

MANAGED HEALTHCARE EXECUTIVE

AUGUST 2006

Cover Everybody

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managed care can evolve
with universal coverage

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story | **Julie Miller**

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Not many CEOs would wish for a massive upheaval in their industries. Georganne Chapin, president and CEO of Hudson Health Plan (HHP), minces no words when she says the United States should transition to universal coverage, and HHP, a not-for-profit managed-care Medicaid plan that covers 60,000 members in New York state, should evolve to play a new role.

Universal coverage is inevitable, and it will happen sooner than many people realize, Chapin says. She believes the contrast between the haves and the have nots is disturbing, and that the country's economy depends on everybody having continuous health coverage, similar to Medicare, TRI-CARE and the Veteran's Administration.

"We don't need more programs; we need fewer programs that cover more people," she says. "We don't need more categories of coverage or more limitations on the period of time people can be covered."

Clearly, Chapin is not alone in her belief that universal coverage—in some form—is coming of age in the United States.

■ A national working group created by Congress reported in June that after approaching 50 communities and hearing from 23,000 people, it found

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that Americans want basic health coverage guaranteed by the federal government. The Citizens' Health Care Working Group will present its strategy report to Congress in the fall, although it doesn't answer all the logistical questions of creating universal coverage. Recommendations indicate that funding streams should be based on shared responsibility and draw from enrollee contributions and various taxes.

■ Also in June, the American Medical Assn. (AMA), the nation's largest physician group, voiced its support for mandated national health coverage for those who can afford it and tax credits and subsidies for those who can't to enable them to purchase coverage. This is the first time the AMA has endorsed universal healthcare.

■ With other states eager to follow its lead, Massachusetts is still waiting for health plans to pitch affordable products to ramp up for its 2007 coverage mandate. San Francisco recently approved legislation to cover all uninsured residents, an estimated 82,000 people.

Hot buttons

Chapin wears a button that says, "Cover Everybody!" The buttons also are pinned on anything and everything in her office at HHP headquarters in Tarrytown, N.Y. This word-of-mouth awareness effort was developed under an HHP division called the Hudson Center for Health Equity & Quality (Hcheq) that promotes the delivery of quality care for all. The Cover Everybody Web site gathers news and resources regarding universal coverage and offers buttons like Chapin's to anyone who would like to promote awareness.

"We jokingly call it the 'cult

of Cover Everybody,' but it's hardly a cult, and it's hardly radical," she says. "I think it's amazing that this is considered a radical concept when most of the world covers everybody, and everybody needs to be covered."

She says continuous universal coverage is needed—not just more programs to cover the uninsured—because the longer the United States goes without it, the more likely the country's economy will implode. While the working poor represent many of the uninsured, an increasing segment of middle-class America has joined the ranks. Americans who contribute to society, such as entrepreneurs, freelance writers, artists and small-business owners, for example, are changing not just their lines of work

but their lives specifically because they can't afford the health coverage they need. Even short coverage gaps for those who are changing jobs or moving can result in health decline and higher associated costs.

Some tout consumer-directed healthcare (CDHC) as a solution to make coverage affordable and portable, but Chapin doesn't agree. The value-based decision making process required to make CDHC work is extremely difficult for even savvy consumers to wade through. "If I can't, nobody can," she says. "Physicians are trained for a decade or more, and why would we believe that the average person can make better decisions?"

Universal coverage with contracts among existing managed care organizations is a better, if not inevitable, way to go, she says.

"I don't believe there's any reason why we couldn't have a national healthcare system that contracts with local entities to contract with physicians to make treatment decisions, to manage chronic diseases and acute illnesses...and even pay claims," she says. "I don't see why that isn't completely feasible in the current environment. It's also a way of including insurers in the solution. Clearly you aren't going to achieve anything in this country by putting large insurance companies out of business."

Chapin says the centralized healthcare system with contracted private entities might look like Canada's system, but with HMOs and optional extras. Consumers might have PCPs or medical homes, but they would have the option to purchase extra benefits or added flexibility. The managed care model would remain, and insur-

AT A GLANCE



HUDSON HEALTH PLAN

HEADQUARTERS:
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YEAR FOUNDED: 1985

MEMBERS: 60,000

MARKET SERVED: Westchester, Rockland, Orange, Dutchess, Sullivan, and Ulster Counties, N.Y.

NUMBER OF EMPLOYEES: 280

FINANCIALS: \$130 million in revenues, 2005

PRODUCTS OFFERED: Medicaid Managed Care; Child Health Plus; Family Health Plus

AWARDS:

2006 *Poughkeepsie Journal* Diversity in the Workplace Award; 2005 Advancements in Health Care Award from Hudson Valley Life and Hudson Valley Parent; 2005 Dr. Martin Luther King, Jr. Corporate Award for Diversity from the YWCA of White Plains and Central Westchester; 2003 Community Leadership Award from the New York Health Plan Assn.

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ers would still have a role in the delivery process.

By covering everybody and eliminating the costly, unhealthy gaps in care, the savings gained could be put into more care and better quality. Each year, about 40% of Medicaid managed care beneficiaries lose their coverage because they don't complete the annual recertification process, Chapin says. They're still eligible for Medicaid managed care, but if they fail to file their recertification form, their coverage does not continue. Once they lose coverage, they are more likely to incur the added expense of poor health and increased emergency room use. Continuous coverage, similar to Medicare, would eliminate that costly gap and reduce the administrative costs.

Rather than spending so much time, money and effort on billing disputes and administration among multiple businesses, stakeholders could be concentrating on effective care with universal coverage. Fifteen percent of the health-care dollar goes toward "administrative paper-shuffling," and a single-payer system could reduce that amount significantly just by streamlining the paperwork, according to Chapin.

Making the change

But all the buttons and awareness campaigns in the world won't spark a transition to universal coverage. Something else will have to give first.

While Chapin isn't certain how a radical change in healthcare's status quo will come about, she has a few theories. First, should a major disaster take place that affects health or delivery of care on a national level, it would be a real wake-up call about the need to have healthcare for all, she says.

At a recent Hcheq conference, an emergency physician discussed the triage situation after Hurricane Katrina last year. Typically, after a large-scale disaster, physicians would treat acute injuries,

broken bones, cuts or dehydration. After Katrina, some doctors treated the acute injuries but far more were treating chronic illnesses that hadn't been cared for on a regular basis prior to the hurricane. The historic lack of care for the evacuees became glaringly obvious.

Scale the disaster on the Gulf Coast to encompass the entire nation—a flu pandemic, for example—and it leaves the government in a critical role of organizing and ensuring care for the nation.

Another situation that could press the

country into universal care is simply battle fatigue, Chapin says. She believes there is little leadership in healthcare on a national level, and too many programs compete and conflict. One family in New York state could have four members who qualify for four different New York Medicaid programs, while the father of the family wouldn't qualify for any, she says. Increasingly, more people are finding the complex system unsustainable.

"We don't even realize the consequences our healthcare system has for

"If you consider that the entire insured population supports the care of people who have no insurance, and at a much higher rate, then basically, we are all paying for it anyway."



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the rest of our society," she says. "We have a labor force issue where people are staying in the labor force for longer periods of time because their health insurance needs simply cannot be accommodated any other way."

Young adults have fewer job prospects when established workers stay in the work force longer. This is evidenced by a recent move by some insurers to extend dependent coverage to age 25 or 30, thus acknowledging that young adults are unable to afford and obtain health insurance on their own.

"Our economy in many ways is driven by the decisions we've made about healthcare," Chapin says. Statistics show that the government pays approximately 40% to 50% of the nation's healthcare directly, but there are other indirect costs, such as tax exemptions and subsidies for charity care, that ultimately the government compensates. Insured Americans also subsidize uncompensated care.

"If you consider that the entire insured population supports the care of people who have no insurance, and at a much higher rate, then basically, we are all paying for it anyway," she says. "If I'm uninsured and I cut myself and go to the emergency room and I don't have any money, they are going to stabilize me and treat me. If I come in later with gangrene, then they'll admit me and cut off my leg, then maybe I'll qualify for something. We're paying for that!"

Chapin says universal coverage wouldn't need new money because the money is already in the system. She says the problem is not financial, but ideological. "Nobody benefits from having so many people without coverage," she says.

So then, if Americans are interested in universal coverage, the industry supports it, and the money is already in the system, when will it happen?

"In 1996, I said it would come in 10 years," Chapin says. "We still have four more months." MHE



HHP drives electronic processes for Medicaid managed care

Hudson Health Plan's (HHP) division, the Hudson Center for Health Equity & Quality (Hcheq), raises awareness about the need for quality care and coverage for all and backs up its commitment by driving the region's healthcare IT infrastructure through its own innovations.

HHP's biggest challenge is the Medicaid managed care enrollment and annual recertification process, which is as cumbersome for the MCO as it is for the members. According to HHP's President and CEO Georganne Chapin, the lengthy paper enrollment form is more involved than an annual 1040 tax filing form, and many people make inadvertent errors when filling it out.

To address the problem, HHP recruitment teams walk members through the process to ensure that errors don't cause loss of coverage. They also follow up with a concentrated effort to recertify every eligible member every year through frequent reminders, letters and phone calls.

"[Unfortunately] the default in the system is to leave people without coverage," Chapin says. "We don't default toward assuming people need care; we default toward getting them out if they don't fill in their paperwork or if they don't get their paperwork in on time."

To improve the enrollment process and help members maintain their coverage continuously from year to year, Hcheq created the Facilitated Enrollment Electronic Application (FEEA). The IT application automatically populates redundant data and calculates numeric fields. Plus, the enrollment form can be stored and transmitted electronically.

"We invested in FEEA because we had a huge amount at stake," Chapin says. "We had people out there with big bags of [paperwork]. There were lots of errors and lots of downtime processing applications. FEEA was immediately valuable to us."

Hcheq has made the tool available to all enrollment agencies in New York state and is working with local Medicaid agencies to institute electronic transmission of data in lieu of mailing bundles of paper forms. Just a few weeks ago, Westchester County agreed to consider accepting enrollment forms from HHP in an electronic format, although the specific timeframe has not yet been decided.

—Julie Miller