



Advocacy

ADVISORY

Vol.8 No. 15, October 8, 2008

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HOT TOPICS FOR ADVOCACY IN THIS ISSUE

THIS ISSUE of the Advocacy Advisory will focus on topics of current interest to health care, including ongoing federal and state issues related to patient access, covering the uninsured, and reimbursements. The CHRISTUS position is consistent that health care dollars must be preserved in programs such as Medicare and Medicaid, as both of these programs these serve a vital function as part of the health care safety net for the uninsured and underserved population.

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BOTH CANDIDATES SEEK TO INCREASE HEALTH CARE

John McCain's health plan would reduce the ranks of the uninsured by about 21.1 million people if fully put in place by 2010, while Barack Obama's would reduce the number by 26.6 million, an analysis predicts. Some previous reviews of the presidential candidates' health plans indicated that Republican McCain's proposals would amount to little more than a wash when it comes to the number of uninsured, now at about 45 million. But The Lewin Group, a consulting firm, drew a more optimistic scenario about the overall number of people who would get health coverage under the Republican nominee's plan.

McCain's plan was projected to cost more than \$2 trillion from 2010 through 2019, while Obama's would cost \$1.17 trillion, according to the analysis released Wednesday. Neither candidate provides specifics on how to cover the total. McCain has proposed a tax credit of \$2,500 for individuals or \$5,000 for a family that buys health insurance. The credit would replace the tax break people now get for obtaining health coverage through their work. He also wants to let people shop across state lines when buying insurance; that would bypass states where insurance is more expensive and comprehensive.

The Lewin Group agreed that many workers would lose their employer-sponsored health coverage under McCain's plan. That is because some companies would discontinue coverage if most workers could use the tax credit to get coverage elsewhere. In all, about 16 million would lose coverage, the firm said. Some businesses would begin offering health insurance for the first time, partially offsetting those losses. In particular, companies with younger workers would benefit from McCain's proposal to let them shop in other states, said John Sheils, the firm's senior vice president. They would find that lower premiums made it possible to offer a health insurance benefit. Also, nearly 24 million people would use the tax credits McCain has proposed to buy coverage directly from insurers through the individual market.

Kenneth Thorpe, a professor at Emory University who conducts similar analysis and advice for Democratic candidates' health plans, said he disagreed with the firm's estimate for McCain's plan. More than half of the workers who would lose employer-sponsored coverage have a chronic health condition that would price them out of getting insurance in the individual market. "They pulled the same overestimates for Bush last time with a similar bill," Thorpe said.

About half the uninsured adults are age 19-34. They are the youngest and cheapest to cover, and the ones who generally would gain coverage under McCain's proposal, Sheils said. "The people who are sick are going to have a lot of trouble affording coverage, even with the credit," Sheils said. Sheils said Obama's plan is friendlier to those with chronic health conditions. It will cover about half the uninsured with chronic conditions, such as diabetes. Meanwhile, McCain's plan will cover about a quarter of the uninsured with a chronic condition. Obama's plan would expand health insurance coverage through public programs such as Medicaid and the State Children's Health Insurance Program. He requires all children to have health coverage. In all, about 16 million people would gain coverage through those programs. An additional 10 million would use government subsidies to buy insurance coverage.

Neera Tanden, domestic policy director for the Obama campaign, disputed several aspects of the report. In particular, she said gains in coverage under Obama's plan would come primarily from people using the tax credit to buy private insurance, not through the expansion of Medicaid and SCHIP.

Source: Associated Press, 10/8/08.

MEDICARE DRUG OPTIONS SHRINK FOR LOW-INCOME POPULATIONS

Low-income beneficiaries in Medicare's prescription drug program have fewer plans to choose from next year in every state except Wisconsin, raising concerns among advocates that millions will be forced to change plans — and may find skimpier coverage. An analysis out this week by Avalere Health, a for-profit research firm in Washington, found 308 stand-alone drug plans nationwide next year eligible to serve low-income residents, down about 200 from this year. Those beneficiaries are subsidized by the government. They pay little or no

monthly premiums and generally have lower out-of-pocket costs, called deductibles, for drugs than do higher-income policyholders. Avalere estimates 1.3 million low-income beneficiaries will be reassigned to new coverage, up from 1.2 million in 2008 and 250,000 in 2007.

To serve low-income Medicare members, insurers must keep their premiums below a government-set median benchmark. Many insurers raised their premiums overall for next year, so they no longer qualify to offer the low-income coverage but will still offer policies to higher-income Medicare members. One large insurer, Humana, which this year offered low-income coverage in 43 states, won't have any eligible low-income plans next year. Cigna, another large insurer, will drop from low-income coverage in 29 states to 14, according to the analysis. Bucking the trend is UnitedHealth, whose partner is AARP. Next year United will boost low-income coverage to 42 states, up from 30. The changes mean low-income residents of Nevada will have only one stand-alone drug plan. Arizona residents will have two. Four other states — Florida, Hawaii, Maine and New Hampshire — will have five or fewer.

Source: Gannett News Service, 10/7/08.

CENSUS BUREAU EXAMINES DEMOGRAPHICS OF UNINSURED

A new report from the United States Census Bureau provides a detailed analysis of the uninsured population in the U.S., providing breakdowns by state, county, and demographic groups. For the study, researchers at the bureau's Small Area Health Insurance Estimates division used 2005 data from all states across gender, age and income. The report is the most wide-ranging estimate the Census Bureau has published on the rates of uninsured U.S. residents. According to the report, about 16% of U.S. residents did not have health insurance in 2005. Nationally, Minnesota and Hawaii had the lowest uninsured rates in 2005 at 9.5% and 9.7%, respectively, followed by Wisconsin at 10.3%. The study also found Florida, New Mexico and Texas had the three highest rates of uninsured residents younger than age 65. In addition, the report found that states have wide variances between racial-ethnic groups. Mississippi and Texas had greater shares of uninsured Hispanic residents, while Montana and Oklahoma had higher rates of uninsured white residents. The Census Bureau noted that previous data gathered in 2000 were not applicable because the researchers used a different method to gather the data in 2005.

Source: Kaiser Daily Health Policy Report, 10/8/08.

MEDPAC EXAMINES FACTORS CONTRIBUTING TO HEALTH CARE SPENDING GROWTH

The Medicare Payment Advisory Commission last week examined some of the factors contributing to U.S. health care spending growth. According to the briefing papers presented by two staffers, overall health care spending between 1999 and 2008 increased by 50%, compared with 20% in other economic sectors, the staffers said, while health care sector construction spending rose slightly more than 50%, compared with less than 20% in other sectors. Imaging centers and home health care both experienced the largest employment growths at 50% each, compared to a 25% growth in overall health care employment and 5% in other sectors.

MedPAC Vice-Chair Robert Reischauer said that while the data presented at the meeting was very interesting, he noted it did not give enough information about what was or was not sustainable, expressing concern about how Congress and the public would receive the data and whether the information would divert attention away from necessary U.S. health care policy changes.

Commission Executive Mark Miller said that commissioners also should focus on the benefits of construction spending in the health care sector and whether they meet the objectives proposed by policy analysts. Miller asked, "Thirty billion [dollars] was spent last year on construction -- how much of that went to mental health, how much of that went to manage diabetes, how much of that went for IT?" He said answers to such questions are needed to develop better health care policy.

Source: Congressional Quarterly Health Beat, 10/7/08.

FINANCIAL TROUBLES LEADING MANY TO FORGO MENTAL HEALTH CARE

Psychiatrists and psychologists nationwide say they are seeing more patients limiting mental health treatments to save money amid broad financial concerns, according to a report released recently by the *Wall Street Journal*. Patients reduce costs by limiting the length of therapy sessions, calling doctors rather than making in-person appointments, attempting to negotiate reduced fees or reducing their medications' dosage to make them last longer. The trend of limiting psychological care comes amid a broader trend of people limiting their spending on overall health care. However, previous studies have found that in times of economic crisis -- during which people lose their jobs and subsequently their health insurance -- people tend to "more readily" decrease the amount of mental health care they receive, often with harmful consequences. The studies also found that hospitalizations for mental illnesses and suicides also increase when the economy falters, as people put off treatment.

More than half of U.S. residents report negative health effects from increased stress related to concerns about the economy, according to a poll by the American Psychological Association. The poll surveyed 1,791 adults in August and found that 80% of respondents named the economy as their top stressor and that 46% are worried about their ability to provide for their family.

Source: *Kaiser Daily Health Policy Report*, 10/8/08.

SCIENTISTS EXPLORE NEW SOURCES OF STEM CELLS

Scientists have converted cells from human testes into stem cells that grew into muscle, nerve cells and other kinds of tissue, according to a study published this week. The stem cells offer another potential alternative to embryonic stem cells for researchers who aim to treat diseases such as diabetes and Parkinson's by replacing damaged or malfunctioning cells with custom-grown replacements. Scientists have also derived flexible adult stem cells from skin, amniotic fluid and menstrual blood. The new cells were created from sperm-making cells obtained from testicular biopsies of 22 men. They are theoretically superior to traditional embryonic stem cells because they can be obtained directly from male patients and used to grow replacement tissue that their bodies won't reject, Sabine Conrad of the University of Tuebingen in Germany and her colleagues wrote. The cells also have an ethical advantage in that they do not require the destruction of human embryos.

Experiments in mice suggested that reproductive cells -- also known as germ cells -- were good candidates for making stem cells because they naturally express low levels of the "pluripotency" genes that make embryonic stem cells so versatile, said Renee A. Reijo Pera, director of the Center for Human Embryonic Stem Cell Research and Education at Stanford University, who was not involved in the study.

The German researchers obtained biopsy samples from men between the ages of 17 and 81. They extracted the individual testicular cells and grew them in laboratory dishes. After about three weeks, some of the cells formed colonies resembling embryonic stem cells, the team reported. The so-called germ line stem cells grew nearly as fast as embryonic stem cells and produced many of the specialized protein markers associated with embryonic stem cells. Cells from eight of the patients were injected into mice, where they grew into jumbles of tissue that included cartilage, muscle, nerve cells and other building blocks of glands and internal organs, according to the study.

Source: *The Associated Press*, 10/9/08.

Of Physician Interest

CMS OFFICIALS URGE ADOPTION OF E-PRESCRIBING

Officials with the Centers for Medicare and Medicaid Services (CMS) appealed to more than 1,400 health care industry officials and professionals this week at the agency-sponsored National E-prescribing Conference in Boston to adopt electronic prescribing technology as a way to improve the U.S. health care system. Many observers believe the medical community will be divided in their response to a federal e-prescribing incentive program scheduled to begin January 1, which was included in the recently passed Medicare law. Under the law, physicians who adopt e-prescribing technology in 2009 and 2010 will receive a 2% bonus in their Medicare payments; those who use the technology in 2011 and 2012 will receive a 1% bonus; and those who use it in 2013 will receive a 0.5% bonus. Medicare payments for physicians who do not use the technology will be reduced by 1% in 2012, 1.5% in 2013 and 2% in 2014. Some health care providers will be exempt from the requirements.

Health and Human Services Secretary Michael Leavitt said, "We need the health care system to get better, and e-prescribing is the next logical step." CMS acting Administrator Kerry Weems said the government has yet to determine a preferred e-prescribing vendor. Weems said, "We've kept it vendor-neutral," adding, "We said, 'Let's have standards and let the market dictate who meets them.'"

Source: Kaiser Daily Health Policy Report, 10/8/08.

Of Regional Interest

ARKANSAS

State's Revenue Falling Behind Medicaid Long Term Care Costs. Long-term-care costs for state Medicaid programs are expected to grow faster than overall health spending and states' revenues in the next 20 years, according to a report by the health insurance industry. "States will have a difficult time paying for both Medicaid and other priority areas such as education, criminal justice and transportation," Daniel I. Shostak, a co-author of the report, said in a call with reporters last week. Nationwide, long-term expenses — such as for nursing home and at-home care — paid by the states are expected to total \$ 1. 6 trillion for the next 20 years, according to the report by America's Health Insurance Plans, an association that represents about 1,300 companies that provide health insurance coverage to more than 200 million Americans. Combined with federal Medicaid dollars, the amount is forecast at more than \$ 3.7 trillion. The numbers are in 2008 dollars. On an inflation-adjusted basis, states' spending on such care is expected to grow 4. 1 percent annually from 2008 through 2027, compared with 4.3 percent between 1995 and 2007. The authors did not project the growth of state revenues, but — based on historical patterns — expect they will be slower than the growth of long term care costs.

For example, Arkansas' share of long-term care expenses paid by Medicaid rose an average of 5. 8 percent a year from 1995 to 2008, while overall state revenue grew by 4.7 percent a year during that period, according to data provided by Shostak. Unlike other figures in the report, those were not adjusted for inflation. Experts say the increasing number of baby boomers reaching retirement age and expensive new technologies are sending costs upward. The report was written in anticipation of possible changes in health-care policy under a new Congress and president in 2009 and to inform people of possible strains on Medicaid, Karen Ignagni, president and chief executive officer of the insurance association, said in the call with reporters. Medicaid is a program for low-income Americans funded by state and federal sources. The program pays about 49 percent of all long-term-care costs nationwide.

In Arkansas, the state provides 27 percent of Medicaid funding, while the rest is federal money. Although it was designed for poor people, Medicaid has become the “de facto insurer for millions of middle-class Americans” who need long-term care, the report said.
Source: Arkansas Democrat Gazette, 10/8/08.

LOUISIANA

Deeper Budget Cuts Possible. The cuts needed to balance the budget in the state’s Medicaid program will be deeper if lawmakers continue to delay voting on how to fill the \$81 million gap, the state’s health care secretary Alan Levine said this week. He said the effect of budget cuts worsen as the fiscal year progresses because he will have a shorter time period during which to shrink spending. Lawmakers who must approve a deficit reduction plan have delayed voted twice on Levine’s budget-cutting proposal, amid opposition from health care providers. Lawmakers on a budget subcommittee are questioning why Levine would bring the deficit projections so soon after the fiscal year, with less than a quarter’s worth of data to back up his estimates. Rep. Jim Fannin (D-Jonesboro) chairman of the House Appropriations Committee, asked why Levine didn’t wait to present the deficit figures along with a plan for cuts in November, the month the Medicaid deficits were outlined in recent years. The health secretary said he and the Legislature knew the agency would be underfunded when lawmakers didn’t allocate the money he requested to continue ongoing services this year. “Everybody knew when the budget was passed, we passed a deficit budget. I think we are trying to be prudent by giving you the information as early as possible,” Levine said. “Had I waited longer, I think there would have been an equally angry number of people asking, “Why did you wait so long?”

To fill much of the gap, Levine suggested shifting \$65 million from other parts of the health care budget that were not expected to be spent this year. He recommended the final \$16 million be filled with reductions to private and community hospitals and hospices. Specifically, Levine proposed cutting the room and board rates Medicaid pays to hospice providers for patient they care for in nursing homes. The larger adjustment involves changing how Medicaid pays hospitals for inpatient admissions, to update 1995 criteria to present-day standards.

Source: The Associated Press, 10/7/08.

NEW MEXICO

Bond Issues Will Benefit Health Care and Higher Education. Two bond proposals, which would provide funds for institutions of higher education and healthcare facilities in New Mexico, will be included on the November ballot. The General Obligation Bond for Education, or Bond D, is placed on the ballot every two years and the 2008 cycle proposes allocating nearly \$140 million for capital improvements to New Mexico higher education institutions and Constitutional Special Schools. This bond proposal was formerly known as Bond B and its position on the ballot has been moved to D for the 2008 election. Under Bond D, New Mexico State University - Grants will receive \$1 million for capital improvements, including renovation and expansion. If the bond measure is approved, the branch campus will use the funds to stucco and weatherize the exteriors of both the McClure and Fidel buildings and to undertake a major renovation of the library. Other higher education institutions to receive funds under the bond measure include the University of New Mexico, Central New Mexico Community College, Eastern New Mexico University, and New Mexico Military Institute, NMSU's main campus in Las Cruces and branches in Eddy, Otero as well as Cibola County. Also included are Western New Mexico University, New Mexico Junior College, Mesalands Community College, Northern New Mexico College, Eastern New Mexico Community College, Luna Community College, New Mexico Highlands University, the Institute of American Indian Arts, Santa Fe Community College, New Mexico School for the Deaf, New Mexico Institute of Mining and Technology, New Mexico Institute of Mining and Technology and UNM campuses in Taos and Gallup as well as Albuquerque. The total amount of \$140 million would be raised by passage of Bond D.

Bond C would finance capital improvements to healthcare and research facilities in the amount of \$57.8 million. Projects include new facilities for the UNM dental residency program and construct the cancer research and cancer treatment center at the health sciences center. Also planned is a health sciences center neuroscience research building for the UNM campus. Other projects, which could be funded by the bond funds, include regional health centers and public health offices throughout the state. These General Obligation Bonds would be funded by property taxes collected by the state. A property assessed at \$100,000 would be taxed on an average of \$4.04 per year in property taxes for Bond C and \$9.77 per year for Bond D.

Source: The Associated Press, 10/8/08.

OKLAHOMA

Parents' Status Tied to Health of Children. The mortality rate for infants of Oklahoma high school dropouts is nearly double the rate for children of mothers who completed college, a new national study states. Released by the nonprofit Robert Wood Johnson Foundation, the study is the first of its kind to link child health to a parent's income and educational level, said Dr. Paula Braveman, one of the study's authors. "What may be most startling to people is that middle-class children also fare worse than children in wealthy families," she said during a media teleconference this week. Overall, the general health of Oklahoma children in every income or education group did not meet the national benchmark, the report said. According to the report, nearly half of Oklahoma children live in poor or near-poor households. A third live in middle-income households, and one-fifth live in high-income households, the report said. Oklahoma was ranked as having the 40th-largest gap in the country between infant mortality and the mother's education. In other words, the state's infant mortality rate among the least-educated mothers is 7.6 deaths per 1,000 live births, higher than the 4.7 deaths per 1,000 live births among the most-educated mothers, the report said. The national benchmark is 3.2 deaths per 1,000 live births, it said.

Oklahoma ranked as having the 34th-largest gap between child health and family income among states. Among lower-income Oklahoma families, 13.7 percent of children have lower than optimal health, while 5.3 percent of children in higher-income families have less than optimal health, the report said. One-third of children in Oklahoma live in households where no one has education beyond high school. An additional 36 percent of children live with at least one person who has attended but not completed college, and 31 percent live with at least one college graduate, the report said. Income is often linked with quality of housing and neighborhood and the ability to afford a healthy diet.

Source: Tulsa World, 10/9/08.

TEXAS

Texas Uninsured Statistics Staggering. About one in six people living in the U.S. under the age of 65 had no health insurance in 2005, but closer to 1 in 3 Hispanics were uninsured, newly released data from the U.S. Census Bureau confirms. Roughly one in four people living in Florida, Texas, and New Mexico lacked health insurance, while only one in 10 of those living in Minnesota and Hawaii were without coverage. The new report includes some of the most detailed estimates ever of health insurance coverage rates by state and county. Insurance coverage was broken down by race, and the data showed that Hispanics were far less likely to have health insurance than African-Americans and whites. In Texas, 40.5% of Hispanics under age 65 had no health insurance, compared with 24.3% of blacks and 15.8% of whites. Almost 40% of Hispanics living in Arkansas, Florida, Louisiana, Mississippi, Montana, Oklahoma, Oregon, and South Carolina also had no health insurance. Texas had the highest percentage of uninsured residents under the age of 65, with 26.3% of the population lacking health coverage, followed by New Mexico, with 24.2% and Florida with 24.0%.

Source: The Associated Press, 10/9/08.

UTAH

Utah Has Second Lowest Infant Mortality Rate. A new report from the Robert Wood Johnson Foundation says Utah has the nation's second lowest infant mortality rate. Utah is second only to Maine for infant deaths, with an overall average of about 5.1 deaths for every 1,000 babies born. "Utah, by almost any measure, is a pretty great place for kids, and the fact that we have such a low infant mortality rate is a good thing," Karen Crompton, executive director with Voices for Utah Children, said. But some of the numbers are troubling to Crompton. When the mother hasn't finished high school the mortality rate jumps to nearly eight deaths per 1,000. Crompton says education is part of it, but the underlying issue is poverty, which means Utah has some work to do to make sure all kids get a fair chance at life. Crompton says we need to start earlier in life to give the disadvantaged a fair shake. "By the time a child is three years old, 80 percent of its brain has been formed. And yet from birth to three, we invest almost nothing as a state or a country in those children," she said. Crompton also said, "It goes back to other studies that have been done that show poverty is the greatest negative predictor of outcomes for kids." Crompton says poverty is not something that can be fixed overnight. But she says there are some things that will help in the short term, starting from early childhood with educational programs and children's health insurance right on up to providing resources to young mothers.
Source: Deseret News, 10/8/08.

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