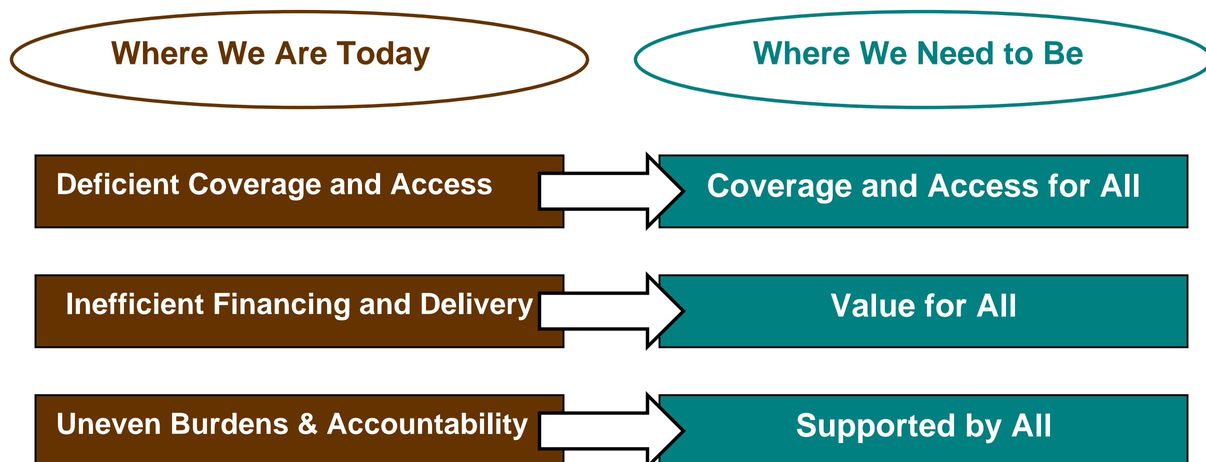
A Values-Based Dialogue Document

Trinity Health

March 2007
Revised: January 2008

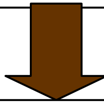


Executive Summary
A Dialogue Document

Trinity Health believes the nation must find a way to transform healthcare.
We should no longer tolerate a system that leaves nearly 47 million people without insurance and adequate access to healthcare. As a nation we can a must "find a way for all."

WE BELIEVE….

- Every person has inherent dignity and deserves respect
- Public policy should serve the common good
- Justice calls us to view healthcare as a basic human right
- Concern for the poor is a moral measure of society
- There must be a responsible stewardship of resources
- Respect for pluralism should prevail for the religious and ethical values of patients and providers



BASED ON THESE BELIEFS, WE ARE CALLING FOR SYSTEMIC HEATLHCARE REFORM THAT INCLUDES…

Coverage and Access for All

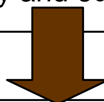
1. Ensure coverage for everyone with uniform, core benefits
2. Organize coverage for continuous protection and broad pooling of risk
3. Ensure personalized care and "continuous healing relationships," especially for persons with special needs and those at the end of life

Value for All

4. Align payment to coordinate care, improve health status, and ensure cost-effectiveness
5. Facilitate the use of information to continuously improve quality, coordinate services, and maximize efficiency
6. Promote wellness and prevention
7. Optimize administrative efficiency and minimize administrative cost

Supported by All

8. Encourage personal responsibility for maintaining health
9. Ensure shared responsibility and equitable financing of the system



WE ARE DOING OUR PART TO ADVANCE THIS VISION FOR HEALTH REFORM IN OUR OWN COMMUNITIES

FIND A WAY

Transforming Healthcare in America: Essential Elements of Systemic Healthcare Reform

Based on our values, Trinity Health is calling for systemic healthcare reform to achieve "coverage and access for all" in a cost-effective system of care.

"Coverage and access for all" is a top advocacy priority for Trinity Health. Based on our ministry values and beliefs, this document describes the essential elements of a reformed health system that includes coverage for all. The document also shows how Trinity Health is already working to transform healthcare in our local communities in light of this vision for a more inclusive and effective system of care.

"Coverage and access for all" is both a **moral** and a **pragmatic** imperative:

- **Morally,** healthcare is a basic human need required for people to flourish. In a just society, nobody should be left behind.
- **Pragmatically,** coverage for all will mean more efficient care, a healthier population, and a more competitive economy.

Purpose of this Dialogue Document

This discussion document is offered as a contribution to the debate on healthcare reform. It is being used by Trinity Health to engage national leaders and promote dialogue on a path for change. It is also being used to assess emerging policy proposals and guide us in our efforts to influence legislation.

Trinity Health originally issued these "essential elements of reform" in March of 2007. The document has since been revised to complement and build on the Catholic Health Association's *Vision for U.S. Health Care* and the American Hospital Association's *Health for Life: A Framework for Health Reform.*

Organization of this Document

- **Overview**
- **Where we Are Today**: Nobody Would Design This System from Scratch
- **The Context**: Recent Developments Making the Time Ripe for Reform
- **Our Beliefs**: Values Underlying our Vision for Reform
- **Our Vision:** Essential Elements of Systemic Reform
  - Coverage and access for all
  - Value for all
  - Supported by all
- **Our Contributions**: How We Are Advancing the Vision in our Communities
- **Appendices**
  - A. Coverage for All: A Moral and Pragmatic Imperative
  - B. Cost of Coverage for All

Overview

Trinity Health is Calling for Systemic Healthcare Reform:
Coverage and Access for All
Value for All
Supported by All

Where We Are Today	**Where We Need to Be**
Deficient Coverage and Access ➢ Nearly 47 million uninsured ➢ Insurance market inefficiency and risk selection ➢ Uncoordinated and depersonalized care	**Coverage and Access for All** **1.** Ensure coverage for everyone with uniform, core benefits **2.** Organize coverage for continuous protection and broad pooling of risk **3.** Ensure personalized care and "continuous healing relationships," especially for persons with special needs and those at the end of life
Inefficient Financing and Delivery ➢ Uneven accountability for health maintenance and outcomes ➢ Unaligned payment to providers ➢ Underdeveloped Information Systems ➢ High administrative and transactional costs	**Value for All** **4.** Align payment to coordinate care, improve health status, and ensure cost-effectiveness **5.** Facilitate the use of information to continuously improve care, coordinate services, and maximize efficiency **6.** Promote wellness and prevention **7.** Optimize administrative efficiency and minimize administrative cost
Uneven Burdens & Accountability ➢ Few incentives for individual accountability for health ➢ Inequitable and unstable financing	**Supported by All** **8.** Encourage personal responsibility for maintaining health **9.** Ensure shared responsibility and equitable financing of the system

Where We Are Today: Nobody Would Design this System from Scratch

Our current healthcare system is ineffectively organized for improved health, efficiency, access, and quality. Costs are escalating at twice the rate of inflation, making coverage increasingly unaffordable while hurting businesses in our global economy. The number of uninsured continues to grow, even during periods of economic strength. People are often bewildered by the system's complexity and worried about their individual health and financial security. These trends are unsustainable. Specifically:

Deficient Coverage and Access

1. **Nearly 47 Million Uninsured** (See Exhibits 1 & 2)
   - Morally reprehensible for our nation to leave so many without protection and adequate access
   - Postponed care leads to more severe and expensive conditions
   - 18,000 avoidable deaths per year due to postponed and inadequate care (IOM)
   - $65 billion in societal economic loss due to diminished productivity (IOM)
   - Free riders (firms and individuals)
   - Cost-shifting and uneven competitive playing field for firms that provide coverage
   - Worker turnover for firms unable to afford or obtain insurance

2. **Insurance market inefficiency and risk selection**
   - Rewards for avoiding persons who most need insurance
   - Use of benefit design, churning, and medical underwriting to avoid risk
   - High administrative and underwriting costs for small employers and individual products

3. **Uncoordinated and depersonalized care**
   - Lack of coordination across settings, especially for chronic conditions
   - Patient frustration with lack of information and impersonal care
   - Low emphasis on palliative care and compassionate support for the dying

> **Medical underwriting** refers to the denial or pricing of insurance based on health status or the assessed risk of individuals or groups.

Inefficient Financing and Delivery

4. **Uneven accountability for health maintenance and outcomes**
   - Within the hospital and across the care continuum (including prevention and wellness)
   - For many insurers who save costs via discounted payments, coverage exclusions, risk avoidance, and payment obstacles rather than care coordination

5. **Unaligned payment to providers**
   - Uncoordinated payments to hospitals and physicians; few incentives for collaboration
   - Rewards for filling beds, but not avoiding hospitalizations
   - Conflict of interest for physician-owned facilities and services

6. **Underdeveloped information systems**
   - Inefficiencies and errors associated with paper medical records
   - High cost and low reward for lead innovators; lack of standards for interoperability

7. **High administrative and transactional costs**
   - Lack of standardized insurance and claims process; high ratio of non-delivery to delivery costs

Uneven Burdens & Accountability

8. **Few incentives for individual accountability for health**
   - Insulation of consumers from cost; uneven incentives and supports for staying well
   - Few opportunities for consumer participation in their own care

9. **Inequitable and unstable financing**
   - High burdens on low-income families without health insurance
   - Cost-shifting and unstable reimbursement systems

Exhibit 1

Varied Characteristics of Nearly 47 Million Uninsured

Moderate to high income
> 300% of the FPL
$60,000

FREE RIDERS 19%
- Working and probably able to afford coverage
- Often healthy and/or young

Moderate income
200-300% of the FPL
$40,000

WORKING WITH SOME ABILITY TO PAY 16%
- Working but employee coverage is not offered or is unaffordable although some sharing of cost is possible
- Job transitions

Low income
100-200% of the FPL
$20,000

WORKING LOW INCOME 29%
- Working but employee coverage is not offered or is unaffordable
- Job transitions

UNINSURABLES
Denied coverage or "priced out" due to existing conditions and/or age

(Small number but high costs)

Very low income
<100% of the federal poverty level

ELIGIBLES
Eligible for public programs but not enrolled
- Awareness and /or perceived need
- Enrollment hassle/disincentives
- Stigma

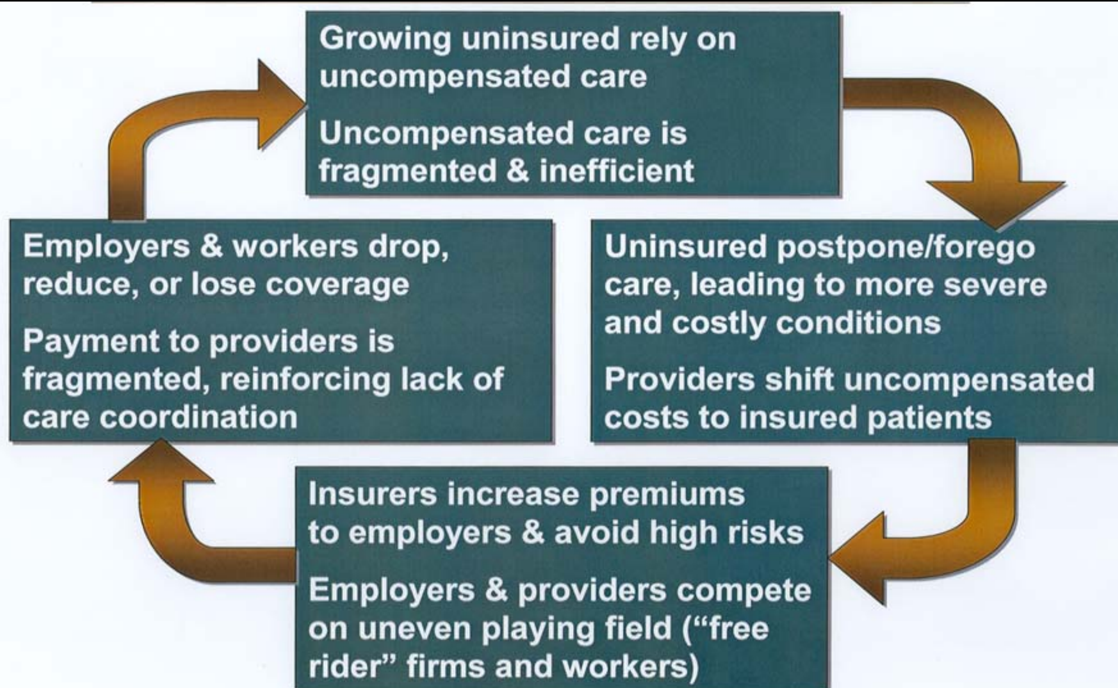
36%

VERY POOR
Not eligible for public programs
- Unemployed
- Employed with low income
- Adults that cannot qualify for Medicaid regardless of employment status

Note: Poverty levels are for family of four, 2005. "Working" includes families with a full-time or part-time worker.
Sources: Estimated based on: Kaiser Family Foundation, 2006; Urban Institute, 2006

Exhibit 2

The "Vicious Cycle" of Cost and Access



The Context: Recent Developments Making the Time Ripe for Reform

Since the early 1990s when healthcare reform was last on the national policy agenda, several new developments have increased both the need and the momentum for serious consideration of the issue in this decade, including:

- Continued increases in the number of **uninsured,** reflecting an erosion in employer-based coverage. This increase has been accompanied by new empirical evidence that the uninsured receive care that is “”too little too late,” especially when compared to their insured counterparts.

- **Global competition** as a stronger factor when employers consider the impact of escalating health expenses on their business – including the “hidden tax” created by cost shifting for the uninsured. This trend has been accompanied by greater **employer activism** in quality, safety, and efficiency (e.g. The Leapfrog Group). For **employees**, it has meant volatility and uncertainty in whether their next job will include coverage or whether their current coverage will continue.

- Increasing awareness of the high **administrative and transactional costs** associated with our complex, multi-layered system of insurance and payment processes.

- Growing recognition that the **delivery** of healthcare is often uncoordinated and inefficient, contributing to high insurance premiums for employers and individuals. For example, the Institute of Medicine (IOM) “Crossing the Quality Chasm” series documented the need for fundamentally redesigning the delivery of care to address safety and quality shortcomings in the system.

- Advances in **health information technology** that have opened new possibilities for coordinating care, basing it on real-time quality measures, making it safer, and involving patients more directly in their own care.

- Major advances by **healthcare providers** and systems in experimenting with better and more efficient delivery of care, including:
  - Implementation and use of electronic health records
  - Systematic use of quality measures based on empirical evidence
  - Real-time use of evidenced-based medicine to redesign care processes

- Increasing recognition by public policy makers that **Medicare payment** needs to be realigned for greater efficiency:
  - Pay-for-performance initiatives
  - Incentives for management of chronic diseases and other high-cost cases
  - Increasing interest by MedPAC and other organizations in “bundled payments” and other methods for paying for a full cycle of care rather than episodic treatments

MEDPAC EXPLORES BUNDLED PAYMENTS

1/18/07: Washington, D.C. Bundling payments to hospitals and physicians for inpatient care could reduce hospital costs and unnecessary physician visits, a researcher told the Medicare Payment Advisory Commission….Hospitals and physicians could form organizations to receive and allocate bundled payments …

Modern Healthcare

- Interest in **“consumer-driven” models** of healthcare designed to make patients more sensitive to cost and to empower them with information for making choices among health plans and providers.
  - Health Savings Accounts linked with high-deductible coverage
  - Personal Health Records

Our Beliefs: Values Underlying Our Vision For Reform

WE BELIEVE….[1]

Human Dignity

1. **Every person has inherent dignity and deserves respect.** Because each person is created in the image of God, each life is sacred and possesses inalienable worth. Healthcare is essential to promoting and protecting the inherent dignity of every individual from conception to natural death.

Common Good

2. **Public policy should serve the common good.** The health and well-being of each person is intertwined with the health and well-being of the broader community. Access to healthcare is an essential element contributing to the common good alongside others such as education, employment, and a safe environment.

Justice

3. **Justice calls us to view healthcare as basic human right.** Healthcare is a basic human right alongside food and shelter, all of which are necessary for individuals to participate fully in society.

Concern for the Poor and Vulnerable

4. **Concern for the poor is a moral measure of society.** The poor and vulnerable are particularly marginalized by the lack of access to healthcare. The moral measure of society is how it treats these persons.

Stewardship

5. **There must be responsible stewardship of resources.** Our societal resources are finite, and we must make wise choices for how they are allocated. Healthcare resources should focus on the well-being of the community and be structured to deliver care that is most medically beneficial and promotes public health.

Pluralism

6. **Respect for pluralism should prevail for the religious and ethical values of patients and providers.** The healthcare system should allow and encourage involvement of the public and private sectors including voluntary, religious and not-for-profit organizations, and it should respect the religious and ethical values of patients and healthcare providers alike.

We believe it is morally reprehensible that nearly 47 million persons lack health insurance and adequate access to healthcare. As a nation, we should no longer tolerate this injustice.

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[1] Catholic Health Association of the United States. *Our Vision for U.S. Health Care*, 2008

Our Vision: Essential Elements of Systemic Reform

Coverage and Access for All
Value for All
Supported by All

Coverage and Access for All

1. **Ensure coverage for everyone with uniform, core benefits**
   - Required participation by all (whether or not employer-based) – no free riders
   - Continuous, stable coverage regardless of life changes
   - Standard, core benefits with option to "buy above"
     - Preventive and medical services adequate to support health and well-being
     - Sufficiently comprehensive to avoid the need to "buy above" for most people
     - Similar to Federal Employee Health Benefits Plan (FEHBP) Blue Cross/Blue Shield standard option
   - Subsidies or vouchers for low income populations
   - Cost sharing (co-pays and/or deductibles) set at an affordable level that encourages shared responsibility and prudent purchasing without discouraging needed care
   - Equalizing of tax benefits for employers and individuals

2. **Organize coverage for continuous protection and broad pooling of risk**
   - Incentives for risk pooling and care management rather than risk avoidance
   - Guaranteed issue and no exclusions for pre-existing conditions
   - No consumer price variation for the health status of individuals or groups
   - Mechanisms to avoid or compensate for adverse selection such as:
     - Risk-adjustment to account for plan variations in the health status of their enrollees
     - Pooling of high-cost cases to be funded federally or equally by all insurers
     - Regional purchasing organizations ("Insurance Exchanges")

> **Defining "Coverage"**
> Coverage refers to the spreading of risk for unpredictable health expenses by having all individuals (or an entity on their behalf) make regular payments unrelated to episodes of illness, thereby entitling them to a defined set of services. This can be accomplished with private insurance, public insurance, and/or direct tax support making all providers accessible to the covered population.

3. **Ensure personalized care and "continuous healing relationships,"[2] especially for persons with special needs and those at the end of life**
   - Seamless, easy-to-navigate systems of care and payment simplicity
   - Accessible, standardized information for consumers on satisfaction and outcomes
   - Appropriate support services for low income populations, minorities, and others that face barriers to care (e.g., transportation, language, referrals to social services)
   - Incentives for palliative services, hospice, and compassionate care for persons at the end of life
   - Capacity for focus on the whole person: mind, body, and spirit

[2] Institute of Medicine (IOM), *Crossing the Quality Chasm.*

Value for All

Aligning payments
Medicare & Medicaid can take the lead in these payment reforms, serving as models for private plans.

4. **Align payment to coordinate care, improve health status, and ensure cost-effectiveness**
   - Rewards for coordinating care across settings and over time
   - Unified or coordinated payment to hospitals, physicians, and other providers to encourage coordination for high-expense illnesses and chronic conditions.
   - Incentives for integrated networks of hospitals, physicians, and other providers that are accountable for outcomes as a team
   - Payment to providers for effective care coordination for chronic conditions
   - Rewards for provider quality and process redesign that can demonstrate outcomes

5. **Facilitate the use of information to continuously improve quality, coordinate services, and maximize efficiency**
   - Incentives for adoption of electronic health records and physician order entry
   - Interoperability standards for health information technology
   - Consumer access to health records to encourage participation in their own health
   - Price transparency structured to allow for effective competition based on value:
     - Integrated with quality and health outcome data
     - Applied to insurers and pharmaceutical/devise companies as well as providers
     - User-friendly to support choice without compromising clinician judgment

6. **Promote wellness and prevention**
   - Coverage and payment for preventive services, including periodic health assessments
   - Tax or insurance premium incentives to reward individuals for: (a) timely screenings and immunizations, and b) healthy lifestyles (e.g. smoking cessation), but only for activities with clear personal responsibility and linkages to health

7. **Optimize administrative efficiency and minimize administrative cost**
   - Standardized billing and claims processing rules
   - Streamlining of coverage determinations and payment transactions
   - Increased ratio of patient care costs to non-patient care costs

Supported by All

8. **Encourage personal responsibility for maintaining health**
   - Shared responsibility for healthcare costs (see above) and incentives for staying well
   - Efforts to encourage appropriate involvement in health, especially through personal health records

9. **Ensure shared responsibility and equitable financing of the system**
   - Financial participation by individuals based on ability to pay
   - Progressive financing and subsidies for persons and entities least able to pay
   - Adequate and equitable payment for services to minimize cost-shifting and avoid distortions in competition
   - Programs to ensure an appropriate supply of health professionals
   - Oversight of the system by an independent, expert body insulated from the political process (like the Federal Reserve Board)

Our Contributions: How we are Advancing the Vision in Our Communities

Coverage and Access for All
Value for All
Supported by All

Coverage and Access for All

- **Investing $24 million to over 3 years to jumpstart new projects to:**
  - Expand **access** to equitable care, including coverage for the uninsured
  - **Integrate care** for chronic conditions to reduce readmissions and save costs
  - Use electronic **health records** to improve care for the underserved

- **"Finding a way" to healthcare reform with local innovations**
  - Demonstrating access, quality, and efficiency
  - Replicating successful practices across 43 hospitals and seven states
  - See: *Finding a Way to Healthcare Reform Through Community Innovations*

Value for All

- **Investing over $300 million into a pioneering, system-wide HIT initiative**
  - Electronic health record (EHR) & computerized order entry
  - 14 of 31 scheduled hospitals now "live"
  - One of the nation's largest, interconnected clinical data repositories
  - "Ranks among the industry's most ambitious IT projects." *HealthLeaders Magazine*

- **Hardwiring evidenced-based quality for 5.9 million patients**
  - Comparative effectiveness based on EHRs
  - Rules and order sets for clinicians

- **Redesigning clinical practices and creating new efficiencies**
  - 25% reduction in severity adjusted mortality over 3 years
  - Exceeding national average on 97% of CMS quality measures
  - 45% reduction in pressure ulcers
  - Reduced hospitalizations by managing chronic conditions
  - Urgent medications given to patients 40% faster
  - Reduced hospital liability costs

Supported by All

- **Providing $323 million in community benefits**
  - Increased by 48% percent in the last 3 years
  - Includes free or discounted care for all low-income uninsured and underinsured patients

- **Piloting a patient information portal to support consumer-directed health care**

Appendices

Appendix A
Coverage for All:
A Moral and Pragmatic Imperative

Some people have argued that "coverage for all" is unnecessary in a reformed system, so long as appropriate care is available to the uninsured through clinics and charity care. They argue that "access for all" is a sufficient goal. Trinity Health believes that reform needs to achieve "coverage for all" while also ensuring access to appropriate and equitable care for all. This is both a moral and a pragmatic imperative.

Defining Coverage

Coverage refers to the spreading of financial risk for unpredictable health expenses by having all individuals (or an entity on their behalf) make regular payments unrelated to episodes of illness, thereby entitling them to a defined set of services. This can be accomplished with private insurance, but can also be accomplished through public insurance (e.g. Medicare) or direct tax support making all providers accessible to the covered population. In most cases, this will mean that every individual carries a "card" that identifies their eligibility for services with any provider, or within a defined network of providers.

Both a Moral and Pragmatic Imperative

"Coverage for all" is a necessary ingredient for systemic reform because:

- Everyone needs to contribute their fair share (adjusted for ability to pay) rather than imposing treatment costs on society when they become ill.
  - Like car insurance, everyone should participate
  - Otherwise people become "free riders" when they become ill and incur expenses that they cannot or will not pay
  - Free riders drive up premiums because they do not contribute on a regular basis

- Lack of coverage leads to costly and inefficient care.
  - Postponed treatment and inappropriate settings (e.g. emergency rooms)
  - More severe conditions
  - Deaths and loss of productivity (IOM)

- Coverage is empirically our strongest lever for enhancing access, often improving by two to three times:[3]
  - Use of a regular source of care
  - Use of preventive, screening, and diagnostic services
  - Health outcomes

- Cost shifting caused by lack of coverage is destabilizing and anti-competitive
  - Uneven playing field for employers
  - Uneven playing field for providers

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[3] Hadley, Jack. "Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income." Medical Care Research and Review (60:2), June 2003. Institute of Medicine. "Care Without Coverage: Too Little, Too Late," 2002.

- Coverage is consistent with our values
  - *Human dignity:* the security of coverage rather than relying on "charity"
  - *Common good:* everybody is participating to spread the risk of unpredictable events
  - *Stewardship:* avoids driving up costs when care is postponed and eliminates the inefficiency of cost-shifting
  - *Care of the poor:* ties the fate of the poor to the average American rather than relying on a separate system of subsidized services

Covering the uninsured makes economic sense because it will mean more efficient and effective care, a healthier population, and a more competitive economy. More importantly, "coverage for all" is the right thing to do. In a just society, no one should be left behind.

Achievable through Sequential Steps

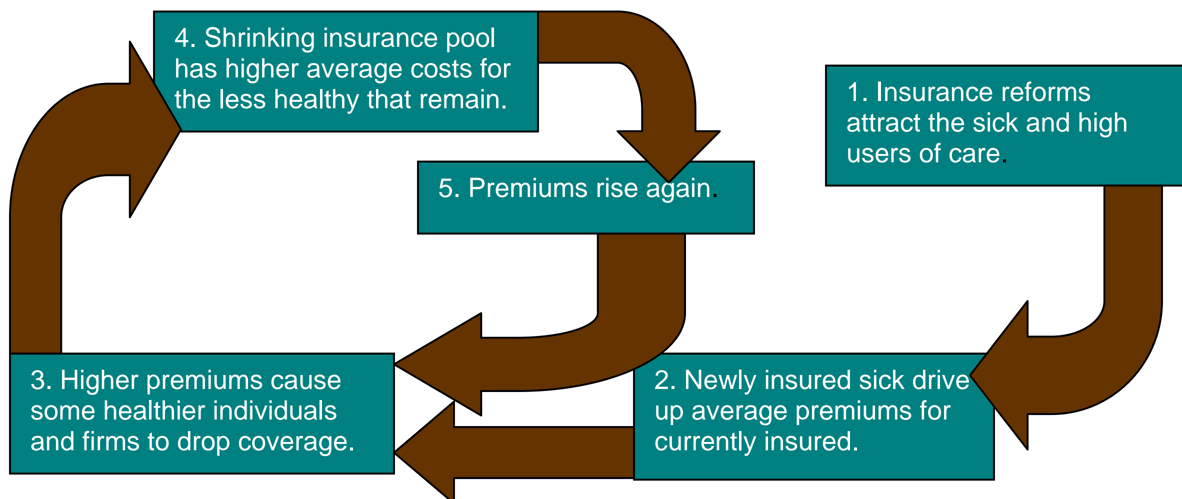
We may not be able to achieve "coverage for all" through a single piece of legislation or "all at once" approach. We are, however, calling on Congress to make measured, sequential progress toward the goal while achieving other "essential elements" of reform outlined in this document to address cost and quality.

However, we cannot and should not stop short of the ultimate goal. Efforts to simply expand coverage without eventually achieving universal coverage will be self-defeating in the long run. This is because most efforts to make insurance more affordable or available will usually attract less healthy populations (they are the ones needing insurance and therefore more likely to purchase it), thereby driving up the cost of an average premium. The result will be an "upward vicious spiral" in health premiums (Exhibit 3). The way to avert this spiral is to ensure that everyone is covered. "Coverage for all" brings healthier, lower-cost individuals into the insurance pool, thereby holding down average premiums.

Exhibit 3

The Upward Spiral in Premiums

Caused by Insurance Reforms without Eventually Achieving Coverage for All



Appendix B
Cost of Coverage for All

The cost of providing coverage for all Americans is less than most people assume. Several studies have concluded that, depending on the type and extensiveness of systemic health reform, the overall additional cost of covering the 46.6 million uninsured ranges from a net savings (i.e. a reduction) to a 3 to 6 percent increase in national healthcare expenditures. There are two reasons for this counterintiutive finding:

- The uninsured are already using about one-half the amount of care used by their insured counterparts. This existing care is covered through out-of-pocket payments, cost-shifting, and public subsidies. Thus, when the uninsured receive full coverage, the increase in national health spending will be less that the full cost of coverage. Researchers have projected, for example, that covering the uninsured would result in a 3 to 6 percent increase in national health spending, raising healthcare's share of GDP by less than one percentag point. [4]

- Some reform proposals include substantial efficiency savings that will offset the cost of covering the uninsured. For example, a Lewin Group analysis of the "Healthy Americans Act" introduced by Senator Wyden finds that the cost of full coverage will be more than offset by the pooling and standardization of insurance coverage, combined with competition among health plans. Lewin projects that the plan would actually reduce national health spending by $4.5 billion out of total national expenditures of $2.3 trillion.[5]

If reform includes the "essential elements" outlined in this document, we believe that coverage of the uninsured can be achieved with little or no increase in national health spending. There would, of course, be a redistribution of health spending, probably including an increase in public expenditures. Also, there would likely be a short term increase in spending while new efficiencies and adminstrative savings are achieved. But, as a nation, we can afford to cover the uninsured in a more efficient and inclusive system of care.

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[4] Jack Hadley and John Holahan. "Covering the Uninsured: How Much Would it Cost?" *Health Affairs*, June, 2003
[5] The Lewin Group. "Cost and Coverage Estimates for the Healthy Americans Act," December, 2006.