SUNDAY, FEBRUARY 27, 1994 THE WASHINGTON POST

Health Overhaul Has Medical Schools Worried

Educators Say Clinton Plan Could Cut Revenue, With Major Impact University-Wide

By Mary Jordan
Washington Post Staff Writer

The presidents of many of the country's best-known universities are worried that the movement to reform the nation's health care system will weaken their medical schools and jeopardize their universities.

"We are all very concerned about this," said Richard C. Levin, president of Yale University, which spends 42 percent of its nearly $1 billion budget on its medical school. "Medical centers are a big share of our budgets and if they are less viable, it could have an impact on undergraduate teaching, an impact on the whole university."

The chief worry of the university medical centers is this: Because they cost about 20 percent to 30 percent more to operate than regular hospitals, cost-conscious medical plans will increasingly refer patients away from them and to less expensive care.

Empty beds mean less money and fewer resources for the work that has made them prominent: teaching graduate medical students, caring for the most complex diseases and conducting research. It is in these hospitals, for instance, that the latest laser surgery is performed, the expensive burn units are located and the most innovative cancer therapies tried.

And less revenue for the teaching hospitals could result in less money for faculty, programs and buildings for the main universities, the presidents say.

"There is a much closer interaction than most people realize," between a university and its affiliated hospital, said Terry L. Hickey, associate vice president for the medical center at the University of Alabama at Birmingham. His university hospital donates about $150,000 a year to a library used by undergraduate chemistry, biology and physics students, and because of declining hospital revenue, that sum may shrink next year.

"That's just one little example of how a reduction in the hospital will have effects all over campus," said Hickey. "There are hundreds, if not thousands of conversations like that going on right now."

Empty hospital beds are already a problem for some of the hospitals associated with the nation's 126 medical schools. Some are considering mergers, and others, which can easily cost more than $1 million a day to operate, are losing money rapidly.

Gerald Lazarus, dean of the medical school at the University of California at Davis, said managed care, a system of cost containment included in the Clinton health plan and others, is already well underway in California, and it has meant that health maintenance organizations are referring patients away from the medical centers to less expensive care. Now, he is worried that problem will spread. If it does, he said, "Who do we help by crippling a Massachusetts General or a Johns Hopkins?"

Nearly one-half of university expenditures at Johns Hopkins go to its medical center, so any financial harm could easily be felt in other parts of the university. The investment is huge, too, at many of the largest and best-known medical schools, including Duke, Columbia, UCLA, Harvard, Ohio State and Georgetown.

University medical centers "are going to discover the genes that cause Downs syndrome," said Sen. Daniel Patrick Moynihan (D-N.Y.). "It's going to be expensive and it's going to be worth it. We are doing this for the world and it must be protected and encouraged."

But the White House insists that its health plan, more than any other, recognizes that the Yales and Johns Hopkinses of the nation's health system are national treasures that need to be protected.

Clinton said in an interview last week that only his health reform bill recognizes those concerns. Clinton said he is committed to a direct federal subsidy for comprehensive university medical centers. But the proposed subsidy is $9.5 billion for the year 1999, an amount medical schools say is too little.

Next week, as Congress begins debating and reshaping health care legislation, university officials will be lobbying for a safety net.

Levin applauds the president and Hillary Rodham Clinton, both Yale Law School graduates, for addressing the complex problems, and said he is no fan of the current federal system of funding medical schools.

It's just the details of the Clinton remedy that has people like Michael E. Johns, dean of the medical school at Johns Hopkins, so worried that he convened a "Saturday morning" working group of the heads of major medical schools.

The current government payment system to medical schools is convoluted. Medicare funds pay for the training of graduate medical students. There are direct and indirect funding payments. And there are formulas that depend on factors such as the number of resident physicians and beds in each hospital. Estimates of the government payment range from $5 billion to $7 billion a year.

The present system also relies on patients who get more routine care, such as an operation to strip varicose veins, paying a higher price than they would at a non-teaching hospital. That premium pays for other parts of the university hospital, from high-tech baby incubators to risky heart operations.

"I believe we will solve the university hospital" problem, Clinton said. "Suppose [the medical schools] say we were $5 billion or $8 billion short or something over a five-year period. In the context of a government which is now paying up to $300 billion [cost of Medicare and Medicaid] . . . they're not talking about a lot of money."

Medical school officials say there are too many unknowns—such as the future inflation rate and whether all patients really will be covered by insurance in the new system—to determine how much of a federal subsidy they will need. These hospitals, often located in large cities, currently incur huge costs for charity care.

"The dollars put forward to safeguard the academic health centers fall short of what the actual costs are today," said Johns. He said he was also worried that managed care would mean that these specialized medical centers will become increasingly inaccessible to millions of Americans.

Anticipated geographic restrictions that funnel patients only to the hospitals within a given region are also a worry to places like Johns Hopkins, where one in five of patients comes from outside the area. The same is true for specialized medical centers like Sloan Kettering in New York or the Mayo Clinic in Minnesota.

Many medical school officials are also uneasy about the Clinton plan's proposed national mandate that 55 percent of the doctors produced by medical schools should be general practitioners. Many of the most prestigious medical schools train 80 percent or more specialists, from neurosurgeons to cardiologists.

While the 55 percent goal is a national one not meant to be enforced at every school, the momentum now is to make the Ivy League schools and others train more family doctors. Currently, only about one-third of physicians are family doctors, which even the medical profession says is too few.

The Clinton plan proposes that a new National Council on Graduate Medical Education would decide how many specialists and residents an individual teaching hospital will have. Many schools are nervous about a single council having that kind of management power over individual hospitals.

Manuel Tzagournis, dean of medicine at Ohio State College of Medicine, said he thought an aim of health reform was to decrease expensive bureaucracy and paperwork. "But there will be a national agency telling you how many residents and what specialists, adding bureaucracy. . . . There will just be a different set of paperwork to do."

Philip R. Lee, assistant secretary of health and human services, dismissed many of the worries as understandable concern in a time of rapid change. "Change, of course, is the thing they fear the most," he said.

Arnold M. Epstein, senior White House health adviser, said the university medical centers also will be buoyed by other parts of the Clinton health plan: Every health plan would be required to contract with a highly specialized health center; more than $1.5 billion is specifically set aside for research, much to be done at these centers; and every patient, even the poorest, would now be a paying customer.

"They will not only survive, they will flourish under health reform," Epstein said.

But these promises are not good enough for Johns and others, who worry that until sick people realize the options they have lost, or universities start seeing their medical school decline, there will not be an outcry. "We're worried," Johns said. "And we are watching this carefully."

Health Plans Would Reshuffle Billions With Little Net Impact on the Economy

HEALTH CARE, From H4

integrating the Medicaid program with the private insurance market.

The practical effect of this integration, however, would be to increase the community rated premiums charged to businesses. Because these Medicaid recipients tend to require a disproportionate amount of health services, adding them to the larger insurance pool effectively raises the rate for everyone else by 14 percent, according to Lewin—about $45 billion in 1998.

Household Income

The gist of the Cooper and Chaffee plans is to make the private insurance market more fair, so that those who are now uninsured can afford to buy their own policies. The Cooper plan merely encourages the purchase; the Chaffee plan requires it. Both would provide subsidies to low-income families to help pay for insurance.

In a recent article, however, Aaron points out that this approach risks setting up a "poverty trap," in which people would lose benefits as their incomes rise. Aaron calculated that every extra dollar earned by families making $12,000 to $24,000 would essentially be "taxed" at a rate of 88 percent. Such schemes, he argued, would be a "devastating disincentive to work."

Although it also would provide subsidies to low-income households, the Clinton plan would avoid most of this problem by requiring employers to provide insurance, according to the Aaron. But the Clinton plan would generate other work disincentives.

The Congressional Budget Office, for example, estimated that more than 500,000 Americans would choose to retire early because of the Clinton plan's guarantee of continued health coverage. And the CBO predicted that some working spouses who now take jobs primarily to gain health insurance for themselves and their families would simply drop out of the labor market.

Because of the employer mandate and family subsidies, most studies found that Americans' out-of-pocket spending for health care for the average household would decline about $300 under the Clinton plan. But in this case, the average conceals wide variations.

Lewin found that 23 percent of households would save at least $1,000 in spending for premiums, deductibles and payments to doctors and hospitals, while 15 percent of households would see expenditures rise by that amount.

The big divide would be between households now covered by insurance and those that are not.

Families that now have health insurance would see total out-of-pocket spending drop, on average, by $340, according to Lewin. Those that now have no insurance would see spending increase by $160.

These out-of-pocket estimates, however, capture only half the story. Economists say a complete analysis would include changes in wages that result as employers pass on the new costs of health insurance to their previously uninsured workers.

Although employers write the checks for employee health insurance, nearly all economists believe that they eventually pass along at least 80 percent of this cost to their workers in the form of lower wages.

Economists June and David O'Neil calculated that workers who received health insurance for the first time would see their wages reduced 7 percent from what they would have been otherwise. At the same time, they concluded that the wages of workers who previously had insurance would increase 1 percent as their employers reaped the savings from the Clinton plan.

This sort of change is what scares politicians most about the Clinton health plan. But Harvard University economist Joseph Newhouse warns that no matter which approach Congress settles on, it will mean winners and losers.

"You can't have meaningful change in a trillion-dollar industry without generating some redistribution," he said.