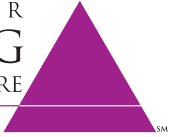


# The Role of Nonprofit Health Care Organizations in Promoting and Operating Under Universal Health Care Coverage

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Health care reforms, in particular the expansion of public and/or private health care benefit coverage to some or all population groups, is becoming an increasingly hot topic for discussion—and in some cases for action—at all levels of government. With almost 16 percent of Americans estimated to be uninsured for at least part of the year, opinion polls show health care near the top of the general public's list of concerns. Little wonder that many of the presidential candidates for the 2008 election incorporated "universal health care coverage" proposals in their campaign platforms.

Debates over "national health insurance" or "universal coverage" are not new; they go back as far as President Teddy Roosevelt. The three most recent debates have occurred during the lives of the post-World War II baby boomers, in the administrations of Presidents Harry Truman, Richard Nixon, and Bill Clinton. Will "cradle-to-grave" coverage for all become a reality in these baby boomers' remaining years or will they just experience cradle-to-grave debates over this issue?

That is essentially one of the questions posed in the following discussion on the role of nonprofit health care organizations in promoting, and operating under, universal health care coverage. This edited discussion is another in an ongoing *Inquiry* series called "Dialogue," which is cosponsored by the Alliance for Advancing Nonprofit Health Care to provide a variety of voices on important nonprofit health care issues.

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The panelists for this discussion, held on Oct. 1, 2007, were: **Terry Andrus**, president and CEO of the East Alabama Medical Center in Opelika, Ala.; **William (Bill) Cox**, president and CEO of the Alliance of Catholic Health Care in Sacramento, Calif.; **Bradford (Brad) Gray, Ph.D.**, principal research associate at the Urban Institute in Washington, D.C., and editor of *The Milbank Quarterly*; **Cleve Killingsworth**, president and CEO of Blue Cross Blue Shield of Massachusetts in Boston; and **Paula Steiner**, senior vice president of marketing and sales for Blue Cross Blue Shield of Illinois in Chicago. **Bruce McPherson**, president and CEO of the Alliance for Advancing Nonprofit Health Care in Washington, D.C., moderated the discussion.

**Bruce McPherson:** *How important is universal health care coverage?*

**Terry Andrus:** In a sense, we all have access to care, but not necessarily appropriate access. For those without health care benefit coverage in my community, access tends to be through my hospital's emergency room (ER). Probably 40 percent to 50 percent of our ER visits could be taking place sooner and in a better setting, which would be better from both quality and cost perspectives for patients, payers, and society. For instance, many folks with chronic care conditions don't have ready access when they need it to a primary care physician or appropriate specialists. There have to be better ways to finance and deliver care for everyone. I talk to colleagues in Alabama and across the nation, and too many hospitals are experiencing shrinking operating margins or even teetering on the brink of insolvency because of uncompensated care burdens. They don't know how much longer they can be the safety net for our system.

**Brad Gray:** Research supports Terry's point that lack of insurance has adverse consequences for a person's access to care and health status.

Universal access to coverage is also important because indirect efforts to secure access for uninsured people, and to sustain the viability of the institutions that serve them in large numbers, have a distorting effect on public policy. Examples of indirect approaches are Medicare or Medicaid "disproportionate share" and "indirect medical education" payments to hospitals, state uncompensated care pools, and cross subsidies by individuals and companies paying for insurance. We see this distortion extended to public debates about the tax-exempt status of

nonprofit hospitals, which tend to focus narrowly on whether institutions are providing enough charity care. This is an important aspect of the community benefits that nonprofit hospitals provide, but it is not the only justification for tax exemption.

**Cleve Killingsworth:** To me, the access issue is fundamentally a delivery system issue, in that we should strive for universal access to effective care, and I don't think we're very close. Having said that, universal coverage is also very important to deal with the realities associated with the lack of insurance that Terry and Brad have described. Before health reform legislation was passed recently in Massachusetts, we had an uncompensated care pool. That pool had a distorting effect, as there was no preventive care or any coordinated care for the uninsured with chronic care diseases. So the uninsured had access to care, but to something far less than effective medical practice.

**Paula Steiner:** My health plan believes that universal access to health care coverage is vital to enhancing the health status of everyone in this country. We also believe that it will not only reduce the personal and financial burdens for those not having coverage, but also lessen the financial burdens of the insured who currently are subsidizing the costs of care to the uninsured.

**Bill Cox:** The members of the Alliance of Catholic Health Care agree with all of the reasons that have been stated for moving to a system of universal coverage. In addition, we believe that access to needed care is essential to human dignity and is, therefore, a moral imperative.

**McPherson:** *Do you feel there is a reasonable chance over the next four to six years that we will have achieved universal or near-universal access to coverage in the United States?*

**Killingsworth:** I think it is very likely that we'll get universal coverage in that time frame, out of frustration, but we will be worse off because we will not have dealt adequately with the fundamental issues involved in the delivery of care. Moreover, I believe that we have sufficient resources now to cover everybody. I'll elaborate on that point later.

**Gray:** Coverage for the uninsured is going to be an issue in this year's presidential election in a way that it hasn't been since 1992, so that makes one feel optimistic in the sense that at least we are talking about it again. The fact that we have

about 16 percent of Americans uninsured has become very visible and, for whatever reasons, more people think we need to do something about it.

But anybody who has been watching health politics and policy in this country for a long time cannot feel confident that it is going to happen just because it is back on the agenda. I hope that Cleve is right that it will happen. It is at least again possible to say that it could happen. I hope that policymakers will have learned from what went wrong back in 1994. The key is whether a political consensus can be developed around any particular set of proposals because right now there seems to be a lot of division in this country about which way we should go in trying to achieve this goal.

I also think there is a growing awareness that we have to do something about health care costs and quality. Whether and how we address the financing and delivery issues together is going to be one of the big challenges for whoever is making health care reform proposals this year. At least it's going to be on the agenda, and I think we have a better chance now than at any time since 1994.

**Cox:** When opinion polls reveal that Americans are very anxious about health care and very desirous of reform, we need to remind ourselves that five times in the last century, beginning with Teddy Roosevelt, health care reform failed. This demonstrates the degree of difficulty of achieving consensus on this issue at the federal level; people are in very different places. Achieving consensus will require convincing the majority of voters who are insured that they are going to be better off with reform—that it may cost them some money but that they will be net “winners” with guaranteed coverage. Voters also need to be convinced that it will be a net benefit for government to play a larger role in the health care system and, therefore, to control a greater portion of the gross domestic product than it currently does.

It will be very difficult to achieve, however desirous it is.

**Steiner:** I am optimistic. I don't believe we have been failing since Teddy Roosevelt. We are now at a stage in our country where the vast majority of people have access to health care coverage. We have instituted reforms aimed at various populations lacking coverage, the aged under Medicare and

the most financially disadvantaged under Medicaid, and most recently children under the State Children's Health Care Program, commonly referred to as S-CHIP.

There is also a great deal of activity in the states, much of which is focused on those individuals who are employed but lacking coverage. In my state, Blue Cross Blue Shield of Illinois has introduced a bill in the Illinois legislature promoting greater access to health insurance.

The collective impact of all of these efforts demonstrates that public policy progress at both the federal and state levels occurs incrementally. To achieve universal coverage in four to six years would be a huge change in social policy—unprecedented in this country. I believe we will continue to make progress as we always have, one step at a time.

**Andrus:** To me, the cost of financing universal coverage and who is going to pay for it is the big issue. If this year's election results in a Democratic president, House, and Senate, will the Republican members of Congress filibuster or not?

I am a little more optimistic about universal coverage than I would have been two or three years ago, but change in this arena comes very slowly.

**Cox:** This is so true. We need to remember that Bill Clinton, a Democratic president who ran on health reform and may in part have won because of it, enjoyed Democratic control of both chambers of Congress. Yet his health reform plan still failed. So, control by one party doesn't guarantee success by any means.

We can make some incremental progress towards health care reform, and expanding S-CHIP would be an important first step.

**McPherson:** *Taking up one of the earlier comments, do all of you see quality and cost issues being addressed before, in tandem with, or after significant health care coverage reforms?*

**Steiner:** Political disagreements and the issue of cost—our inability or unwillingness to fund expansion of the system—are very much putting the reins on coverage reforms in Illinois. The governor has been attempting to introduce his own universal healthcare coverage bill and regulations that would affect the industry, but the General Assembly has not been supportive.

**Cox:** This is true in California as well. Democrats enjoy a nearly two-thirds majority in both houses of the state legislature, and the governor is strongly in favor of health care reform. The issue troubling the legislature, however, is whether it can mandate coverage and raise enough revenue to provide adequate subsidies for low-income people to purchase the mandated coverage. The governor originally proposed subsidized health plans with a \$5,000 deductible, which the Democratic legislature does not believe is affordable coverage for low-income people.

**Gray:** This is one of the big dilemmas. A lot of people appear to think that the most politically viable thing to do is to expand coverage first because any kind of serious cost containment proposal is going to generate tremendous resistance. The more it appears that any coverage proposal will include some sort of governmental cost controls, the more special interest groups will rally opposition to it. So those in favor of universal coverage tend to want to get that done, and then go to work on the cost issue.

**Killingsworth:** With the Institute of Medicine (IOM) studies telling us that we are wasting 30 cents of every dollar we spend on health care, it is an enormous challenge to expand coverage without having dealt with that problem first. But that is what we did in Massachusetts. If we don't find a way to reduce cost and improve quality, which go hand-in-hand, we could be facing a major financial crisis in June 2008.

**McPherson:** *Do you see a unique opportunity or role for nonprofit health care organizations in influencing the pace and direction of health care coverage reforms at the federal and/or state levels?*

**Cox:** The four Catholic hospital systems in California have been very involved in advocating reform. For instance, late last year they developed a policy position that was largely in support of the governor's initiative, with some caveats. They were the first group of nonprofit health care providers in the state to support his vision. One of the major elements of his vision was a 4 percent tax on hospital revenues, which they supported as long as it was fairly applied with no big winners and losers. Much remains to be done for health care reform to become a reality in California, and the Catholic health care systems are seeking to provide as much leadership and support as they can.

**Steiner:** I mentioned earlier that Blue Cross Blue Shield of Illinois has introduced a bill to expand health care coverage in the state. However, we are not waiting for the government to act. Even if things aren't happening as fast as we would like at the federal level, we believe that there is still much that can be done on a local level. For instance, our plan has been working with a group of providers, public health agencies, and local employer groups in a county that has a very high rate of diabetes. Our "Diabetes Checks and Balances" program helps physicians communicate with type 2 diabetes patients needing baseline tests. The objective is to start this population on the road to better management of their disease. We are beginning to jointly encourage screening for diabetes and are finding that many type 2 diabetes patients need to be more tightly managed. Together we are putting care plans in place to ensure access for those individuals that have been identified as at risk.

So a lesson is that if you set your immediate sights on perfection, you can easily get discouraged. We must remember that health care is local, and we need to continually focus on what is needed and feasible at the community level.

**Killingsworth:** In Massachusetts, our Blue Cross and Blue Shield plan has significant market share and everybody expected us to have a point of view on health care reforms to be considered when the debate began. Consequently, we served as a consultant at the highest levels in the evolving key discussions. Our foundation also played an important role. Much of the coverage expansion debate emerged from an Urban Institute "Roadmap" study commissioned by our foundation, which stimulated statewide discussions on covering the uninsured in our state. The Urban Institute presented the results of its study at the Kennedy Library, where most of the major politicians announced their commitment to quickly bring universal health care coverage to Massachusetts.

Now that coverage reform has been passed and we are in the process of implementation, our organization is working very hard with the "Connector," a key administrative agency under the law. We will continue to participate in a variety of ways to try to make the reforms work as efficiently and effectively as possible.

One of the things we've learned is that when you have a major issue like this, which is being broadly discussed among many different stakeholders, you can have an impact if you have a

positive, community-oriented agenda. You can't sit on the sidelines waiting for it to be over and hoping it will not be harmful to your business.

**Andrus:** My medical center by itself isn't a big enough "fish" to play a significant role on health care coverage reform, which in our state is not even up for discussion. Just maintaining our current Medicaid program has been a challenge. Without intergovernmental transfers, it would crumble. Federal action is probably the only way that significant coverage expansion will occur in my state in the foreseeable future.

**McPherson:** *Setting aside the timing between health care coverage reforms and delivery system reforms, what opportunities or roles do you see for nonprofit health care organizations in achieving delivery system reforms?*

**Killingsworth:** We need to think of delivery system problems in the context of quality and patient safety, not costs per se, which are largely a by-product. We need to eliminate overuse, underuse, misuse, and medical errors. There are huge opportunities to make improvements, as enumerated in various studies: tens of thousands dying in our hospitals needlessly; medical mistakes injuring over 1.5 million Americans each year; only half of the 100 million antibiotics prescribed annually being necessary; 400,000 unnecessary C-sections performed every year; only 60 percent of patients with chronic conditions receiving the care they need; and only 21 percent of the elderly who need beta-blockers receiving them.

We as a society, and we in the nonprofit health sector, must correct these quality problems as soon as possible. There is a moral issue here. Improvements in health information technology are an essential enabler, but not sufficient in and of themselves to get the job done. The technology must be used to reengineer the way in which care is actually delivered.

Our organization is embarking on an ambitious community-based effort to address cost and quality in our state. The plan includes improving the incentives that we use in paying hospitals and doctors related to quality, helping our community hospitals with health information technology and other investments necessary to achieve their transformations into high-quality organizations, and educating health care governing bodies and the general public about the facts and myths surrounding health care quality.

**Gray:** I think we are making progress in addressing quality issues, although I don't see any progress yet on the cost issue. Health coverage expansion might accelerate the pace of change on the delivery side if it created more power for the purchasers of care, but otherwise I don't see how reductions in the number of uninsured will help with either quality or cost issues except, of course, for the uninsured.

**Cox:** I agree. Improving clinical outcomes and patient safety is not only the right thing to do, it also lowers costs, which can make coverage for everyone more affordable. In the practical world of politics, however, especially at the federal level there is a reluctance on the part of budget scorers at the Office of Management and Budget and the Congressional Budget Office to assume cost savings in quality-related initiatives that could be used to fund coverage expansion.

**Steiner:** Without a government movement or political will to mandate coverage, we in the nonprofit health care sector will need to do everything we can to address issues of waste, quality, and cost to allow more Americans to get access through the private sector.

For instance, we have one of the largest remaining capitated health maintenance organizations (HMOs) in the country. Its cost per member is about 23 percent less than that of preferred provider organization (PPO) plans, and its member satisfaction ratings are the highest. We also know that physician incentive programs can positively affect costs. For example, in our asthma condition management program, we motivate physicians to provide asthma action plans. From 2000 through 2005, over 3,300 asthma ER visits were prevented, more than 1,000 asthma admissions were avoided, and more than 2,400 hospital days were saved. So we do know that certain contracting arrangements can have an impact on results.

**Andrus:** I don't disagree with everything that has been said on this. However, if it were easy to improve quality and save money in the process, it would be happening more quickly. The incentives are often perverse. For example, we were a participant in the Premier, Inc./Centers for Medicare and Medicaid Services (CMS) demonstration project under Medicare where our hospital would get incentive payments for doing certain things. There were no complementary incentives, however, for the physicians.



**Killingsworth:** Terry's point about perverse incentives is absolutely correct and, as Paula suggests, we have experiences from the managed care era about what incentive arrangements work and don't work and why. We're developing what we call an alternative quality contract that builds in some of the principles that we know have worked. It is primarily directed at hospitals, but requires hospitals and physicians that choose to participate to form groups to work together. Our intent in this contract is to make winners of health care providers who do those things that we know work in clinical practice. The goal of this alternative contract is not to create savings for the plan's coffers. We expect our health care spending to grow each year, but hopefully at a much slower rate of increase.

**McPherson:** *The foregoing discussion suggests that quality will be a prominent feature of competition for both nonprofit health care providers and nonprofit health plans, and is viewed by many to be vital to help fund universal coverage before or after the fact. If and when we get to universal or near-universal coverage, do you see the competition being faced by nonprofit health care organizations changing in any other respects?*

**Gray:** It's not clear to me that universal coverage by itself is going to affect the competitive situation between for-profit and nonprofit health care providers. For instance, for-profit hospitals do not typically locate in areas where there are high portions of uninsured residents and/or Medicaid recipients where the payments are woefully inadequate.

The increasing availability of performance information about providers on a growing number of dimensions is going to move everybody to better performance, which could make it increasingly difficult over time for nonprofits to differentiate themselves from for-profits on dimensions other than community benefits.

**Cox:** On the other hand, in a system of universal coverage, nonprofit hospitals with large portions of uninsured, low income and Medicaid patients should experience increases in their revenues. Improved earnings would enable them to make the types of investments in information systems and other quality and safety-related improvements that would benefit their patients and allow them to be rewarded for those improvements.

**Killingsworth:** In Massachusetts, we have traditionally had a form of community rating and prohibitions against medical underwriting to protect consumers and promote fair competition. The main change under our state health care coverage reforms is that plans must now competitively bid a premium rate on a benefit package to the state's Connector agency, which decides which plans will be allowed to offer coverage to the risk pool of individuals who are uninsured. There will undoubtedly be some vigorous advertising among the competing health plans targeted at uninsured people who are young and healthy.

**Steiner:** Setting aside the quality issue, I don't see universal coverage changing the competitive landscape very much for our plan. A wide range of carriers compete in Illinois, where we already have small group rate regulations. These regulations have offered many protections for small businesses and have provided a lot of stability to the market. They essentially create classes of risk, limiting the premium spread between the top and the bottom of the risk pool. It isn't classic community rating, but it has led to a very vigorous and generally fair, competitive marketplace.

**McPherson:** *Do you think achievement of universal or near-universal health care coverage has any implications for the future of nonprofit health care tax exemptions?*

**Gray:** Uncompensated care has been traditionally a big part of the community benefits provided by certain hospitals. If we had universal coverage, it would surprise me if other forms of community benefit activities ramped up as quickly if uncompensated care were to decline for these institutions. But it's difficult to anticipate what forms of community benefit activities might increase if the number of uninsured patients were to substantially decrease.

Regarding tax exemptions, one pressure point would generally disappear under universal coverage: challenges from federal and state government to nonprofit hospitals to demonstrate that they are doing as much as they can to make services available to patients who lack the means to pay for it.

But that hasn't been the only source of pressure for tax exemption reform. Another source of pressure has been erosion of the tax base, particularly as it relates to local property tax exemptions for nonprofits like hospitals and universities. That pressure will continue, as will pressure for

a more meaningful system of accountability. A new source of pressure may come from the for-profits themselves, arguing that the nonprofits have an unfair competitive advantage under universal coverage if they remain tax-exempt.

To address these pressures, nonprofit hospitals will have to use arguments other than charity care to justify all of their tax exemptions under universal coverage. The community benefit guidelines developed by the Catholic Health Association and VHA, Inc., will be very useful in that regard.

**Cox:** Large nonprofit institutions, such as hospitals and universities, are going to be increasingly pressed to reach agreements with local tax assessors to provide some financial support to their communities for services such as fire protection and education from kindergarten through grade 12.

However, even under a system of universal coverage, there will remain innumerable health and wellness issues that nonprofit, tax-exempt hospitals can and should address. All of the problems are not going to go away with universal coverage. In addition, nonprofit health care institutions will continue to serve lower-income communities that for-profit providers have left or are unwilling to enter.

**Gray:** Examples of issues that will still need to be addressed under universal access are providing transportation to care for those who can't afford it or providing outreach for uncovered services in low-income communities. Many communities also need nonclinical help to improve housing, the environment, education, the local economy, and other parts of their infrastructures that can have important impacts on health status.

**Andrus:** To me, whether we are talking about community benefits, quality, or costs, this is all part of the larger movement toward greater transparency. Over time, under universal coverage, questions may well be asked about whether nonprofit hospitals and systems should have the same tax treatments as nonprofit Blue Cross Blue Shield plans. We will need to have good answers.

**Killingsworth:** We are exempt from some state taxes because the state qualifies our plan as a charitable organization and treats it no differently than it does a nonprofit hospital or other nonprofit health care provider. I don't see that changing under universal coverage in Massachusetts. Ninety-two percent of our premium dollar is spent on health care, above a typical for-profit plan's percentage. That is just one example of the community benefits we provide.

It is important to note that even in our state, it is unlikely that coverage will ever be 100 percent universal. Penalties for noncompliance with coverage mandates may never be sufficient to ensure coverage. The uncompensated care pool will be smaller, but it will still exist. There will continue to be gaps that nonprofit health care organizations will need to fill.

**Steiner:** Good point, Cleve. Research on a nationwide basis shows that close to one-third of the uninsured are actually eligible for existing public programs.

On the tax exemption issue, even though we pay taxes in Illinois as a mutual company, we're very proud to be a member-owned organization that always puts first the needs of members and the broader community.

**Cox:** Let me add a final observation on a point that others have made about individual coverage. Every adult driver in California is mandated by law to have a driver's license and liability insurance. Nonetheless, in California a high percentage of the population drives without either. Mandated health insurance coverage will not necessarily produce universal coverage. Under such a system, there will still be a significant role for nonprofit health care organizations to serve the uninsured.