American Hospital Association

Capitol Place, Building #3
50 F Street, N.W.
Suite 1100
Washington, D.C. 20001
Telephone 202.638-1100
FAX NO. 202.626-2345

April 21, 1993

Dear Rosalind:

Here's the update of the available times in May that work for Mr. Davidson and Rick Pollack of the American Hospital Association. Thanks for your help.

May 3	9am-noon
13	2:30-5pm
14	3-5pm
17	noon-5pm
19	3-5pm

Donna Zebe
Executive Assistant
202/626-2311

Roz
Before you set this up talk to C. Heenan to whom I referred the original letter. I think she & the 2 of us should do it together.

12:00-1:00
* Good for all including C. Heenan

Sending new list for June dates

Later found the note from C.H. I've attached. Set up 30 min. meeting on 3rd. if possible. Make sure C.H. or someone is free to sit in

April 19, 1993

TO: CAROL RASCO

FROM: CHRISTINE HEENAN
MOLLY BROSTROM

RE: MEETING WITH AMERICAN HOSPITAL ASSOCIATION

As per our discussion, we have contacted the AHA and indicated your willingness to meet with them. Jim Bentley, the Senior Vice President for Policy, says that they requested the meeting with you at the suggestion of Russ Harrington and Roger Bufield of Arkansas.

Ira has met with Dick Davidson, Rick Pollack, and Jim Bentley of the AHA three times (2/18, 3/15, 4/6). They are very supportive and want to work with us. As you suggesed, one of us will sit in on your meeting with them.

The AHA's reform plan proposes capitated, collaborative "community care networks" centered around hospitals. A primary concern of theirs is that, in the new system, HIPCs and health plans maintain a community focus and are not dominated by large "mega-insurance" HIPCs. Their members fear that large HIPCs will become new regulators. In addition, rapid phase-in of universal access is very important to the AHA.

Their meeting with you is intended to be a reinforcement of their meetings with Ira. Primarily, they want you to know where they are coming from and why they want the Administration to succeed. They would also like to discuss the impact of the plan on rural areas and small towns. Whichever of us attends the meeting with you will talk to Lois Quam about this issue and can brief you prior to the meeting.

Finally, attached are copies of the AHA's statement before the Task Force hearing and their reform plan.

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Statement
of the
American Hospital Association
before the
President's Task Force on National Health Care Reform

March 29, 1993

Madam Chairman, I am Dick Davidson, President of the American Hospital Association representing 5,300 health care institutions across America. I have four thoughts I want you to leave this room with today.

First, hospitals strongly support and are working for radical change in the status quo in health care in this country. The problems are too big to be solved by simple tinkering. That's why we want real, community-based restructuring of the health delivery and financing non-system we have today.

Second, the radical change hospitals support is the development of Community Care Networks[SM]. Community care networks have three distinct characteristics: collaboration, capitation, and community focus on health.

Our idea for community care networks is consistent with the local health networks the President talked about in the campaign.

As we see them, community care networks are consortia of hospitals, physicians, other providers and community groups, and others locally organized and managed.

These community care networks would provide a package of essential health services for a set annual payment per person and be publicly accountable for community health needs. The goals: coordinate care throughout a community, keep people well, and get rid of unnecessary care or duplicate services.

Third, community care networks are the solution to the problems in the health care system that you have been so effectively highlighting around the country over the past few weeks: high costs, concern about quality, and consumer satisfaction.

If we are concerned about putting patients first, about having a truly patient centered health care delivery system, our approach does that.

As enrollees in community care networks, patients enter a seamless system of care. They will no longer have to wander unguided through a fragmented system, but will have a single entry point for all needed services.

Everybody is concerned about cost. Our vision attacks rising health care costs by encouraging collaboration among providerrs. A set annual payment will drive collaboration by aligning the incentives of health care providers.

When providers are paid as a group, they will act as a group to monitor the use of health care resources and avoid unnecessary care. Over time, excess capacity and duplication of services and technology will be eliminated.

Precious resources now spent on excessive paperwork, unnecessary competition, and the administrative demands of multiple payers can be harnessed to improve patient care.

The job of this important task force in our view is to include in your reform plan incentives to speed up the kind of behavior changes we are talking about to bring providers and communities together with one aim: keeping people as healthy as possible and improving the entire community's health status.

I want to emphasize one final point. Communities and community care networks can't alone solve the problem of the five-dollar aspirin. The insured patient who pays for a five-dollar aspirin is buying aspirin for the uninsured patient who later walks in the

hospital door seeking care. That is the wrong way to provide universal health care.

We must have a national commitment to providing health care coverage for all Americans. Anything short of that will force our health care givers to continue to levy the hidden tax that enables them to care for those without resources.

For the record, I am submitting a full explanation of AHA's vision for reform that details how we can bring a more rational set of incentives to our current delivery system. Thank you for this opportunity.

CCN, Inc. and San Diego Community Healthcare Alliance use the name Community Care Network as their service mark and reserve all rights.

A Healthier America through Community Care Networks℠

The American Hospital Association's Vision for National Health Care Reform

This document was approved by the AHA Board of Trustees in May 1992. It is the Association's most current policy on health care reform. The AHA will continue to develop and improve its vision for change.

Executive Summary

Hospitals and their leaders have a professional responsibility to their patients and their communities to provide leadership in solving the problems of our health care system and making this nation the healthiest in the world. Toward that end, our nation must come together on strategies to promote health and well-being and to assure judicious use of a health care system reshaped to put patients first.

The challenge of health care reform is to simultaneously expand access to health care and contain costs while at the same time promoting improvement in the quality of care. The AHA's vision for reform, described below, provides for universal access, economic self-discipline for the delivery system, and quality care.

Universal access to health care coverage would be provided through:

- A pluralistic system of financing, combining private coverage and a new single public program consolidating and expanding Medicare and Medicaid.
- An emphasis on private coverage through the workplace, where employers ultimately would be required to provide and help pay for health coverage for their employees and dependents, with employees ultimately required to accept and pay their share of the cost of coverage. A significant phase-in period, with tax breaks for employers and low-wage earners and other types of assistance, would protect against economic dislocations.
- A basic benefit package in the public program that would serve as the floor for coverage offered in the private sector. Benefits should cover the full continuum of care, from preventive through long-term care. Issues of affordability should be addressed first by reducing unnecessary or marginal care and by adjusting cost sharing, before consideration of limitations on the scope of services. Following an opportunity for public comment, an independent commission would select the most beneficial combination of coverage and cost sharing, given the funds made available for the public program by the Congress.
- A plan to ensure the availability of physicians and other health professionals needed to provide adequate access to health care services for everyone.
- Insurance reforms that prohibit practices such as the use of pre-existing condition clauses, which result in avoiding rather than managing risk, diminishing the value of private health insurance.

Economic self-discipline in the health care system would be provided through:

- Fundamentally restructuring health care delivery through the establishment of community care networks that would provide patients with integrated care organized at the community level.
- Restructuring financial incentives using risk-adjusted capitated payments to networks to encourage providers within the network to promote the health of patients through primary and preventive care, collaborate with other providers to avoid unnecessary duplication of services, and conserve health care resources.
- Other complementary efforts, such as development and dissemination of medical practice parameters, medical liability system reform, reform of antitrust and other laws that impede efficient use of resources, and strategies for reducing administrative costs in the system.

The quality of care would be improved through:

- Reorienting the system to focus on improving the health status of communities and on coordinating and better managing patient care.
- Focusing attention on continuous quality improvement, which will further facilitate the integration of care and referral of patients within networks.
- A sustained level of governmental and private support for innovation and the evaluation of new clinical approaches.

The Need for Change

The U.S. health care system is unique, both in its strengths and weaknesses. In the aggregate, the United States has a wealth of health care facilities and highly trained personnel. We have long been recognized as a leader in the high quality of care provided. Our health care system has encouraged clinical innovation and is known for state-of-the-art treatments and technologies.

Despite these strengths, many problems remain. Chief among these is inadequate access to health care coverage in this country. There are currently 36 million uninsured individuals in the U.S., 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 40 percent of the poverty population. Because of strained federal and state finances, even those who qualify for Medicaid face limitations on the services they receive. Many state Medicaid programs, for example, do not pay for screening and preventive services. 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.

A compounding problem is the continuing rapid growth in health care spending. National health expenditures in 1992 are expected to exceed $800 billion, rising at an annual rate of over 10 percent. We currently devote more than 13 percent of our Gross National Product to health care spending, more than any other nation in the world. Despite this level of spending, the U.S. still suffers significant deficits in health status. For instance, among the western industrialized democratic nations, the U.S. ranks first in spending per capita, but 21st in infant mortality.

Faced with growth in health care costs, federal and state lawmakers have frequently opted to reduce payments to hospitals and physicians over the last 10 years. In the aggregate, the Medicare program now pays hospitals for only 90 percent of the cost of treating Medicare patients. State Medicaid programs frequently pay even less. While payment varies from state to state, in the aggregate Medicaid now pays hospitals for only 80 percent of the cost of treating Medicaid patients. In addition to these payment short-

families. Employers would retain the ability to self-fund coverage, but they would assume responsibilities and obligations for health care coverage that are equal to those of insured businesses, such as participating in state risk pools.

The employment-based coverage provided would have to meet minimum specifications of a federally-defined basic benefit package, described below, thereby pre-empting state mandated benefit laws. Employers would be free to offer more than basic health benefits if they and their employees so desire. Employees would be required to accept employer-sponsored coverage (unless they were otherwise covered) and pay their share of the cost of coverage. Low-income employees would be assisted by tax incentives (e.g., tax credits) to help cover their share of premiums.

In the area of taxes, Congress would grant the same tax advantages to self-employed individuals and unincorporated businesses for the purchase of health benefits (100 percent, rather than 25 percent, deductibility of premiums as a business expense) that large employers and their employees currently enjoy.

Incentives such as these can be used to maintain a pluralistic financing system with heavy reliance on employer-sponsored private coverage. The key is to design incentives that make private coverage economically feasible and desirable for employers and employees.

A New Public Program

On the public side, a new program would consolidate and expand upon Medicaid and Medicare, providing basic health benefits to these individuals as well as to all others unable to obtain private coverage. Government's first priority in subsidizing coverage under the public program should be targeted at those least able to afford coverage.

Enrollees in the public program with income less than 150 percent of the federal poverty level would receive fully subsidized basic benefits, with the possible exception of nominal cost sharing. Those with income greater than 150 percent of the federal poverty level would make contributions to premiums scaled to their ability to pay, in addition to copayments and deductibles. The public program would pay for all Medicaid recipients in full and would pay all or part of the premiums and cost-sharing for most Medicare beneficiaries.

The public program would be financed by a combination of broadly based federal tax revenues and premium contributions from those covered who can afford them. These monies would be dedicated to an off-budget trust fund that would pay for covered health care costs for public program enrollees. With a single public program, states' financial responsibility for Medicaid could gradually be phased out, but they could continue to subsidize those unable to pay the long-term care deductible proposed as part of basic benefits coverage. Federal and state financial responsibilities for other domestic programs could be realigned to maintain current levels of state health funding support.

BASIC BENEFIT COVERAGE

Private Coverage	Public Coverage
Employer-based coverage of employees and dependents Other privately covered individuals	Medicare Medicaid Individuals unable to obtain private coverage

Basic Benefits

AHA believes that coverage of the full continuum of care is a necessary first step in refocusing on efficient clinical decision making. AHA calls for a broad basic benefit package covering the full continuum of care from preventive care through long-term care. Historically, public and private benefit packages have addressed the affordability issue by excluding or severely limiting coverage of certain types of services. This approach has had several practical but unfortunate effects: discrimination against certain types of illnesses (such as Alzheimer's disease) and creation of incentives for health care practitioners and providers to deliver whatever services are covered, rather than the most efficient service to meet a patient's need.

In order to provide incentives for the responsible use of health care services by consumers, some cost sharing would be required. To create the right incentives, cost sharing would not be applied to preventive services, but would be focused on those points where consumer judgment on whether, when, and where to seek services plays a significant role in appropriate utilization. For example, if enrolled in a network where a primary caregiver oversees access to specialty care, cost sharing might focus on primary care visits, emergency room visits, and outpatient prescriptions. If not enrolled in such an arrangement, cost sharing might apply to all but preventive services. This approach, in addition to being sensitive to the consumer's decision making role, has the added advantage of providing the incentive of reduced exposure to out-of-pocket costs for those consumers who enroll in networks where utilization could be better managed.

To maintain incentives for families to continue their role as caregivers, long-term care (other than post-acute recuperative care) would carry a $10,000 deductible. These deductibles and copayments would be waived for low-income individuals to assure that they do not serve as barriers to access.

Determining the basic set of benefits is perhaps the most difficult and critical element of this proposal — difficult because it means reconciling benefits with available funding; critical because it determines the core of health care coverage. An independent commission, established outside the federal political and budgetary process, would be responsible for defining the basic benefits package. On a biannual basis, Congress would determine the aggregate funding level for the new public program. The independent commission would then determine the specific benefits that could be provided by the public program within that budget. This set of benefits also would serve as the benefit floor for coverage offered in the private sector, thereby pre-empting state mandated benefit laws. Coverage under the benefit package would be defined by health care needs and services, not specific provider settings, leaving latitude to assure that care is delivered in the most appropriate, cost-effective setting.

The primary objective of establishing an independent commission is to stimulate a public debate on the proper balance between the health care benefits to be promised and the funds available. The independent commission would first provide Congress the information and advice it needs to set a budget target for the public program. This might include information on benefit levels and cost sharing, the adequacy of public program funding, and the adequacy of provider payments under the public program. Given the funds made available for the public program by Congress, the independent commission would select the most beneficial combination of coverage following an opportunity for public comment. If the funding level is inadequate to cover some services that the public wants, Congress and the President would be pressured by voters to increase health care funding levels.

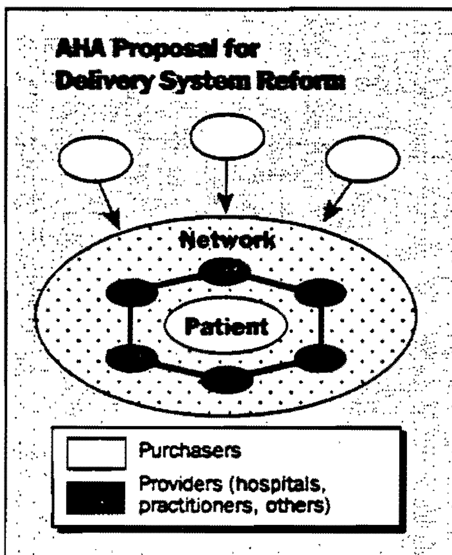
Several approaches are available for balancing health care benefits with available funding. The first step would be to identify and eliminate inappropriate

Focus on prevention and primary care. Networks would emphasize wellness in addition to the treatment of illness.

Focus on community-level solutions to community problems. Networks would match local health care resources and strategies to local community needs and circumstances.

Community care networks represent a self-disciplining system with coherent and consistent incentives that encourage providers to do what they do best — manage the health care of their patients.

Community care networks hold the promise for



true management of patient care. Many of the current "managed care" arrangements are simply insurer programs that contract with a selected group of providers who agree to discounted prices. The providers participating in the plan often change each year as the insurers use their leverage to seek deeper discounts from providers. The insurer then controls access to those providers through a complex system of authorizations that must be obtained from the insurer before anyone can receive non-emergency care. While this approach emphasizes managing *costs*, it does not manage *care*.

True managed care requires assessing patient health risks and needs. It means planning and organizing care so that problems are averted or treated early and all needed services are efficiently provided without unnecessary duplication of capacity. Within community care networks, patient needs would be returned to the focus of the delivery system and the management of care responsibility would be returned to the caregivers.

To meet these goals, as well as to create a more user-friendly system, each network enrollee would choose a primary caregiver to assure a consistent, specified point of entry into the network. The primary caregiver would act as the care manager for that individual. It would be the primary caregiver's responsibility to ensure that an initial evaluation of health status is conducted, that appropriate primary care and preventive services are provided, and that services throughout the system are coordinated for the patient, particularly when specialty services are needed.

Restructuring Financial Incentives

The key to successful community care networks is creating strong incentives for Americans to choose them and aligning provider incentives through risk-adjusted capitated payments to the networks. Capitation — a set fee paid to the network per enrollee — provides the network with its budget for delivering care to the enrolled community. It allows the public program, employers, and employees to manage their outlays, but leaves the allocation of resources to local decision making. Most important, it provides the stimulus for reorienting our health care focus from sickness to wellness. This type of approach encourages providers to:

Promote the health of patients and prevent future, more costly illnesses. If the network's enrolled population is relatively stable, then the network has an incentive to provide its enrollees with low-cost preventive care now in order to avoid the use of more costly acute care in the future.

Collaborate with other providers to avoid unnecessary duplication of services. Once providers are linked within a network, the financial incentive will be to avoid duplicative facilities and services that were encouraged previously by the competitive system.

Conserve health care resources by providing only appropriate and necessary care. The collective challenge to providers within networks will be to provide needed health care services within the fixed capitation amount through better patient care management by practitioners and institutions.

The independent commission responsible for determining the basic benefit package would also be responsible for setting actuarially sound capitated rates under the public program to be paid to networks. This commission would balance the public need for cost containment with hospitals', practitioners', and other providers' need for fair payment.

The independent commission also would adjust those rates to reflect the underlying risk of the population covered and the geographic conditions under which services are delivered. By broadly adjusting the capitation payments to networks, the payments would better reflect the expected costs of serving each network's enrolled population. This gives networks the incentive to treat everyone in their community; young or old, sick or well.

Placing capitation rate-setting for the public program in the hands of an independent commission does not guarantee elimination of government cost-shifting to the private sector. The AHA believes it can go a long way, however, toward minimizing it. In the private sector, network payment rates would be negotiated between networks and employers. It would be left to individual states to decide whether to regulate those decisions in any way.

Because capitated payments require the network to take on some financial risk, networks might be required to carry stop-loss insurance coverage to protect against unpredictably large expenses.

Network Characteristics

Networks are designed to foster new relationships among physicians, other health professionals, hospitals, community health centers, and nursing homes as well as private insurers. As the major sources of care in most communities, hospitals and physicians would need to be key partners in the formation of networks.

Hospitals often provide services beyond inpatient acute care, and are the locus of most specialized technology. Moreover, as generally the largest health delivery organizations in their communities, hospitals can provide many of the management and service coordination skills and systems necessary to integrate and manage the delivery of high-quality services.

Physicians and other health professionals are essential to successful formation and operation of networks. Patients build strong relationships with their physicians. For many people, their primary care physician is the first point of entry into the health care system. Networks must actively involve local physicians in order to coordinate and manage patient care.

Networks also offer a range of opportunities for private insurers. Insurers may choose to partner in a network, with providers and the insurer underwriting the risk of the enrolled population. Alternatively, insurers may participate in networks by providing reinsurance to networks, marketing and promoting networks to prospective enrollees, assisting networks in evaluating their cost and quality performance to support marketing, helping with regulatory compliance and insurability decisions, processing provider payments within the network, etc.

Hospitals, physicians, insurers, and other partici-

Research

Health system reform must include a sustained level of governmental and private support for innovation and the evaluation of new approaches. Biomedical research enhances our capacity to diagnose and treat illness; health services research is essential for more complete information on such critical issues as assessing the efficacy of diagnostic and therapeutic regimens and establishing the relationship between treatments and outcomes. Our future ability to improve the value of health care services will depend in significant part on rigorous evaluation of today's and tomorrow's delivery and payment system innovations.

From Vision to Reality

AHA's vision for reform could be implemented incrementally in order to minimize disruption in current coverage patterns and facilitate the broadening of benefits. For example, access could be expanded in stages. Starting with mothers and children, coverage of the poor and near poor who are not currently covered by Medicaid should be provided by the public program over a pre-established period of time. Next, individuals with incomes exceeding 150 percent of the poverty level could be phased in, making premium contributions according to ability to pay.

Similarly, community care networks could be developed in stages, growing in concert with community values and needs. Listed below are some of the changes needed to make the health reform vision a reality.

Changing the Health Care Environment

- ❑ In hospital strategic planning and operations, shift emphasis from provider competition to collaboration and integration. Focus on both hospital/physician relationships and hospital-to-hospital relationships
- ❑ Seek antitrust reform to allow for greater provider collaboration
- ❑ Seek tort reform to reduce the cost of the malpractice system and its effect of stimulating defensive medicine
- ❑ Seek insurance reform to make health insurance more available and affordable for employers and individuals
- ❑ Equalize tax incentives for all employers to provide health insurance for employees and their dependents
- ❑ Seek new programs or waiver authority that offer options for reorienting care delivery in government programs
- ❑ Improve funding for Medicare and Medicaid

Developing Resources and Skills

- ❑ Develop provider skills in accepting and managing financial risk
- ❑ Expand emphasis in medical education programs on primary care careers
- ❑ Invest in medical practice parameters, clinical guidelines, and outcome measures with rapid implementation
- ❑ Develop community health status and needs assessment tools
- ❑ Encourage community reports on population health status
- ❑ Establish uniform data requirements and implement electronic methods to collect, store, and share community and patient data across providers

Encouraging the Formation and Use of Networks

- ❑ Work with physicians and other providers in transitional network arrangements such as IPAs and PPOs
- ❑ Develop networks consistent with existing waiver authority under Medicaid and Medicare HMO/CMP options, and employer opportunities at the local level
- ❑ Require employment-based coverage for basic benefits package
- ❑ Strengthen financial incentives for public program beneficiaries to use networks, including required network enrollment where there are at least two networks from which to choose
- ❑ Offer tax or other incentives aimed at employers, employees, insurers, and providers to offer and use networks

American Hospital Association

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American Hospital Association
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(202) 638-1100

"FAX" COVER SHEET

To: Rosalind Kelly

From: Donna Zebe

Date: 6/18/93

Pages: 2

Comments: Thanks for your help. Sending this again, not sure if you got the first one.

James Bentley P6/b(6)
Richard J. Davidson P6/b(6)
Herb Kuhn P6/b(6)

Waved 6/22/9

June 15 1993

Rosalind Kelly
Office of Domestic Policy
216 17th and Pennsylvania Avenue NW
Old Executive Office Building
Washington, DC 20500

Dear Rosalind,

Thank you for all your help in trying to pull together this meeting with Carol Rasco, Dick Davidson, Herb Kuhn and either Jim Bentley or Rick Pollack of the American Hospital Association. I was just informed yesterday that Mr. Davidson is going to be in Washington all of next week. After that we won't see him till September. Therefore, with your kind help I would like to take advantage of this unprecedented block of his time to schedule an appointment with Ms. Rasco. Basically, any day, any time, June 21-25. I can be reached at 202/626-2311. Thanks for your help.

Sincerely,

Donna J. Zebe

Donna J. Zebe
Executive Assistant

c c: Molly Brostrom

If no cabinet meeting Fri. a.m.
Can see for about 15 minutes
at 10. Alert Christine &
make sure she's available -
tell her this is one rescheduled
from an earlier date.