. + Incentives for development of integrated delivery systems.	+ Definition of qualified health plans could accommodate networks. + Independent commission would balance benefits and financing. + Removes many barriers to network formation.	+ Definition of accountable health plans could accommodate networks. + Pluralistic financing. + Uniform benefit package. + No formula-driven global budget.	+ Insurance reforms. + Malpractice reforms. +Antitrust relief.	+ Removes barriers to provider collaboration and network formation. + Provides for malpractice liability reform.
STUMBLING BLOCKS	- Single-payer system using formula-driven global budgets. - Preserves the fragmented care delivery system.	- Uses formula-driven global budgets and Medicare rate-setting for all. - Preserves the fragmented care delivery system.	- Formulistic approach to setting annual spending limits. - Significant cuts in Medicare and Medicaid. - Arbitrary subsidy cap jeopardizes universal access. - Medicare left out of delivery reform.	- Universal access achieved too slowly and excludes part-time workers. - Would cut Medicare and Medicaid.	- No universal access or coverage. - Significant short-term Medicare cuts. - Medicare not under similar reformed incentives. - No consistent source of funds for low-income subsidies.	- No universal coverage. - Preserves the fragmented delivery system and all current incentives.	- No universal access or coverage. - No delivery system restructuring. - Significant Medicare and Medicaid cuts. - No Medicare reform.

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Statement
of the
American Hospital Association
before the
Senate Finance Committee
on
Medicare Spending Reductions
and the
Integration of Medicare into a Reformed Health Care System

April 12, 1994

Mr. Chairman, I am Dick Davidson, president of the American Hospital Association. On behalf of AHA's 5,000 institutional members, I am pleased to have the opportunity to testify here today. The issues we are discussing -- the role Medicare will play in financing health care reform, and whether Medicare beneficiaries will become part of the reformed health care system -- are absolutely central to the reform debate.

Hospitals strongly disagree with the idea that Medicare reductions are a reasonable way to finance reform. We don't believe there are resources in the system to allow such large -- truly unprecedented -- reductions without seriously undermining both hospitals' ability to

carry out the changes that will be needed under reform and hospitals' responsibility to provide high quality care for Medicare patients, and for all patients. Today, we draw on new data, which we asked the health consulting firm Lewin-VHI to develop.

HOSPITALS SUPPORT FUNDAMENTAL REFORM

As we begin, however, I want to be very clear about one thing. Hospitals are firm supporters of fundamental health care reform. I couldn't be prouder of the work our members have done in developing a progressive, practical vision for reform. Our vision is centered on three core objectives:

- Guaranteed coverage and access to care;
- Restructuring the delivery system to deliver more efficient and effective care; and
- fair financing.

We use our three goals as a template, against which we measure all other reform proposals. No proposal now on the table would achieve all our goals -- so we do not endorse any single reform plan. We are, however, working to support elements of proposals that do move us toward our reform vision. And, we are providing constructive suggestions to strengthen areas we feel fall short. That is the procedure we are following today, explaining to you why proposed Medicare reductions and the failure to integrate the Medicare population in reform undermine achieving our fundamental goals.

Many of the congressional health care reform proposals would make unprecedented cutbacks in the rate of increase in Medicare spending to pay for reform. The Administration's proposal would reduce Medicare spending by $118 billion over the next six years in order to finance health care reform. This is twice the size of any reductions previously taken from Medicare. Other proposals, including those offered by Rep. Pete Stark (D-CA), Sen. John Breaux (D-LA)/Rep. Jim Cooper (R-TN), and Sen. John Chafee (R-RI) also would reduce Medicare spending by significantly more than ever before.

It's important to remember that these proposed reductions come on top of OBRA 1993 legislation, which cut $56 billion from projected Medicare spending; and on top of $43 billion in reductions approved just three years earlier as part of the 1990 budget summit agreement. Furthermore, outside of the health care reform debate, many members of Congress favor limiting future spending on entitlement programs, including Medicare and Medicaid. Others support a requirement to balance the federal budget on an annual basis -- an approach that would hit hard on the largest federal programs, particularly Medicare.

We should also put these reductions in the context of current inadequate Medicare payment rates. The Prospective Payment Assessment Commission (ProPAC) -- the independent agency set up by Congress to oversee Medicare -- has concluded that Medicare payments to hospitals already fail to keep pace with hospitals' costs.

NEW ESTIMATES ON IMPACT OF REDUCTIONS

The Lewin-VHI estimates give us a preliminary forecast of what could happen in the future with Medicare reductions of the magnitude envisioned in the Administration's reform proposal. It is important to note that these estimates do not pretend to predict the future with any certainty -- they are highly sensitive to underlying assumptions about future growth in hospital costs. They are, however, illustrative of the kinds of pressures that hospitals face if Medicare spending reductions alone of this size are enacted. And the magnitude of those pressures is sobering:

- By the year 2000, after six years of spending reductions, Medicare could pay hospitals only 71 cents for every dollar of inpatient care delivered to a Medicare patient.

- The spending reductions could make the Medicare program an even poorer payer than today's Medicaid program, which currently pays hospitals about 82 cents on the dollar.

- While most hospitals and all states are affected, teaching hospitals, large urban areas, and communities with hospitals serving a disproportionately large number of low-income patients would be particularly hard hit.

The study uses Medicare reductions contained in the Administration's plan because it was the most detailed available at the time the study began. Among the health care providers and Medicare beneficiaries who would be affected by the President's spending reductions, Administration estimates indicate that hospitals are hardest hit, taking $70 billion of the $118 billion in proposed reductions.

The data show that reductions like these, with no accompanying reform steps such as expanding health care coverage, could cause significant financial losses for hospitals. While arguably losses might be mitigated by reducing the rate of growth in hospital costs, hospitals' ability to squeeze down costs is limited. As ProPAC recently reported, 60 percent of hospitals' cost increases from 1985 to 1989 were due to factors beyond hospitals' control -- inflation in the general economy (39 percent) and increasing complexity of patients treated (21 percent). Hospitals are deeply concerned that losses of the size estimated by Lewin-VHI cannot be made up through increased efficiency and will therefore undermine our ability to deliver high quality care and to participate in health care reform.

One reason for our concern is that the current health care environment, with its growth in managed care, means that Medicare reductions will be felt by hospitals, patients, and communities more deeply than ever before. In the past, hospitals have been able to shift unfunded costs to other non-government payers -- meaning higher costs for these patients and their employers. Managed care contracts, however, narrow this option. So, too, do the growing number of private insurers who negotiate discounted prices. And, under many of

the comprehensive health care reform proposals that seek to limit private sector spending, the ability to cost-shift is reduced even more.

HOSPITAL CHOICES ARE FEW UNDER MEDICARE REDUCTIONS

This leaves hospitals with unpalatable choices for controlling costs: reduce the size of the hospital work force, or reduce services and programs, or both. Hospitals are reluctant to reduce their work force, because doing so jeopardizes their ability to do their job well -- hospitals are very labor-intensive institutions. Similarly, it is often easier to eliminate certain services than to restructure services in order to cross-subsidize care. Hospitals will continue to work to provide care more efficiently. But, given these economic facts of life, additional Medicare payment reductions would be felt more deeply than ever by hospitals, patients, and the communities they serve.

Such reductions also threaten the ability of hospitals to participate in health care reform. Expanding the covered population, restructuring the delivery system, reconfiguring hospitals and other services for the future, and investing in new technologies to meet the demands of the new system -- all will need adequate resources. For example, the infrastructure improvements we all endorse in order to reduce administrative costs -- electronic billing, computerized patient records, new information systems -- will require an up-front investment.

Specifically for hospitals, getting beyond the traditional acute care role that will be necessary under reform would be jeopardized by excessive spending reductions. For example, consumer education, wellness, and outreach programs -- not funded by the current system -- are among the most vulnerable when finances are squeezed.

Alternative sources of financing health care reform are available to spread the cost of reform more broadly, beyond hospitals, physicians, and other health care professionals who will already be deeply affected by change. For example, more than $75 billion could be raised by increasing or imposing federal excise taxes on handguns, assault weapons, ammunition, tobacco and alcohol. Significantly, the use of many of these items often contributes to poor health and hospital emergency department visits.

IMPLICATIONS FOR PATIENTS AND COMMUNITIES

Hospitals want to see reform done right. Many hospitals have already begun to provide care in more cost-effective, collaborative ways. For example, ProPAC reports that the number of hospitals with health maintenance organization and preferred provider contracts increased from 37 percent in 1985 to nearly 62 percent in 1992. And, ProPAC also reports that in 1993, more than 30 percent of the nation's hospitals were involved in collaborative relationships with physicians, whether a formal physician/hospital organization (14 percent), a management services organization (7 percent), or a foundation that negotiated managed care contracts for the hospital and physicians as a unit (4 percent). Forming collaborative provider networks and reconfiguring services for the future, however, present major financial

and organizational challenges for hospitals. It is unfair to expect hospitals to deliver on health care reform and pay for it, too, through deeper Medicare spending reductions.

We understand that not all hospitals will survive in a reformed health care system. In fact, the kind of massive restructuring that we propose will result in mergers, consolidations, and closures -- this is the most responsible and thoughtful way to reduce excess capacity and eliminate overlap and duplication in high technology and services.

But the kinds of indiscriminate Medicare spending reductions proposed hit hardest on the most financially vulnerable institutions -- those barely breaking even or already operating at a loss and those treating large numbers of Medicare beneficiaries. These hospitals may be the very facilities that need to remain open to assure access and coverage to underserved populations and achieve the broader goals of health care reform. Hospital closures should be based on the needs of communities, not on a particular hospital's financial health. Decisions to merge or close facilities should be made at the local level within the community.

RESTRUCTURED DELIVERY SYSTEM AND MEDICARE "INTEGRATION"

The size of proposed Medicare reductions presents another obstacle for achieving fundamental health care reform -- it creates a greater-than-ever schism between how we pay for and provide care for Medicare beneficiaries and for the rest of the population. This is the opposite direction of where we want to go.

Currently, Medicare beneficiaries are presented with a delivery system that stresses specialization over primary care; administrative complexity over simplicity; and fragmented care rather than coordinated care. Many of us have had the experience of helping an elderly friend or family member deal with stacks of confusing bills and forms, or trying to coordinate their medical care between the physician and the hospital or some other health care provider.

At the same time, some Medicare beneficiaries still face barriers to receiving basic primary care. According to the Physician Payment Review Commission, the independent congressional commission overseeing payment to physicians under Medicare and Medicaid, the lack of availability of primary care is the most common complaint made by Medicare beneficiaries.

We believe it's absolutely essential that the Medicare population be part of the same reformed system as other Americans -- that Medicare beneficiaries be "integrated" into reform. And, just as strongly, we believe that the reformed health care system include the kinds of collaborative provider networks we touched on earlier. In AHA's reform vision, such collaborative arrangements are called "community care networks[SM]" -- locally based, networks of hospitals, doctors, other health care providers, and social service and community agencies, working together to improve the health of people in the community.

Community care networks focus on primary care, prevention, and coordinating care to ensure that all patients -- young and old -- receive the right kind of care at the right time and in the most appropriate setting. A capitated payment system -- an upfront fee for each enrolled person -- improves efficiency and creates the proper incentives for providers to work together to keep patients healthy.

Networks would also help patients navigate the complex maze of available health care services. This is particularly important for Medicare patients, because they use more services more often.

In addition, if the Medicare and non-Medicare populations are part of the same reformed health care system, providers would have the same incentives to deliver appropriate and cost-effective care to Medicare beneficiaries as they would for other patients. Imagine hospitals trying to improve coordination and efficiency if more than 30 percent of what they do is driven by a set of incentives that represent the inefficiencies of our current fragmented system -- which would be the case if Medicare, comprising, on average, a third of hospitals' patient revenue, remains out of the reformed health care system of the future.

But it is not clear that these opportunities for better patient care and more efficient case management will be available to Medicare beneficiaries and encouraged under health care reform. As a first step, all reform plans should encourage Medicare beneficiaries to join managed care plans where available. Interest and participation could be increased through

education and information about the advantages managed care offers, by providing financial incentives or increased benefits for joining managed care plans, and by expanding the types and numbers of managed care plans offered to Medicare beneficiaries to allow them more flexibility to choose their own physician. We support these and a number of similar initiatives contained in Sen. Dave Durenberger's (R-MN) bill, S. 1996, that work toward these ends.

Integrating Medicare patients into the reformed delivery system makes good public policy sense. But more importantly, it makes good sense for the older Americans we serve.

CONCLUSION

Hospitals have been and will continue be a constructive force as our nation moves toward a fundamentally reformed health care system. We believe our role on the front line of health care delivery gives us valuable insight and experience to bring to that process. We are willing to contribute to the shared sacrifice that will inevitably be part of reform. Our vision of reform does just that, with its incentives for economic discipline and dramatic changes in the structure of health care delivery.

What we are not willing to do, however, is jeopardize the quality of the health care we deliver to our Medicare patients, and to all our patients. We firmly believe that the Medicare spending reductions proposed in the Administration's plan and in many other congressional health reform proposals would undercut our ability to deliver high quality care.

Continued Medicare reductions are likely to result in further staffing reductions, delays in purchasing new equipment, postponing the upgrading of facilities, closing certain services in order to maintain other services at peak quality, and jeopardizing the research and education programs that have kept America's health system on the cutting edge of scientific development.

In addition, we believe it is absolutely essential that the Medicare population be part of the same reformed system as other Americans, and that the reformed system expand managed care opportunities for Medicare patients and for all patients. Only through such Medicare "integration" will beneficiaries have strong incentives to seek cost-effective care and their providers have consistent incentives to treat them in the most cost-effective way.

It is for these reasons that we urge you to reject Medicare reductions contained in the Administration's plan and in other congressional reform proposals and instead consider the many alternative sources of financing available as your committee goes about the difficult work of shaping health care reform. And, we urge you to include Medicare beneficiaries under the reform umbrella as the best way to work toward more cost-effective delivery of care for these patients.

NOTICE

This document is not available for public release until 10:00 a.m. Eastern time, Tuesday, April 12, 1994

MEDICARE REDUCTIONS:

UNFAIR TO EXPECT HOSPITALS TO DELIVER ON HEALTH CARE REFORM AND PAY FOR IT TOO

BACKGROUND:

Hospitals support comprehensive health care reform centered on three goals:

- Guaranteed coverage and access to care;
- More efficient and effective delivery of care; and
- Fair financing.

Hospitals understand that extending health coverage to the uninsured will take additional resources. We cannot, however, support unprecedented reductions in Medicare funding as a major source of these resources. Such reductions would be counter productive -- they would undermine our ability to achieve reform and threaten patient services.

For example, health care reform -- forming collaborative provider networks; reconfiguring hospitals and other services for the future -- will present major financial and organizational challenges for hospitals. It is unfair to expect hospitals to deliver on health care reform and pay for it too through deeper Medicare spending reductions.

Many of the congressional health care reform proposals would make unprecedented cut backs in the rate of increase in Medicare spending to pay for reform. The President's proposal would reduce Medicare spending by $118 billion over the next six years in order to finance health care reform. This is twice the size of any reductions previously taken from Medicare. Other proposals, including those offered by Representative Pete Stark (D-CA), Representative Jim Cooper (D-TN), and Senator John Chafee (R-RI) also would reduce Medicare spending by significantly more than ever before.

Outside the health care reform debate, many members of Congress favor limiting future spending on entitlement programs, including Medicare and Medicaid. Others support a requirement to balance the federal budget on an annual basis -- an approach that would hit hard on the largest federal programs, particularly Medicare.

Alternative sources of financing health care reform are available to spread the cost of reform more broadly, beyond hospitals, physicians, and other health care professionals who will already be deeply affected by change. For example, increasing alcohol and cigarette excise taxes ($86 billion), scaling back nuclear weapons production ($3 billion), and asking host nations to share in more of the cost of U.S. troops stationed abroad ($10 billion) would raise nearly $100 billion over five years toward health care reform financing.

STUDY FINDINGS:

New estimates prepared by Lewin-VHI look at the impact on hospitals of Medicare spending reductions. It is important to note that these estimates do not pretend to predict the future with any certainty -- they are highly sensitive to underlying assumptions about future growth in hospital costs. However, these estimates are illustrative of the kinds of pressures that hospitals face if Medicare spending reductions alone of this magnitude are enacted.

The Prospective Payment Assessment Commission (ProPAC) has already concluded that today, payments to hospitals under Medicare's Prospective Payment System do not keep pace with hospitals' costs. The new Lewin-VHI estimates confirm that this pattern will likely continue.

The study uses the President's plan -- the most detailed available -- as an example. Among the health care providers and Medicare beneficiaries who would be affected by the President's Medicare spending reductions, administration estimates show that hospitals are hardest hit, taking $70 billion of the $118 billion in proposed reductions.

Data show that reductions like these, with no accompanying reform steps such as expanding health care coverage, could cause significant financial losses for hospitals. Losses might be attenuated by reducing the rate of growth in hospital costs. But hospitals are concerned that losses of this size can not be made up through increased efficiency. Medicare reductions could undermine hospitals' ability to transform and improve the health care system for patients and threaten their ability to continue to deliver quality care in the communities they serve.

The Lewin-VHI data show:

- By the year 2000, after six years of spending reductions, **Medicare could pay hospitals only 71 cents for every dollar of inpatient care delivered to a Medicare patient.** The overall Medicare Prospective Payment System (PPS) inpatient operating margins for all hospitals in the U.S. could be *negative* 29 percent (see table 3).

- These spending reductions could **make the Medicare program an even poorer payer than the Medicaid program is today**, which currently pays hospitals 82 cents on the dollar.

- **Coping with the spending reductions already enacted in the Omnibus Budget Reconciliation Act (OBRA 1993) will be difficult enough for hospitals.** Lewin-VHI data show that by the year 2000, the overall Medicare PPS inpatient operating margin for all hospitals in the U.S. would be *negative* 12 percent as a result of changes enacted in OBRA 1993 (see table 1). The additional reductions proposed by the President could lower this margin by an additional 17 percentage points (see table 3).

- **Particularly hard hit are teaching hospitals, hospitals in large urban areas, and hospitals serving a disproportionately large number of low-income patients.** By the year 2000, Medicare PPS inpatient operating margins could be reduced by 22 percentage points for teaching hospitals; reduced by 19 percentage points for large urban hospitals; and reduced by 26 percentage points for hospitals receiving both indirect medical education and disproportionate share adjustments.

- **After six years, regardless of hospital type -- large or small, urban or rural, teaching or non-teaching -- most hospitals face significant Medicare losses.** Under current law, Medicare PPS inpatient operating margins for various types of hospitals are expected to average between positive 4 percent and a negative 18.5 percent (see table 1). If the President's reductions were enacted, Lewin-VHI data suggest these margins could average between a negative 19.9 percent and a negative 32.2 percent (see table 3).

- **All states are negatively affected.** After the enactment of OBRA 1993, hospital margins varied considerably by state (see table 2). But Lewin-VHI data show that if the Medicare reductions proposed by the President are enacted, <u>all</u> states would lose significant shares of revenue, driving Medicare PPS inpatient operating margins down (see table 4).

IMPLICATIONS:

Medicare spending reductions have serious implications for the future of health care reform, hospitals, patients, and communities.

Hospitals may be without the resources needed to achieve comprehensive reform -- to reconfigure the way in which they deliver care to be more efficient and to refocus on the health of the patients and communities they serve.

Cuts will be felt by hospitals, patients, and communities more deeply than ever before. In the past, hospitals have been able to shift unfunded costs to other non-government payers, meaning higher costs for patients and employers. But this avenue will be narrowed, if not closed, by the current rapid growth in managed care in the private sector as well as by many of the comprehensive health care reform proposals that propose to limit private sector spending. Thus, hospitals will have to cut costs which could mean personnel and service cutbacks.

Some communities may see their hospitals close for the wrong reasons -- not because they are no longer needed, but because they are financially weak. The kinds of Medicare spending reductions proposed hit hardest on the most financially vulnerable hospitals -- those barely breaking even or already operating at a loss and those that treat large numbers of Medicare beneficiaries. These hospitals may be the very ones that need to remain open to assure access and coverage to underserved populations and achieve the broader goals of health care reform.

Table 1:

4/4/94

Projected Medicare PPS Inpatient Operating Margins by Hospital Group Under OBRA 93

		Pre OBRA 93			OBRA 93						
	N	1991*	1992	1993	1994	1995	1996	1997	1998	1999	2000
All Hospitals	5185	-3.3%	-4.0%	-4.1%	-6.4%	-8.8%	-10.9%	-11.7%	-11.9%	-12.0%	-12.2%
All Teaching Hospitals	1008	1.1%	-0.5%	-0.3%	-2.1%	-4.4%	-6.3%	-7.1%	-7.2%	-7.1%	-7.1%
Major Teaching	213	8.3%	7.8%	8.3%	7.6%	5.7%	4.1%	3.5%	3.5%	3.7%	4.0%
Minor Teaching	795	-2.3%	-4.3%	-4.4%	-6.6%	-9.2%	-11.3%	-12.1%	-12.3%	-12.3%	-12.4%
Non-Teaching	4177	-7.8%	-7.7%	-7.9%	-10.9%	-13.3%	-15.7%	-16.6%	-16.8%	-17.1%	-17.4%
Type of Hospital											
Urban	2914	-3.1%	-4.5%	-4.6%	-6.1%	-8.6%	-10.7%	-11.4%	-11.6%	-11.6%	-11.7%
Large Urban	1545	-1.9%	-3.6%	-3.5%	-4.5%	-7.0%	-9.0%	-9.8%	-9.9%	-9.9%	-10.0%
Other Urban	1369	-4.9%	-6.0%	-6.2%	-8.5%	-11.0%	-13.1%	-13.9%	-13.9%	-14.1%	-14.2%
Rural	2271	-4.2%	-0.7%	-0.8%	-8.5%	-10.1%	-12.7%	-14.0%	-14.6%	-15.1%	-15.7%
Sole Community	541	1.0%	1.6%	1.6%	-9.8%	-9.9%	-12.6%	-13.9%	-14.5%	-15.1%	-15.8%
Sole Comm and Rural Referral	46	4.1%	9.4%	9.4%	-2.1%	-5.0%	-7.5%	-8.6%	-9.1%	-9.6%	-10.0%
Rural Referral	188	-5.9%	-3.1%	-3.0%	-9.1%	-12.1%	-14.5%	-15.6%	-15.9%	-16.3%	-16.6%
Other Rural	1496	-6.4%	-1.7%	-1.8%	-8.8%	-9.6%	-12.3%	-13.7%	-14.5%	-15.3%	-16.0%
Payment Adjustments											
IME & Disp Share	483	4.1%	2.8%	3.2%	1.9%	-0.3%	-2.2%	-3.0%	-3.1%	-2.9%	-2.8%
IME Only	774	-5.0%	-5.5%	-6.3%	-8.5%	-11.1%	-13.6%	-14.7%	-15.1%	-15.4%	-15.7%
Disp Share Only	383	-4.0%	-5.4%	-5.5%	-8.1%	-10.7%	-12.7%	-13.6%	-13.6%	-13.7%	-13.8%
None	3545	-6.9%	-7.0%	-7.1%	-10.0%	-12.3%	-14.6%	-15.4%	-15.5%	-15.8%	-16.1%
Medicare Proportion of Rev.											
Over 60%	1175	-6.6%	-7.2%	-7.4%	-11.2%	-13.7%	-16.3%	-17.4%	-17.8%	-18.2%	-18.5%
Under 60%	4010	-2.7%	-3.5%	-3.6%	-5.7%	-8.0%	-10.1%	-10.9%	-11.0%	-11.1%	-11.2%
Size											
1-50 Beds	1362	-4.5%	-2.1%	-2.4%	-9.3%	-10.5%	-13.3%	-14.7%	-15.5%	-16.4%	-17.3%
50-99 Beds	1123	-6.0%	-4.7%	-5.0%	-10.1%	-11.8%	-14.5%	-15.9%	-16.6%	-17.2%	-17.9%
100-199 Beds	1226	-5.8%	-5.5%	-5.8%	-9.0%	-11.5%	-14.0%	-15.0%	-15.4%	-15.7%	-16.1%
200-299 Beds	670	-5.6%	-6.3%	-6.5%	-8.7%	-11.4%	-13.6%	-14.5%	-14.8%	-14.9%	-15.1%
300+ Beds	804	-1.0%	-2.5%	-2.5%	-4.0%	-6.3%	-8.2%	-8.8%	-8.8%	-8.7%	-8.7%
Ownership											
Church	674	-3.9%	-4.9%	-5.2%	-7.0%	-9.3%	-11.2%	-11.9%	-11.9%	-11.9%	-11.9%
Voluntary	2327	-2.9%	-3.8%	-3.8%	-6.4%	-8.9%	-11.2%	-12.1%	-12.4%	-12.5%	-12.7%
Proprietary	748	-5.6%	-6.5%	-6.4%	-7.4%	-9.4%	-11.2%	-11.5%	-11.2%	-11.2%	-11.3%
Government	1436	-1.6%	-1.6%	-1.6%	-4.8%	-6.9%	-9.2%	-10.2%	-10.5%	-10.8%	-11.1%

* Actual

Table 2:

4/4/94

Projected Medicare PPS Inpatient Operating Margins by State Under OBRA 93

			Pre OBRA 93			OBRA 93						
		N	1991*	1992	1993	1994	1995	1996	1997	1998	1999	2000
State												
	Alabama	116	-2.5%	-3.3%	-3.3%	-5.6%	-7.5%	-9.3%	-9.5%	-9.3%	-9.4%	-9.5%
	Alaska	16	-1.4%	-2.6%	-2.7%	-13.4%	-14.7%	-16.5%	-16.6%	-16.3%	-16.4%	-16.6%
	Arizona	57	1.2%	0.4%	0.5%	-0.7%	-2.2%	-3.3%	-3.0%	-2.3%	-1.9%	-1.6%
	Arkansas	81	-0.1%	-1.5%	-1.9%	-8.3%	-10.7%	-13.2%	-14.1%	-14.5%	-15.0%	-15.6%
	California	437	-0.1%	-2.4%	-2.4%	-2.4%	-4.4%	-6.0%	-6.1%	-5.9%	-5.9%	-5.9%
	Colorado	67	-4.4%	-2.7%	-2.8%	-5.1%	-7.3%	-9.3%	-9.8%	-9.8%	-10.2%	-10.6%
	Connecticut	34	-11.8%	-15.1%	-14.6%	-16.3%	-20.1%	-23.3%	-25.7%	-26.6%	-27.4%	-28.1%
	Delaware	7	-12.0%	-12.4%	-12.0%	-14.8%	-16.6%	-18.3%	-18.4%	-18.0%	-17.8%	-17.6%
	Washington DC	9	-3.5%	-7.2%	-7.4%	-9.1%	-11.2%	-12.8%	-12.9%	-12.5%	-12.5%	-12.5%
	Florida	219	-9.2%	-10.3%	-9.7%	-10.3%	-12.2%	-13.6%	-13.5%	-12.9%	-12.6%	-12.3%
	Georgia	160	-7.8%	-6.6%	-6.8%	-9.6%	-11.9%	-14.1%	-14.8%	-14.9%	-15.4%	-15.8%
	Hawaii	20	-14.1%	-22.0%	-22.7%	-28.8%	-32.2%	-35.7%	-37.1%	-37.6%	-38.6%	-39.5%
	Idaho	42	-0.1%	3.2%	1.2%	-6.6%	-8.7%	-11.0%	-11.7%	-12.0%	-12.4%	-12.9%
	Illinois	204	-7.0%	-9.1%	-8.7%	-10.3%	-12.3%	-14.0%	-15.2%	-15.0%	-14.9%	-14.8%
	Indiana	116	-11.5%	-12.0%	-11.9%	-15.3%	-17.9%	-20.1%	-21.7%	-21.8%	-22.2%	-22.5%
	Iowa	123	-6.8%	-4.8%	-5.1%	-10.1%	-12.4%	-14.8%	-15.6%	-15.9%	-16.3%	-16.6%
	Kansas	131	-5.6%	-6.3%	-6.5%	-10.2%	-12.1%	-14.2%	-14.7%	-14.7%	-15.0%	-15.3%
	Kentucky	104	-4.2%	-5.3%	-5.2%	-8.1%	-9.9%	-11.8%	-12.1%	-11.9%	-11.9%	-11.9%
	Louisiana	138	-11.2%	-11.6%	-11.3%	-11.5%	-13.3%	-15.0%	-15.2%	-14.8%	-14.8%	-14.9%
	Maine	39	-9.0%	-13.1%	-13.6%	-16.1%	-18.8%	-21.7%	-24.1%	-24.8%	-25.6%	-26.4%
	Maryland **	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	Massachusetts	99	2.7%	1.3%	0.9%	-1.2%	-3.9%	-6.2%	-7.7%	-8.1%	-8.4%	-8.6%
	Michigan	171	1.1%	-1.2%	-0.8%	-3.6%	-5.6%	-7.5%	-8.7%	-8.6%	-8.5%	-8.4%
	Minnesota	149	2.8%	1.4%	0.4%	-3.5%	-6.1%	-8.7%	-9.8%	-10.4%	-11.1%	-11.8%
	Mississippi	104	-1.3%	-0.8%	-0.8%	-6.0%	-7.7%	-9.9%	-10.4%	-10.6%	-10.8%	-11.0%
	Missouri	132	-4.3%	-7.8%	-7.2%	-9.9%	-12.0%	-13.8%	-14.0%	-13.8%	-13.9%	-13.9%
	Montana	54	-0.9%	-0.2%	-0.2%	-8.5%	-10.2%	-12.3%	-12.8%	-12.9%	-13.3%	-13.7%

** Projections were not made for Maryland, which operates an all-payer rate setting system under a waiver from the Medicare program.

* Actual

Table 2:

4/4/94

Projected Medicare PPS Inpatient Operating Margins by State Under OBRA 93

			Pre OBRA 93			OBRA 93						
		N	1991*	1992	1993	1994	1995	1996	1997	1998	1999	2000
State												
	Nebraska	89	-14.6%	-13.0%	-13.3%	-12.3%	-14.1%	-16.0%	-16.3%	-16.1%	-16.3%	-16.4%
	Nevada	22	-4.6%	-4.8%	-4.1%	-3.5%	-4.6%	-5.2%	-4.6%	-3.5%	-3.4%	-3.3%
	New Hampshire	26	-18.5%	-16.6%	-16.3%	-13.5%	-16.3%	-18.8%	-20.5%	-20.8%	-21.0%	-21.2%
	New Jersey	88	-9.6%	-11.4%	-10.8%	-12.7%	-16.7%	-20.3%	-22.3%	-23.7%	-24.3%	-24.8%
	New Mexico	35	9.4%	9.4%	9.5%	3.7%	2.3%	0.5%	0.2%	0.3%	0.3%	0.3%
	New York	218	7.8%	8.7%	8.5%	6.9%	3.8%	0.7%	-1.3%	-2.9%	-2.6%	-2.4%
	North Carolina	126	-6.1%	-1.5%	-2.3%	-5.0%	-8.1%	-11.0%	-12.4%	-13.3%	-14.0%	-14.6%
	North Dakota	48	-4.5%	-1.8%	-1.3%	-6.7%	-8.0%	-9.5%	-9.4%	-9.0%	-8.7%	-8.5%
	Ohio	185	-6.5%	-6.7%	-6.7%	-11.3%	-13.7%	-15.6%	-17.1%	-17.0%	-17.0%	-17.0%
	Oklahoma	115	0.8%	-0.1%	0.0%	-6.9%	-9.1%	-11.4%	-12.0%	-12.3%	-12.7%	-13.1%
	Oregon	65	8.1%	4.1%	4.2%	-2.1%	-4.2%	-6.1%	-6.5%	-6.5%	-6.6%	-6.8%
	Pennsylvania	218	-2.4%	-3.0%	-2.9%	-4.9%	-7.3%	-9.2%	-9.7%	-9.8%	-9.9%	-10.1%
	Rhode Island	12	3.8%	1.9%	4.9%	0.1%	-2.5%	-4.7%	-6.0%	-6.3%	-6.4%	-6.6%
	South Carolina	69	-13.9%	-9.3%	-9.6%	-11.6%	-14.3%	-16.9%	-17.9%	-18.4%	-18.5%	-18.7%
	South Dakota	53	-2.5%	-2.6%	-2.8%	-8.3%	-9.8%	-11.4%	-11.7%	-11.6%	-11.7%	-11.8%
	Tennessee	132	-6.9%	-10.6%	-10.4%	-12.4%	-14.3%	-16.1%	-16.4%	-16.2%	-16.3%	-16.4%
	Texas	398	-6.8%	-7.6%	-9.6%	-9.9%	-12.0%	-13.9%	-14.2%	-14.0%	-14.2%	-14.4%
	Utah	39	7.5%	9.2%	9.5%	5.4%	3.4%	1.6%	1.3%	1.2%	1.1%	0.9%
	Vermont	15	-10.9%	-11.2%	-11.8%	-18.1%	-21.0%	-24.2%	-26.7%	-27.4%	-28.0%	-28.6%
	Virginia	99	-6.2%	-6.9%	-7.0%	-10.8%	-13.2%	-15.5%	-16.1%	-16.3%	-16.6%	-16.9%
	Washington	92	2.7%	2.3%	1.6%	-1.8%	-4.3%	-6.5%	-7.2%	-7.5%	-7.9%	-8.4%
	West Virginia	58	-7.1%	-5.4%	-5.4%	-14.1%	-16.8%	-19.5%	-20.5%	-21.0%	-21.5%	-22.1%
	Wisconsin	128	0.6%	0.8%	0.5%	-4.7%	-6.9%	-8.9%	-10.4%	-10.5%	-10.8%	-11.1%
	Wyoming	26	-1.8%	-12.6%	-10.7%	-23.7%	-24.7%	-26.7%	-27.1%	-26.9%	-27.4%	-27.3%

* Actual

Table 3:

4/4/94

Projected Medicare PPS Inpatient Operating Margins by Hospital Group Under the Health Security Act

		Pre OBRA 93			OBRA 93	Health Security Act					
	N	1991*	1992	1993	1994	1995	1996	1997	1998	1999	2000
All Hospitals	5185	-3.3%	-4.0%	-4.1%	-6.4%	-10.4%	-14.8%	-17.5%	-23.7%	-26.3%	-28.9%
All Teaching Hospitals	1008	1.1%	-0.5%	-0.3%	-2.1%	-7.5%	-14.0%	-16.6%	-24.4%	-26.8%	-29.3%
Major Teaching	213	8.3%	7.8%	8.3%	7.6%	0.2%	-10.2%	-12.6%	-24.9%	-27.0%	-29.2%
Minor Teaching	795	-2.3%	-4.3%	-4.4%	-6.6%	-11.0%	-15.6%	-18.3%	-24.2%	-26.7%	-29.3%
Non-Teaching	4177	-7.8%	-7.7%	-7.9%	-10.9%	-13.3%	-15.7%	-18.4%	-23.0%	-25.7%	-28.5%
Type of Hospital											
Urban	2914	-3.1%	-4.5%	-4.6%	-6.1%	-10.4%	-15.1%	-17.7%	-24.2%	-26.7%	-29.3%
Large Urban	1545	-1.9%	-3.6%	-3.5%	-4.5%	-9.2%	-14.5%	-17.1%	-24.1%	-26.5%	-29.0%
Other Urban	1369	-4.9%	-6.0%	-6.2%	-8.5%	-12.2%	-16.0%	-18.6%	-24.4%	-27.0%	-29.7%
Rural	2271	-4.2%	-0.7%	-0.8%	-8.5%	-10.2%	-13.1%	-16.1%	-20.3%	-23.3%	-26.4%
Sole Community	541	1.0%	1.6%	1.6%	-9.8%	-9.9%	-12.6%	-15.7%	-20.5%	-23.5%	-26.6%
Sole Comm and Rural Referral	46	4.1%	9.4%	9.4%	-2.1%	-5.0%	-7.5%	-10.2%	-14.4%	-17.1%	-19.9%
Rural Referral	188	-5.9%	-3.1%	-3.0%	-9.1%	-12.6%	-15.8%	-18.7%	-23.6%	-26.5%	-29.3%
Other Rural	1496	-6.4%	-1.7%	-1.8%	-8.8%	-9.5%	-12.3%	-15.6%	-19.1%	-22.2%	-25.4%
Payment Adjustments											
IME & Disp Share	483	4.1%	2.8%	3.2%	1.9%	-3.8%	-10.8%	-13.4%	-24.6%	-26.8%	-29.0%
IME Only	774	-5.0%	-5.5%	-6.3%	-8.5%	-11.1%	-13.6%	-16.5%	-24.6%	-27.4%	-30.2%
Disp Share Only	383	-4.0%	-5.4%	-5.5%	-8.1%	-13.1%	-18.6%	-21.3%	-23.9%	-26.4%	-29.0%
None	3545	-6.9%	-7.0%	-7.1%	-10.0%	-12.9%	-15.9%	-18.5%	-22.9%	-25.7%	-28.4%
Medicare Proportion of Rev.											
Over 60%	1175	-6.6%	-7.2%	-7.4%	-11.2%	-14.1%	-17.1%	-20.1%	-23.2%	-26.0%	-28.8%
Under 60%	4010	-2.7%	-3.5%	-3.6%	-5.7%	-9.8%	-14.5%	-17.1%	-23.8%	-26.3%	-28.9%
Size											
1-50 Beds	1362	-4.5%	-2.1%	-2.4%	-9.3%	-10.3%	-13.3%	-16.4%	-18.6%	-21.8%	-25.1%
50-99 Beds	1123	-6.0%	-4.7%	-5.0%	-10.1%	-11.8%	-14.7%	-17.9%	-21.3%	-24.3%	-27.5%
100-199 Beds	1226	-5.8%	-5.5%	-5.8%	-9.0%	-11.8%	-14.7%	-17.6%	-23.5%	-26.3%	-29.2%
200-299 Beds	670	-5.6%	-6.3%	-6.5%	-8.7%	-12.3%	-15.8%	-18.6%	-24.6%	-27.2%	-29.9%
300+ Beds	804	-1.0%	-2.5%	-2.5%	-4.0%	-8.9%	-14.6%	-17.0%	-24.0%	-26.3%	-28.7%
Ownership											
Church	674	-3.9%	-4.9%	-5.2%	-7.0%	-10.4%	-13.8%	-16.3%	-21.5%	-23.9%	-26.4%
Voluntary	2327	-2.9%	-3.8%	-3.8%	-6.4%	-10.9%	-16.0%	-18.8%	-25.1%	-27.7%	-30.4%
Proprietary	748	-5.6%	-6.5%	-6.4%	-7.4%	-9.7%	-12.0%	-13.9%	-18.3%	-20.6%	-23.0%
Government	1436	-1.6%	-1.6%	-1.6%	-4.8%	-8.9%	-14.2%	-17.0%	-26.4%	-29.3%	-32.2%
Alabama	116	-2.5%	-3.3%	-3.3%	-5.6%	-8.3%	-11.3%	-13.2%	-16.9%	-19.3%	-21.8%
Alaska	16	-1.4%	-2.6%	-2.7%	-13.4%	-14.7%	-16.5%	-18.4%	-25.7%	-28.3%	-31.0%

* Actual

Table 4:

4/4/94

Projected Medicare PPS Inpatient Operating Margins by State Under the Health Security Act

		Pre OBRA 93			OBRA 93	Health Security Act					
	N	1991*	1992	1993	1994	1995	1996	1997	1998	1999	2000
State											
Arizona	57	1.2%	0.4%	0.5%	-0.7%	-3.3%	-5.9%	-7.2%	-11.0%	-12.8%	-14.6%
Arkansas	81	-0.1%	-1.5%	-1.9%	-8.3%	-11.1%	-14.1%	-16.8%	-19.8%	-22.7%	-25.7%
California	437	-0.1%	-2.4%	-2.4%	-2.4%	-5.4%	-8.4%	-10.2%	-18.3%	-20.6%	-23.0%
Colorado	67	-4.4%	-2.7%	-2.8%	-5.1%	-8.5%	-12.2%	-14.5%	-17.7%	-20.5%	-23.3%
Connecticut	34	-11.8%	-15.1%	-14.6%	-16.3%	-23.7%	-32.3%	-37.0%	-42.4%	-46.1%	-49.8%
Delaware	7	-12.0%	-12.4%	-12.0%	-14.8%	-19.2%	-24.7%	-26.8%	-28.8%	-31.2%	-33.6%
Washington DC	9	-3.5%	-7.2%	-7.4%	-9.1%	-15.9%	-24.6%	-26.6%	-37.4%	-40.1%	-42.8%
Florida	219	-9.2%	-10.3%	-9.7%	-10.3%	-12.7%	-14.8%	-16.3%	-20.1%	-22.1%	-24.2%
Georgia	160	-7.8%	-6.6%	-6.8%	-9.6%	-12.9%	-16.5%	-19.0%	-25.6%	-28.5%	-31.5%
Hawaii	20	-14.1%	-22.0%	-22.7%	-28.8%	-33.8%	-39.7%	-43.4%	-54.7%	-58.8%	-63.1%
Idaho	42	-0.1%	3.2%	1.2%	-6.6%	-8.8%	-11.4%	-13.8%	-16.3%	-19.0%	-21.8%
Illinois	204	-7.0%	-9.1%	-8.7%	-10.3%	-14.3%	-18.8%	-21.9%	-29.0%	-31.4%	-33.9%
Indiana	116	-11.5%	-12.0%	-11.9%	-15.3%	-19.0%	-22.7%	-26.3%	-30.5%	-33.4%	-36.4%
Iowa	123	-6.8%	-4.8%	-5.1%	-10.1%	-13.4%	-17.2%	-19.8%	-24.0%	-26.8%	-29.7%
Kansas	131	-5.6%	-6.3%	-6.5%	-10.2%	-13.3%	-17.1%	-19.5%	-23.9%	-26.6%	-29.4%
Kentucky	104	-4.2%	-5.3%	-5.2%	-8.1%	-10.6%	-13.5%	-15.6%	-21.4%	-23.8%	-26.2%
Louisiana	138	-11.2%	-11.6%	-11.3%	-11.5%	-14.1%	-16.9%	-18.9%	-25.5%	-27.8%	-30.3%
Maine	39	-9.0%	-13.1%	-13.6%	-16.1%	-20.1%	-24.7%	-29.2%	-36.5%	-40.1%	-43.7%
Maryland **	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Massachusetts	99	2.7%	1.3%	0.9%	-1.2%	-6.8%	-13.3%	-16.9%	-23.3%	-26.0%	-28.9%
Michigan	171	1.1%	-1.2%	-0.8%	-3.6%	-8.2%	-13.8%	-17.0%	-22.8%	-25.1%	-27.4%
Minnesota	149	2.8%	1.4%	0.4%	-3.5%	-8.6%	-14.7%	-17.6%	-21.1%	-24.3%	-27.6%
Mississippi	104	-1.3%	-0.8%	-0.8%	-6.0%	-7.9%	-10.4%	-12.8%	-21.7%	-24.3%	-27.0%
Missouri	132	-4.3%	-7.8%	-7.2%	-9.9%	-13.6%	-17.8%	-19.9%	-23.5%	-26.0%	-28.5%
Montana	54	-0.9%	-0.2%	-0.2%	-8.5%	-10.2%	-12.3%	-14.6%	-17.6%	-20.3%	-23.1%

** Projections were not made for Maryland, which operates an all-payer rate setting system under a waiver from the Medicare program.

* Actual

Table 4:

4/4/94

Projected Medicare PPS Inpatient Operating Margins by State Under the Health Security Act

			Pre OBRA 93			OBRA 93	Health Security Act					
		N	1991*	1992	1993	1994	1995	1996	1997	1998	1999	2000
State												
	Nebraska	89	-14.6%	-13.0%	-13.3%	-12.3%	-15.5%	-19.4%	-21.6%	-26.8%	-29.5%	-32.3%
	Nevada	22	-4.6%	-4.8%	-4.1%	-3.5%	-4.8%	-5.8%	-6.8%	-9.4%	-11.4%	-13.4%
	New Hampshire	26	-18.5%	-16.6%	-16.3%	-13.5%	-17.6%	-21.9%	-25.6%	-28.4%	-31.2%	-34.0%
	New Jersey	88	-9.6%	-11.4%	-10.8%	-12.7%	-18.6%	-25.0%	-29.0%	-35.2%	-38.5%	-41.9%
	New Mexico	35	9.4%	9.4%	9.5%	3.7%	1.8%	-0.6%	-2.4%	-7.5%	-9.7%	-11.8%
	New York	218	7.8%	8.7%	8.5%	6.9%	1.0%	-6.4%	-10.3%	-22.4%	-24.5%	-26.8%
	North Carolina	126	-6.1%	-1.5%	-2.3%	-5.0%	-9.7%	-15.1%	-18.4%	-28.8%	-32.2%	-35.5%
	North Dakota	48	-4.5%	-1.8%	-1.3%	-6.7%	-8.4%	-10.5%	-12.2%	-14.0%	-15.9%	-18.0%
	Ohio	185	-6.5%	-6.7%	-6.7%	-11.3%	-15.9%	-21.0%	-24.4%	-29.4%	-32.0%	-34.6%
	Oklahoma	115	0.8%	-0.1%	0.0%	-6.9%	-9.9%	-13.2%	-15.7%	-20.7%	-23.5%	-26.4%
	Oregon	65	8.1%	4.1%	4.2%	-2.1%	-5.3%	-8.8%	-10.9%	-14.6%	-16.9%	-19.4%
	Pennsylvania	218	-2.4%	-3.0%	-2.9%	-4.9%	-9.6%	-15.1%	-17.5%	-23.5%	-26.0%	-28.7%
	Rhode Island	12	3.8%	1.9%	4.9%	0.1%	-5.4%	-11.8%	-15.1%	-17.8%	-20.2%	-22.8%
	South Carolina	69	-13.9%	-9.3%	-9.6%	-11.6%	-15.5%	-19.7%	-22.7%	-33.2%	-36.0%	-38.9%
	South Dakota	53	-2.5%	-2.6%	-2.8%	-8.3%	-10.0%	-12.5%	-14.5%	-17.1%	-19.5%	-22.0%
	Tennessee	132	-6.9%	-10.6%	-10.4%	-12.4%	-15.3%	-18.6%	-20.7%	-19.1%	-21.6%	-24.1%
	Texas	398	-6.8%	-7.6%	-9.6%	-9.9%	-13.0%	-16.3%	-18.5%	-25.1%	-27.7%	-30.4%
	Utah	39	7.5%	9.2%	9.5%	5.4%	1.9%	-2.1%	-4.2%	-8.0%	-10.4%	-12.8%
	Vermont	15	-10.9%	-11.2%	-11.8%	-18.1%	-23.8%	-31.1%	-35.9%	-40.3%	-43.7%	-47.2%
	Virginia	99	-6.2%	-6.9%	-7.0%	-10.8%	-14.5%	-18.7%	-21.2%	-26.8%	-29.7%	-32.6%
	Washington	92	2.7%	2.3%	1.6%	-1.8%	-5.3%	-9.1%	-11.5%	-17.4%	-20.2%	-23.2%
	West Virginia	58	-7.1%	-5.4%	-5.4%	-14.1%	-18.0%	-22.4%	-25.4%	-32.0%	-35.2%	-38.5%
	Wisconsin	128	0.6%	0.8%	0.5%	-4.7%	-8.3%	-12.4%	-15.7%	-19.8%	-22.5%	-25.3%
	Wyoming	26	-1.8%	-12.6%	-10.7%	-23.7%	-25.3%	-28.3%	-30.7%	-32.3%	-35.4%	-38.6%

* Actual

KEY ASSUMPTIONS MADE BY LEWIN-VHI

- Medicare PPS inpatient operating margins are defined as Medicare inpatient operating revenue minus Medicare inpatient operating costs divided by Medicare inpatient operating revenue (R-C)/R.

- The following provisions of OBRA 1993 have an impact on hospitals and are included in the "OBRA 1993" portion of this analysis:
  - *Reductions in the PPS update factor*
  - *Changes in indirect medical education payments*
  - *Phase-out of day outlier payments*
  - *Hospital protection against certain changes in the wage index*
  - *Regional referral center extension*
  - *Small Medicare-dependent rural hospital payment extension*
  - *Regional floor extension*

- The following provisions proposed by the President would have a further impact on hospitals and are included in the "Medicare Reductions Under the Health Security Act" portion of this analysis:
  - *Reductions in the PPS update factor*
  - *Reductions in the indirect medical education adjustment*
  - *Reductions in disproportionate share hospital payments*

- Margin estimates reflect Medicare PPS inpatient operating revenues and costs only. Capital and other Medicare revenues (e.g., direct medical education) are not included. Margin estimates reflect the impact of the proposed Medicare spending reductions and do not reflect the impact of other provisions included in the Health Security Act.

- Hospital costs are assumed to grow by the rate of increase in the hospital market basket index plus 2.9 percentage points, or about 7.3 percent annually over the projection period. This rate of growth is about 1 percentage point less than historical rates of growth after adjusting for inflation.

- The Lewin-VHI model is a "static" model, so it does not include behavioral changes (e.g., changes in the organization of hospital service delivery) or changes in industry structure (e.g., no hospital closings or consolidations). This is because it is impossible to predict which types of hospitals may restructure, consolidate, or close. Moreover, little information is available to allow experts to model into the future how hospitals and the health care system generally might respond to the system-wide kinds of regulatory and market changes being proposed.

- The proposed change to an "all-payer" pool for indirect medical education costs is not included in the Medicare PPS margin estimates because non-Medicare funds (from regional and corporate alliances) would also be included in the pool, and would distort the Medicare PPS-only analysis. Medicare indirect medical education payments, reduced as specified by the Administration, are included and are assumed to continue until the year 2000.

- The Administration's proposal would significantly reduce Medicare disproportionate share payments as states form health care alliances. Because the timing of states' reform activities cannot be known, margin estimates assume that OBRA 1993 disproportionate share provisions continue in effect through 1997 and the disproportionate share provisions proposed by the Administration are fully implemented in 1998.

- No estimates were made for the state of Maryland because the state operates under a federal waiver and has a distinctive rate setting system.

April 6, 1994

Making the Tough Choices: Alternative Financing Options for Health Care Reform

Options for Increasing Revenues or Reducing Spending	*5-Year Value*

Increase the 10 percent excise tax on handguns and assault weapons to 35 percent — *$1 billion*

This option is modeled after legislation, H.R. 3245, introduced by Congressman Mel Reynolds (D-IL), which would increase the current 10 percent excise tax on handguns to 35 percent. Congressman Reynolds' legislation would specifically earmark 25 percent of the proceeds for general health care purposes.

Increase the federal excise tax on certain alcoholic beverages — *$5.5 billion*

Alcohol abuse is responsible for over 100,000 deaths and $100 billion in economic costs annually. This option would increase the federal excise tax on alcoholic spirits to $16.00 per proof gallon (from $13.50), and on wine at a concomitant rate. (Source: *Reducing the Deficit: Spending and Revenue Options*, March 1994, Congressional Budget Office)

Increase the 24 cents federal excise tax on a pack of cigarettes by $1.25, 50 cents more than the Administration's proposal — *$80 billion*

Cigarette use causes 419,000 deaths each year and $65 billion in tobacco-related health care costs and lost productivity. This option, based on the provision adopted by the House Ways and Means subcommittee on Health during its markup of health care reform legislation, would increase the current 24 cents federal excise tax on a pack of cigarettes by $1.25. The Administration's plan would increase the federal excise tax on a pack of cigarettes by 75 cents, raising $67 billion over six years, and $56 billion over five years. (Source: House Ways and Means Subcommittee on Health, March 1994)

For every $15 billion in increased revenues or reduced federal spending, comprehensive health care coverage can be provided to approximately 1 million people for five years.

LIMIT THE TAX-DEDUCTIBILITY OF EMPLOYER-PAID HEALTH INSURANCE TO THE COST OF AN AVERAGE PLAN — *$104.4 BILLION*

Currently, employees do not pay taxes on income they receive in the form employer-paid health insurance. In addition, employers are allowed to deduct the full cost of any health coverage they provide to their employees. Limiting the amount of tax-free benefits that an employee can receive to $375 per month ($4500 annually) for family coverage and $165 per month ($1,980 annually) for individual coverage increases income tax revenues and payroll tax revenues dramatically. (Source: *Reducing the Deficit: Spending and Revenue Options*, March, 1994, Congressional Budget Office)

SCALE BACK THE SUBSIDY FOR EARLY RETIREES UNDER THE CLINTON PLAN — *$15 BILLION*

The President's proposal would provide a generous benefit to early retirees (ages 55-64) and those employers who have obligations to provide their health coverage, by offering to pay the 80 percent employer share of premiums for those retirees who have paid into the Social Security system. Some observers question the fairness of giving early retiree a subsidy that is greater than those who are either working or unemployed. (The Health Security Act provides individuals and families with incomes of less than $40,000 per year a subsidy for their portion of the health plan premium.) The Administration's proposal would reduce the early retiree subsidy only for singles with an income over $90,000 per year or families with an income over $115,000 per year. If the administration proposal were scaled back to the same $40,000 subsidy level as applies to the working and the unemployed, significant savings could be achieved. (Source: The Financial Impact of the Health Security Act, December 1993, Lewin-VHI, Inc.)

MEANS TEST THE MEDICARE PART B PREMIUM FOR UPPER-INCOME BENFICIARIES — *$5.4 BILLION*

Currently, beneficiaries only pay 25 percent of the Medicare Part B premium; the remainder is paid by the federal government through general revenues. This proposal would require wealthier beneficiaries (individuals with retirement incomes of $125,000 or more and couples with retirement incomes of $150,000 or more) to pay the full cost of the Part B premium. (Source: *Reducing the Deficit: Spending and Revenue Options*, March 1994, Congressional Budget Office)

For every $15 billion in increased revenues or reduced federal spending, comprehensive health care coverage can be provided to approximately 1 million people for five years.

ACCELERATE THE RISE IN THE SOCIAL SECURITY RETIREMENT AGE TO 68 BY THE YEAR 2008 — *$36 BILLION*

When the Social Security system was established in the mid-1930's and the retirement age set at 65, average life expectancy was about 60 years. Today, average life expectancy is 76. In other words, Social Security recipients receive benefits for many more years than envisioned when the program was enacted. Under current law, the age for full-benefit Social Security retirement will increase gradually from 65 to 67 between 2000 and 2017. This proposal would raise the retirement age to 68, increasing by three months each year starting in 1995, until it reached age 68 in 2006. (Source: *The Zero Deficit Plan: A Plan for Eliminating the Federal Budget Deficit by the year 2000*, September 1993, The Concord Coalition)

USE THE FUNDS TARGETED FOR DEFICIT REDUCTION UNDER PRESIDENT CLINTON'S HEALTH CARE REFORM PROPOSAL TO HELP FINANCE THE REFORM EFFORT — *$59 BILLION*

Under the President's health care reform proposal, $59 billion in reduced spending is targeted for deficit reduction over six years (FY 95-2000). It should be noted, however, that the Congressional Budget Office recently reported that these savings would not be achieved under the President's health care reform proposal.

IMPOSE A MINIMUM TAX ON FOREIGN-OWNED BUSINESSES OPERATING IN THE UNITED STATES — *$2.6 BILLION*

Some evidence suggests that some foreign-owned, multinational corporations may be attempting to avoid paying U.S. taxes by manipulating transfer prices and shifting income overseas. When foreign multinational corporations operating in the U.S. import materials and services from affiliated companies abroad, the "transfer price" of imports affects the amount of income that is subject to U.S. tax. By raising the transfer price of imports, foreign-owned companies can shift income out of the U.S. to their foreign affiliates and reduce their U.S. tax. This proposal would impose a minimum tax on all companies that are at least 25 percent foreign-owned and have transactions with foreign affiliates in excess of either 10 percent of their gross income or $2 million annually. (Source: *Reducing the Deficit: Spending and Revenue Options*, March 1994, Congressional Budget Office)

For every $15 billion in increased revenues or reduced federal spending, comprehensive health care coverage can be provided to approximately 1 million people for five years.

IMPOSE EXCISE TAXES ON WATER POLLUTANTS — *$17 BILLION*

In 1991, more than 240 million pounds of toxic materials were discharged by the U.S. manufacturing sector directly into bodies of water, and more than 400 million pounds were discharged indirectly through sewers. Toxic pollutants generally include organic chemicals (such as solvents and dioxins), metals (such as mercury and lead), and pesticides. This proposal would impose varying tax rates based on a pollutant's level of toxicity. (Source: *Reducing the Deficit: Spending and Revenue Options*, March 1994, Congressional Budget Office)

IMPOSE ONE-TIME EMISSIONS TAX ON NEW CARS AND LIGHT TRUCKS — *$13.3 BILLION*

This proposal would impose a one-time tax on new cars and light trucks based on the level of harmful emissions from each automobile. The EPA would determine the tail-pipe emissions for each new model light-duty vehicle and the tax would be based on these emissions rates. The tax would be collected from the purchaser by the auto dealer at the point of sale. (Source: *Reducing the Deficit: Spending and Revenue Options*, March 1994, Congressional Budget Office)

PROHIBIT PEOPLE WITH ANNUAL ADJUSTED GROSS INCOMES OF OVER $100,000 FROM RECEIVING FARM PRICE SUPPORT PAYMENTS — *$300 MILLION*

Current law limits participants in crop price support payments to no more than $100,000 in deficiency payment benefits from the Commodity Credit Corporation during any crop year. This option would prohibit those people with annual incomes of $100,000 or more from receiving farm price support payments. (Source: *Reducing the Deficit: Spending and Revenue Options*, March 1994, Congressional Budget Office)

MEANS TEST UNEMPLOYMENT COMPENSATION, AT TAXABLE INCOME EXCEEDING $120,000 — *$361 MILLION*

This proposal would end the federal portion of unemployment subsidies to any individual who has an after-tax income of over $120,000. (Source: Kerrey/Brown Senate budget-cutting package)

For every $15 billion in increased revenues or reduced federal spending, comprehensive health care coverage can be provided to approximately 1 million people for five years.

REFORM PRISON CONSTRUCTION *$580 MILLION*

This option would require that previously appropriated funds for prison construction be spent before new amounts could be appropriated. (Source: 1993 House GOP Budget)

HALT NEW ACQUISITIONS OF CRUDE OIL FOR THE STRATEGIC PETROLEUM RESERVE (SPR) FOR FIVE YEARS *$325 MILLION*

The SPR, a government-owned crude oil inventory stored in Louisiana and Texas, was authorized in 1975 to reduce the vulnerability of the U.S. to interruptions in oil supplies. This option would halt new purchases of crude oil for the SPR. (Source: *Reducing the Deficit: Spending and Revenue Options*, March 1994, Congressional Budget Office)

ELIMINATE FUNDING FOR THE MAGNETIC LEVITATION (MAGLEV) PROTOTYPE DEVELOPMENT *$700 MILLION*

The MagLev is a high-speed rail prototype development program established by the 1991 highway bill. The Office of Technology Assessment states that the technology is not yet ready to jump to the full-scale operating demonstration as proposed in the highway bill. (Source: Penny/Kasich budget package)

REDUCE TRAVEL ACCOUNTS BY 15 PERCENT FOR SPECIFIC EXECUTIVE BRANCH AGENCIES AND THE LEGISLATIVE BRANCH *$875 MILLION*

The proposal exempts selected agencies because of special requirements of their functions that necessitate the use of their full travel budget allowances. The agencies exempted are the Department of Defense, the Department of Veterans Affairs, the Department of the Treasury (which includes the FBI), and the Department of Justice. (Source: Kerrey/Brown Senate budget package)

ELIMINATE THE MARKET PROMOTION PROGRAM (MPP), WHICH ASSISTS U.S. AGRICULTURAL EXPORTERS IN SELLING THEIR PRODUCTS OVERSEAS *$500 MILLION*

The MPP was authorized by the 1990 farm bill to help U.S. agricultural exporters sell their products overseas. This option eliminates the MPP. (Source: *Reducing the Deficit: Spending and Revenue Options*, March 1994, Congressional Budget Office)

For every $15 billion in increased revenues or reduced federal spending, comprehensive health care coverage can be provided to approximately 1 million people for five years.

IMPOSE A 5-YEAR MORATORIUM ON LAND ACQUISITION BY THE FEDERAL GOVERNMENT — *$1.4 BILLION*

This option would impose a five-year moratorium on the purchase of land by the federal government. The federal government already owns one-third of the nation's land. (Source: *The Zero Deficit Plan: A Plan for Eliminating the Federal Budget Deficit by the year 2000*, September 1993, The Concord Coalition)

REDUCE FUNDS FOR THE STRATEGIC DEFENSE INITIATIVE (SDI OR "STAR WARS") — *$1.85 BILLION*

This proposal would reduce the Star Wars budget by 16 percent. (Source: Amendment to H.R. 3400, the Reinventing Government bill, offered by Reps. Barney Frank (D-MA) and Chris Shays (R-CT), November 1993)

IMPOSE A MORATORIUM ON THE PURCHASE OF FEDERAL BUILDINGS — *$2 BILLION*

According to the National Performance Review report, "Over the next 5 years, the federal government is slated to spend more than $800 million a year acquiring new federal office space and courthouses. Under current conditions, however, those acquisitions don't make sense." (Source: *Creating a Government that Works Better and Costs Less*, Report of the National Performance Review, September 7, 1993)

ELIMINATE FUNDING FOR HIGHWAY DEMONSTRATION PROJECTS — *$2.6 BILLION*

Outside of the normal competitive bidding and selection process, the Congress will earmark special highway demonstration projects through the reauthorization of the highway bill or the annual appropriations process. Often times, these demonstration projects cannot be justified by economic criteria. (Source: *Reducing the Deficit: Spending and Revenue Options*, March 1994, Congressional Budget Office)

SCALE BACK NUCLEAR WEAPONS PRODUCTION TO 3,500 WARHEADS — *$2.7 BILLION*

The end of the Cold War and recent developments in Eastern Europe, the former Soviet Union, and elsewhere around the world, raise questions about the proper nuclear arsenal of the United States. This proposal would scale back the Department of Energy's weapons production to no more than 3,500 warheads, the maximum number of strategic warheads that can be deployed under the Strategic Arms Reduction Talks (START II) Treaty. (Source: *Reducing the Deficit: Spending and Revenue Options*, March 1994, Congressional Budget Office)

For every $15 billion in increased revenues or reduced federal spending, comprehensive health care coverage can be provided to approximately 1 million people for five years.

INCREASE BURDENSHARING BY ALLIED NATIONS HOSTING U.S. FORCES — *$9.6 BILLION*

Countries in which U.S. troops are stationed provide varying amounts of support as the host nation. In 1991, for example, Japan signed a five-year agreement with the U.S. that promises to contribute 75 percent of the total cost of U.S. deployment in Japan, excluding the salaries of U.S. armed forces and civilian personnel. As Congress recommended in the conference report accompanying the 1993 and 1994 defense authorization acts, other allied nations hosting major concentrations of U.S. forces, such as Italy, Germany, the United Kingdom, and South Korea, should follow the lead of Japan in assuming 75 percent of U.S. stationing costs (excluding the salaries of U.S. personnel). (Source: *Reducing the Deficit: Spending and Revenue Options*, March 1994, Congressional Budget Office)

CANCEL THE AIR FORCE'S F-22 AIRCRAFT PROGRAM — *$8.4 BILLION*

The F-22 is being developed to replace the Air Force's current fighter plane, the F-15. The Air Force plans to purchase 650 F-22 aircraft. Given the changing nature of world events, some observers question whether the F-22 fighter, the only prototype of which crashed in 1992, is needed. (Source: *Reducing the Deficit: Spending and Revenue Options*, March 1994, Congressional Budget Office)

CANCEL THE NASA SPACE STATION PROGRAM — *$10.4 BILLION*

Some observers question whether we can continue to affor the NASA space station program. They call into question its scientific merits, particularly in relation to other vital scientific projects. (Source: *Reducing the Deficit: Spending and Revenue Options*, March 1994, Congressional Budget Office)

REDUCE THE FEDERAL SUBSIDY TO FARMERS PARTICIPATING IN FEDERAL COMMODITY PROGRAMS--THOSE WHO PRODUCE CORN AND OTHER FEED GRAINS, WHEAT, RICE, AND COTTON--BY LOWERING TARGET PRICES BY 3 PERCENT PER YEAR — *$11.1 BILLION*

Farmers who participate in federal commodity programs receive a deficiency payment, which is the primary form of direct government subsidy to growers. The size of the deficiency payment is calculated in part from the difference between the market price of a crop and a target price set by law. This option would lower those target prices by 3 percent per year from 1995 through 1999. (Source: *Reducing the Deficit: Spending and Revenue Options*, March 1994, Congressional Budget Office)

TOTAL — ***$393 BILLION***

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April 28, 1994

The Honorable Dan Rostenkowski
U. S. House of Representatives
2111 Rayburn House Office Building
Washington D.C. 20515-1305

Dear Chairman Rostenkowski:

The American Hospital Association (AHA) recently released the findings of a study conducted by a highly respected consulting firm, Lewin-VHI, which analyzed the impact on hospitals of proposed Medicare payment reductions contained in the President's health care reform proposal (and, by inference, the type of Medicare reductions found in most other major health care reform plans). I thought you might be interested in some more detailed information about the impact on hospitals in your district.

It is important to note that the Lewin-VHI findings do not pretend to predict the future with any certainty--they are highly sensitive to underlying assumptions about future growth in hospital costs. They are however, illustrative of the kinds of pressures that hospitals face if Medicare spending reductions alone of this size are enacted.

The key findings indicate that by the year 2000, after six years of spending reductions, nationwide Medicare could pay hospitals only 71 cents for every dollar of inpatient care delivered to Medicare patients--thus making the Medicare program an even poorer payer than today's Medicaid program.

While most hospitals and all states are affected, teaching hospitals, hospitals in large urban and rural areas, and communities with hospitals serving a disproportionately large number of low-income patients would be particularly hard hit.

The negative impact on hospitals of Medicare spending reductions is magnified when combined with price control and spending cap proposals included in many of the reform bills under consideration.

Since the release of this study, several people have raised questions about its scope and the fact that it looked only at Medicare spending reductions, not focusing on any other aspects of health reform, including some proposals which would compensate hospitals for the proposed Medicare shortfalls. We would like to take the opportunity to respond to these questions.

First, the President's plan, and most others, do not include Medicare in reform. The Medicare program remains separate, with only limited incentives for Medicare beneficiaries to move into a reformed health care system--a system which could provide more efficient and cost-effective care through the use of integrated delivery systems, coordinating and providing care in a seamless manner. With Medicare thus kept in isolation, it is logical to look at the effects of the spending reductions only on that program and its beneficiaries.

Second, there is no guarantee that we will get comprehensive reform, but we fear that with or without reform, Medicare spending reductions will be on the table.

But even if we look at this level of Medicare reductions as part of a comprehensive reform package and not in isolation, we still believe that the numbers don't add up.

Enclosed is a chart which helps to illustrate the following points. We have compared the situation in hospitals in your district today and in the year 2000, and we have assumed there is universal access and coverage in place at that time.

- ✓ Medicare today accounts for about 38 percent of the activities of hospitals in your district. According to Lewin-VHI, in the year 2000 hospitals in your state would be paid about 66 percent of cost for this portion of their services.

- ✓ Medicaid today accounts for about 18 percent of your hospitals' activities. Let's assume that this proportion is reimbursed--for argument's sake--at the unlikely level of 100 percent of cost by the year 2000.

- ✓ Uncompensated care--which currently represents about 4 percent of your hospitals' activities--would be significantly reduced if we in fact achieve universal access and coverage. And let's assume it will also be reimbursed in the year 2000 at 100 percent of cost...just for argument's sake. And this argument would put aside the fact that there will always be some uncompensated care given in hospitals, whether to illegal aliens, to the homeless or to those who can't or won't pay the required copayments and deductibles.

- ✓ Private-paying patients account for about 40 percent of your hospitals' activities. The possible increases, described above, in hospital payments for the Medicaid and uninsured populations will be offset by lower payments from privately insured patients. In the future, private-paying patients will expect to pay less for their care, no longer paying for the cost shift. The cost shift would be eliminated in most reform proposals through market forces, ranging from more use of prudent purchasing techniques such as pooling arrangements that create more leverage, to the development of competing integrated delivery systems. Other proposals, however, would impose arbitrary and stringent caps on overall health spending or insurance premiums, meaning hospitals could no longer rely on the private sector to cover government and other payment shortfalls.

Even under this admittedly rosy scenario, hospitals nationwide remain with about 40 percent of their activities reimbursed at about 71 cents on the dollar. And even if the Lewin-VHI estimates are substantially off the mark, the numbers still do not add up.

We appreciate your taking the time to understand the impact of Medicare spending reductions of this magnitude and spending caps on hospitals in your district and state. Please feel free to call on us if we can provide further information.

Sincerely,

Dick Davidson
President

Enclosure

THE MATH DOESN'T ADD UP:

ILLUSTRATIVE IMPACT OF MEDICARE SPENDING REDUCTIONS AND HEALTH CARE REFORM ON HOSPITALS' FINANCIAL STATUS

ILLINOIS - 5TH DISTRICT			
		TODAY•	2000•••
	% OF HOSPITAL ACTIVITY (District)	% OF COST COVERED (State)	% OF COST COVERED (State)
MEDICARE	38	86	66••••
MEDICAID	18	56	(100 ?)
UNCOMPENSATED CARE	4	41••	(100 ?)
PRIVATE PAY	40	137	(100 ?)
BOTTOM LINE:			Patient Care at Risk

• Prospective Payment Assessment Commission, "Medicare and the American Health Care System; Report to the Congress, " June 1993, p. 136, 1991 data.

•• Consistent with Prospective Payment Assessment Commission methodology, payments for uncompensated care are calculated by AHA and reflect operating subsidies from state and local governments.

••• Illustrative calculations of the kinds of financial pressures faced by hospitals in the year 2000 if Medicare spending reductions alone, of the size included in the President's health care reform proposal, are enacted.

•••• Medicare payment estimates based on Lewin-VHI analysis of impact of Medicare spending reductions, excluding changes proposed to capital and direct medical education, on hospitals' Prospective Payment System inpatient operating margin. If payments to hospitals for outpatient care remain as under current law, the total Medicare payment to cost ratio is likely to be somewhat higher, but only by about 3 percentage points.

State	U.S. Representatives	D	Hospital Name	City	Address	Administrator	Beds	Adm	Days	Births	Out Visits	Fte
Illinois	ROSTENKOWSKI DAN	5	BELMONT COMMUNITY HOSPITAL	CHICAGO	4056 WEST MELROSE STREET	CHRISTOPHER L BOYD, DIR	109	2917	34257	0	11238	310
Illinois	ROSTENKOWSKI DAN	5	CHILDREN'S MEMORIAL HOSPITAL	CHICAGO	2300 CHILDREN'S PLAZA	JAN R JENNINGS, PRES	240	10365	70721	0	202034	2350
Illinois	ROSTENKOWSKI DAN	5	COLUMBUS HOSPITAL	CHICAGO	2520 NORTH LAKEVIEW AVENUE	LEE DOMANICO, CEO	299	10583	72791	1436	75034	1259
Illinois	ROSTENKOWSKI DAN	5	GRANT HOSPITAL OF CHICAGO	CHICAGO	550 WEST WEBSTER AVENUE	PETER S FINE, PRES	344	10833	79832	576	102510	1216
Illinois	ROSTENKOWSKI DAN	5	ILLINOIS MASONIC MED CENTER	CHICAGO	836 WEST WELLINGTON AVENUE	GERALD W MUNGERSON, PRES	695	16708	208536	3108	304635	2858
Illinois	ROSTENKOWSKI DAN	5	LINCOLN WEST HOSPITAL	CHICAGO	2544 WEST MONTROSE AVENUE	BARRY S SCHNEIDER, PRES	105	.	.	.	.	.
Illinois	ROSTENKOWSKI DAN	5	OUR LADY OF RESURRECTION CTR	CHICAGO	5645 WEST ADDISON STREET	JOHN SULLIVAN, CEO	273	8219	73571	0	51804	889
Illinois	ROSTENKOWSKI DAN	5	RAVENSWOOD HOSP MEDICAL CENTER	CHICAGO	4550 NORTH WINCHESTER AVENUE	JOHN E BLAIR, PRES	333	11409	93229	2279	142522	1464
Illinois	ROSTENKOWSKI DAN	5	SWEDISH COVENANT HOSPITAL	CHICAGO	5145 NORTH CALIFORNIA AVENUE	EDWARD A CUCCI, PRES	285	10114	68072	1111	54659	.
Illinois	ROSTENKOWSKI DAN	5	WESTLAKE COMMUNITY HOSPITAL	MELROSE PARK	1225 LAKE STREET	DAVID R HEY, EXEC VP	250	8481	55780	827	59119	884
Illinois	ROSTENKOWSKI DAN	5	GOTTLIEB MEMORIAL HOSPITAL	MELROSE PARK	701 WEST NORTH AVENUE	JOHN MORGAN, PRES	252	9184	55762	858	99128	959

American Hospital Association

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April 28, 1994

The Honorable John D. Dingell
U. S. House of Representatives
2328 Rayburn House Office Building
Washington D.C. 20515-2216

Dear Chairman Dingell:

The American Hospital Association (AHA) recently released the findings of a study conducted by a highly respected consulting firm, Lewin-VHI, which analyzed the impact on hospitals of proposed Medicare payment reductions contained in the President's health care reform proposal (and, by inference, the type of Medicare reductions found in most other major health care reform plans). I thought you might be interested in some more detailed information about the impact on hospitals in your district.

It is important to note that the Lewin-VHI findings do not pretend to predict the future with any certainty--they are highly sensitive to underlying assumptions about future growth in hospital costs. They are however, illustrative of the kinds of pressures that hospitals face if Medicare spending reductions alone of this size are enacted.

The key findings indicate that by the year 2000, after six years of spending reductions, nationwide Medicare could pay hospitals only 71 cents for every dollar of inpatient care delivered to Medicare patients--thus making the Medicare program an even poorer payer than today's Medicaid program.

While most hospitals and all states are affected, teaching hospitals, hospitals in large urban and rural areas, and communities with hospitals serving a disproportionately large number of low-income patients would be particularly hard hit.

The negative impact on hospitals of Medicare spending reductions is magnified when combined with price control and spending cap proposals included in many of the reform bills under consideration.

Since the release of this study, several people have raised questions about its scope and the fact that it looked only at Medicare spending reductions, not focusing on any other aspects of health reform, including some proposals which would compensate hospitals for the proposed Medicare shortfalls. We would like to take the opportunity to respond to these questions.

First, the President's plan, and most others, do not include Medicare in reform. The Medicare program remains separate, with only limited incentives for Medicare beneficiaries to move into a reformed health care system--a system which could provide more efficient and cost-effective care through the use of integrated delivery systems, coordinating and providing care in a seamless manner. With Medicare thus kept in isolation, it is logical to look at the effects of the spending reductions only on that program and its beneficiaries.

Second, there is no guarantee that we will get comprehensive reform, but we fear that with or without reform, Medicare spending reductions will be on the table.

But even if we look at this level of Medicare reductions as part of a comprehensive reform package and not in isolation, we still believe that the numbers don't add up.

Enclosed is a chart which helps to illustrate the following points. We have compared the situation in hospitals in your district today and in the year 2000, and we have assumed there is universal access and coverage in place at that time.

- ✓ Medicare today accounts for about 45 percent of the activities of hospitals in your district. According to Lewin-VHI, in the year 2000 hospitals in your state would be paid about 73 percent of cost for this portion of their services.

- ✓ Medicaid today accounts for about 7 percent of your hospitals' activities. Let's assume that this proportion is reimbursed--for argument's sake--at the unlikely level of 100 percent of cost by the year 2000.

- ✓ Uncompensated care--which currently represents about 4 percent of your hospitals' activities--would be significantly reduced if we in fact achieve universal access and coverage. And let's assume it will also be reimbursed in the year 2000 at 100 percent of cost...just for argument's sake. And this argument would put aside the fact that there will always be some uncompensated care given in hospitals, whether to illegal aliens, to the homeless or to those who can't or won't pay the required copayments and deductibles.

- ✓ Private-paying patients account for about 44 percent of your hospitals' activities. The possible increases, described above, in hospital payments for the Medicaid and uninsured populations will be offset by lower payments from privately insured patients. In the future, private-paying patients will expect to pay less for their care, no longer paying for the cost shift. The cost shift would be eliminated in most reform proposals through market forces, ranging from more use of prudent purchasing techniques such as pooling arrangements that create more leverage, to the development of competing integrated delivery systems. Other proposals, however, would impose arbitrary and stringent caps on overall health spending or insurance premiums, meaning hospitals could no longer rely on the private sector to cover government and other payment shortfalls.

Even under this admittedly rosy scenario, hospitals nationwide remain with about 40 percent of their activities reimbursed at about 71 cents on the dollar. And even if the Lewin-VHI estimates are substantially off the mark, the numbers still do not add up.

We appreciate your taking the time to understand the impact of Medicare spending reductions of this magnitude and spending caps on hospitals in your district and state. Please feel free to call on us if we can provide further information.

Sincerely,

Dick Davidson

Dick Davidson
President

Enclosure

THE MATH DOESN'T ADD UP:

ILLUSTRATIVE IMPACT OF MEDICARE SPENDING REDUCTIONS AND HEALTH CARE REFORM ON HOSPITALS' FINANCIAL STATUS

MICHIGAN - 16TH DISTRICT			
		TODAY•	2000•••
	% OF HOSPITAL ACTIVITY (District)	% OF COST COVERED (State)	% OF COST COVERED (State)
MEDICARE	45	90	73••••
MEDICAID	7	85	(100 ?)
UNCOMPENSATED CARE	4	5••	(100 ?)
PRIVATE PAY	44	118	(100 ?)
BOTTOM LINE:			Patient Care at Risk

• Prospective Payment Assessment Commission, "Medicare and the American Health Care System; Report to the Congress, " June 1993, p. 136, 1991 data.

•• Consistent with Prospective Payment Assessment Commission methodology, payments for uncompensated care are calculated by AHA and reflect operating subsidies from state and local governments.

••• Illustrative calculations of the kinds of financial pressures faced by hospitals in the year 2000 if Medicare spending reductions alone, of the size included in the President's health care reform proposal, are enacted.

•••• Medicare payment estimates based on Lewin-VHI analysis of impact of Medicare spending reductions, excluding changes proposed to capital and direct medical education, on hospitals' Prospective Payment System inpatient operating margin. If payments to hospitals for outpatient care remain as under current law, the total Medicare payment to cost ratio is likely to be somewhat higher, but only by about 3 percentage points.

State	U.S. Representatives	D	Hospital Name	City	Address	Administrator	Beds	Adm	Days	Births	Out Visits	Fte
Michigan	DINGELL JOHN D.	16	OAKWOOD HOSPITAL	DEARBORN	18101 OAKWOOD BOULEVARD	GERALD D FITZGERALD, PRES	615	22783	166769	4252	194916	3302
Michigan	DINGELL JOHN D.	16	OAKWOOD DOWNRIVER MEDICAL CTR	LINCOLN PARK	25750 WEST OUTER DRIVE	MINDY L RICHARDS, ADM	36	1393	7462	0	38750	198
Michigan	DINGELL JOHN D.	16	VENCOR HOSPITAL - DETROIT	LINCOLN PARK	26400 WEST OUTER DRIVE	JOSEPH R GORDON, ADM	218	.	.	.	.	
Michigan	DINGELL JOHN D.	16	MERCY MEMORIAL HOSPITAL	MONROE	718 NORTH MACOMB STREET	RICHARD S HILTZ, PRES	182	7624	45880	827	88459	818
Michigan	DINGELL JOHN D.	16	HERITAGE HOSPITAL	TAYLOR	10000 TELEGRAPH ROAD	JAY BRYAN, VP	229	7101	63573	0	43945	673
Michigan	DINGELL JOHN D.	16	SEAWAY HOSPITAL	TRENTON	5450 FORT STREET	ROBERT J CLARK, VP	156	2528	15221	112	46380	313
Michigan	DINGELL JOHN D.	16	RIVERSIDE OSTEOPATHIC HOSPITAL	TRENTON	150 TRUAX STREET	DENNIS A CHRISTEN, VP	185	4876	33156	883	126326	522
Michigan	DINGELL JOHN D.	16	WYANDOTTE HOSP & MEDICAL CTR	WYANDOTTE	2333 BIDDLE AVENUE	WILLIAM R ALVIN, PRES	359	11235	88999	1330	39297	1365