Advocacy

Advisory

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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.

Putting Care Within Reach:

As one of the largest Catholic health care systems in the United States and because of our solid reputation among policymakers at all levels of government, CHRISTUS Health is uniquely positioned to lead in the effort to achieve meaningful and significant health care reform for this nation. Our efforts will be targeted at achieving objectives in support of the goal of universal coverage, and will include continuing to build effective relationships with legislators and members of the new Obama administration, equipping CHRISTUS leadership and associates with the tools needed to engage and participate in this important national debate, and working to build consensus and collaboration among other health care providers.

The national political scene promises change in 2009 and early indicators are that it will be a favorable time in which to work to achieve our goals. However, there remain significant challenges that CHRISTUS will work to help overcome as a primary feature of our campaign of **"Putting Care Within Reach."** Success will require a profound commitment at every level of CHRISTUS Health, as we all work together in our individual communities and on a system-wide basis to promote a message of hope, change, and quality health care for every American.

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SENATE FINANCE WANTS SCHIP IN STIMULUS PACKAGE

Tacking two costly healthcare items onto the economic stimulus package can help clear the path for comprehensive healthcare reform; Senate Finance Committee Chairman Max Baucus (D-MT) said this week. Congress should include a short-term reauthorization of the State Children's Health Insurance Program (SCHIP) in the stimulus package, Baucus said, in addition to $50 billion that President-elect Obama is seeking for health information technology funding. Baucus said including those two items in the economic stimulus would help avoid a fight on healthcare early next year when lawmakers are drafting broader healthcare legislation.
Moving SCHIP in the stimulus would give Congress more time to advance the comprehensive health reform bill, which would include a long-term expansion of the popular children's program, Baucus said. Also, funding health IT in the stimulus will reduce the price tag of the eventual reform bill, he contended. The size of that price tag for health reform will go a long way to determining whether it succeeds. Dumping some of those costs into the stimulus bill will make Baucus' job easier down the road — particularly since Congress is expected to set aside its pay-as-you-go budget rules and not fully offset the cost of the stimulus, Baucus said.

"There are going to be certain costs of healthcare reform — upfront costs," Baucus said. "If I can put some of those upfront costs in the so-called stimulus bill, I'd rather put them there." Though Baucus' advocacy for the health IT spending is consistent with the economic agenda outlined by Obama on Saturday, the SCHIP strategy appears to diverge from the plans outlined by other senior Democrats.
House Speaker Nancy Pelosi (D-Calif.) and members of the Obama team, for one, want to pass a large-scale SCHIP expansion early next year as one of a handful of moves designed to allow Obama to claim some immediate accomplishments on popular issues.

SCHIP must be reauthorized by March 31 or it will shut down. Congress and the Bush administration failed to come to agreement on reauthorizing and expanding the program in 2007, leading the Democratic leadership to punt the matter to the next administration. Baucus indicated that he does not want Congress to get bogged down in a partisan fight over the SCHIP bill before it even gets to the bigger health reform effort. Though he declined to say how long the short-term SCHIP measure in the stimulus should be, he said he wanted it to be "of sufficient duration to fold [a long-term reauthorization] into healthcare reform." In an effort parallel to work being done by Senate Health, Education, Labor and Pensions Committee Chairman Edward Kennedy (D-MA) and the Obama transition team, Baucus is working on broader health reform legislation that he expects to introduce "near the first of the year."

"We've got to create a very significant upfront effort early on and keeps the momentum going on healthcare," said Baucus, who added he was in regular contact with the Obama team, Kennedy and other key lawmakers.
Source: The Hill, 12/10/08.

DASCHLE NAMED TO TOP HEALTH CARE POST

In selecting Tom Daschle to be his health and human services secretary, President-elect Barack Obama said this week that he wanted Mr. Daschle, a former South Dakota senator, to pursue something that had eluded federal officials for decades: securing "affordable, accessible health care for every single American." Mr. Obama said Mr. Daschle, as head of the new office, would be the "lead architect" of proposals to expand coverage and rein in health costs. Jeanne M. Lambert, a former aide to President Bill Clinton, will be deputy director of the office.

Mr. Daschle is well versed in health policy and Senate procedure. However, some observers believe that two of his ideas could reignite the kind of ideological warfare that sidetracked health care proposals in the past. He wants to establish a Federal Health Board, a powerful independent entity modeled on the Federal Reserve, to decide which drugs, devices and treatments are covered by federal health programs. Also, he says the federal government should offer its own health insurance plan, to compete directly with private plans, a proposal that alarms many insurers and Republican members of Congress.

By giving Mr. Daschle double duty, Mr. Obama hopes to avoid a problem that contributed to the collapse of Mr. Clinton's campaign for universal coverage in 1993-94. Donna E. Shalala, who was then health and human services secretary and the experts in her department often had to take a back seat to Ira C. Magazine, the health policy coordinator at the White House.

A major health care initiative "has to be intimately woven into our overall economic recovery plan," Mr. Obama said, adding: "It's not something that we can put off because we are in an emergency. This is part of the emergency." Mr. Daschle echoed that sense of urgency. "Our growing costs are unsustainable," he said, "and the plight of the uninsured is unconscionable."

With a larger majority in Congress, Democrats are increasingly optimistic that they can realize their dream of affordable health care for all next year. Mr. Daschle brings a kind of moral passion to the campaign for more coverage. Health care, he says, is rationed on "the worst possible criteria: one's ability to pay or one's health condition." Daschle said his proposal to establish a Federal Health Board could "reduce or deny payment for new drugs and procedures that aren't as effective as current ones." He predicts that such decisions will "rankle powerful interest groups, such as drug manufacturers." Critics say the board would be picking winners and losers among makers of drugs and medical devices.

The board could have a "spillover effect" in the private sector, Mr. Daschle said. Private insurers already follow many of Medicare's coverage decisions. He said Congress could go further and link tax breaks for private insurance to compliance with the board's recommendations — giving the government far more influence than it now has. Mr. Obama said the idea of a Federal Health Board "holds great promise" for bridging ideological divisions. In his book "Critical," Mr. Daschle said that people without job-based insurance should be able to enroll in any of the health plans offered to federal employees, or in a new "government-run insurance program modeled after Medicare." Democrats said that private insurers would hold down costs and improve care if they had to compete with a public plan. However, Republicans said a government plan would have unfair advantages and could drive private insurers from the market. Still, many watchers believe that the prospects for major health care reform are better now than ever before.

Daschle was in the Senate for 18 years — 10 as Democratic leader — before he was defeated in 2004 by a Republican who said Mr. Daschle had become a creature of Washington. Since then, he has worked as an adviser at a Washington law and lobbying firm, pursued his interest in health policy, stayed active in Democratic politics and kept an office at a liberal research and policy institute, the Center for American Progress. Even though he was not a registered lobbyist, Mr. Daschle advised many health care companies and other corporations for which his firm lobbied. Some consumer groups said the choice of Mr. Daschle appeared to violate the spirit of Mr. Obama's promise to minimize the role of special interests.
Source: New York Times, 12/11/08.

MEDICARE ADVANTAGE PLANS POST HIGHER THAN EXPECTED PROFITS

Insurers offering Medicare Advantage plans made $1.3 billion more in profit in 2006 than projected, according to a Government Accountability Office report released this week. The federal government bases its payment rates for MA plans partly on the plans' anticipated revenue and expenses. The report looked at the MA program for 2006, the most recent year for which data are available. MA insurers reported $50 billion in revenue that year. On average, insurers earned profits of 6.6%, compared with the 4.1% they had projected. They also spent 83.3% of revenue on medical expenses, compared with the nearly 87% that was projected.

House Ways and Means Health Subcommittee Chair Pete Stark (D-CA) -- who requested the analysis -- said that the federal government spends on average 13% more on MA plans than traditional Medicare. The GAO report "puts to bed this idea [that] the plans are offering tremendous extra benefits with the overpayments," he said, adding, "The overpayments are going to profits." He said he plans to push for legislation next year that would lower the federal government's payments to MA plans. Federal officials said that the profits are within the normal range, given the difficulty in forecasting medical trends and spending. Jeff Nelligan, spokesperson for CMS, said, "The goal of the payment structure, as mandated by Congress, was to ensure broader access to MA plans, particularly for lower-income, minority and rural beneficiaries"
Source: Kaiser Daily Health Policy Report, 12/11/08.

STUDY SHOWS IMPACT OF INADEQUATE REIMBURSEMENTS

Medicare and Medicaid underpay hospitals and physicians by $88.8 billion annually, forcing providers to charge private insurers more for their service and in turn driving up premium costs for employers and workers, according to a study sponsored by hospital and insurer groups. The study was commissioned by America's Health Insurance Plans, the American Hospital Association and the BlueCross BlueShield Association. The study, conducted by Milliman, found that higher costs charged by providers to commercial insurers increased average premiums by 10.6%, or $1,512, for a family of four, of which employers paid $1,115 and workers paid $397. The study also found that hospitals in 2006 recorded margins of 23.1% for privately insured patients, compared with a loss of 10.8% for Medicare and Medicaid patients. In 1996, hospitals earned 14.1% from commercially insured patients and 0.2% from publicly insured patients, Milliman actuary John Pickering said.

Milliman said eliminating the payment inequalities would reduce medical expenses for people with private insurance by 15%, assuming no change in total revenue for providers. The study said that Congress could correct the problem by increasing funding to Medicare and Medicaid by $90 billion annually. However, the study's sponsors stopped short of recommending raising spending by that amount. "Our first major objective is to make sure there aren't major cuts in these programs," AHA President Richard Umbdenstock said. The study's findings were endorsed by the U.S. Chamber of Commerce, which said President-elect Barack Obama's administration must address the underfunding as part of its efforts to overhaul the health care system.
Source: CQ Healthbeat, 12/9/08.

CONGRESSIONAL LEADERSHIP DISCUSS MEDICARE PAYMENT FIX

Senate and House leaders and committee staffers have been discussing with members of President-elect Barack Obama's health care team the possibility of cutting $100 billion from the cost of permanently fixing Medicare physician payments by eliminating from the payment formula drugs administered by doctors. Under the sustainable growth rate formula, physicians face a Medicare payment reduction annually, but Congress typically passes a measure to avoid the cut. However, lawmakers next year hope to permanently eliminate the cuts, possibly by rebasing the SGR formula. The plan currently being touted by lawmakers would remove the cost of physician-administered drugs from SGR -- a change long-supported by doctor groups -- and save Congress the task of finding a way to pay for the move. Removing physician-administered drugs from SGR would reduce the estimated $300 billion cost of permanently forgoing physician cuts by one-third. According to sources familiar with the issue, the best way to remove the drugs from the formula would be either by executive order or a CMS rule. Congress plans to address the fix as part of an effort aimed at overhauling the health insurance system next year. A spokesperson for House Majority Leader Steny Hoyer (D-MD) said, "With physicians facing an approximate 20% cut in reimbursements in 2010, it is clear that substantial reforms of Medicare payment policy are needed," adding, "We look forward to working with the Obama administration to develop policy that would yield such reform." Senate Finance Committee Chair Max Baucus (D-MT) in a white paper detailing his comprehensive health care proposal last month also proposed removing the drugs from SGR.
Source: Congress Daily, 12/9/08.

Of Physician Interest

SHORTAGE IN PRIMARY CARE WORSENING

In the last several months there have been reports in medical journals about an impending shortage of primary care physicians. This spring in the health policy journal *Health Affairs*, researchers at the University of Missouri-Columbia and the Department of Health and Human Services published a study that projected a generalist physician shortage of 35,000 to 44,000 by the year 2025. The researchers based their figures on current physician usage patterns and did not take into account increases that might occur because of rising access to health care. The news got worse in September, when The *Journal of the American Medical Association* published a study showing that just 2 percent of graduating medical students are choosing to enter general internal medicine. The students surveyed were concerned in part by what they perceived to be a more difficult personal and professional lifestyle, compared with other fields. They felt that the paperwork and charting required of primary care physicians were more onerous, and they were not eager to care for the chronically ill in a health care system that focuses on acute care. The potentially devastating public health implications of both of these reports rippled out into the medical community. Last month in an official statement, the American Medical Association moved to support financial incentives for medical students who choose to go into primary care.
What are the consequences of these projected shortages for patients? According to the *Health Affairs* report, there are about 75 generalist physicians for every 100,000 individuals. By 2025, when the population will have grown by 18 percent and the number of individuals over age 65 by 73 percent, either primary care doctors will be seeing many more patients than they do now, or several million people will be without a primary care doctor, no matter how accessible health care might be for the rest.
Source: New York Times, 12/11/08.

Of Regional Interest

ARKANSAS

Better Care Sought for Children. Arkansas' 69, 000 uninsured children face several major hurdles in gaining access to health care, particularly through the state's Medicaid program for youngsters, health advocates say. For one thing, two-thirds of that group are eligible for ARKids First, but for whatever reason haven't signed up. For the rest, they face hurdles to getting the coverage or finding doctors who accept it. A three-pronged approach is needed, said Elisabeth Wright Burak, health policy director for Arkansas Advocates for Children and Families, during a forum held last week in Fayetteville. Therefore, the group's Arkansas Finish Line Coalition initiative first will seek broader access to ARKids First, the children's Medicaid program in Arkansas. "Medical bills are a leading cause of bankruptcy for families," Burak said during the health forum, which drew roughly 85 people to the Reynolds Boys and Girls Club in Fayetteville. Families shouldn't have to choose between buying groceries and other basic necessities and paying for uninsured medical costs, she added. The group is calling for an expansion of ARKids First coverage among those currently eligible, loosening the eligibility requirements themselves as other states have done, and allowing middle-income families who aren't eligible to buy into the coverage. Of that 69, 000 uninsured, an estimated 46, 000, or roughly two-thirds, are eligible for ARKids First coverage but for some reason don't have it, Burak said. Another panelist, Dr. Eduardo R. Ochoa Jr., a general pediatrician at Arkansas Children's Hospital, said he sees a need to get parents who lack documentation to prove they're legal U. S. residents to sign up their children, who were born in this country and thus are legal U. S. citizens. "We do need to do a better job of covering kids who are eligible," said Ochoa, who is also assistant dean

of minority affairs for the College of Public Health at the University of Arkansas for Medical Sciences and president of the state chapter of the American Academy of Pediatricians. Second, Arkansas Advocates wants to raise the state's eligibility from 200 percent of the federal poverty level, or $ 42, 500 annual incomes for a family of four, to 300 percent of the level, or $ 63, 600 for four.

At least 20 other states have expanded eligibility by raising the family income limit, Burak said, adding this includes some adjacent states such as Missouri, Tennessee and Louisiana. The third goal of the group is providing another way into the program for families whose incomes are too high to meet its eligibility criteria. But even if the group accomplishes all three goals, there will still be ARKids First recipients who lack primary care physicians, at least until the state's medical school, UAMS, can make headway on its current plan to educate and graduate more medical doctors, the panelists said. The doctor shortage means not all card-carrying ARKids First recipients can find a primary physician who is still accepting Medicaid patients. Burak said her group is seeing this problem in central and northeast Arkansas, but that it's more severe in Washington and Benton counties. It was estimated in 2005 those two Northwest Arkansas counties had between 6, 000 and 7, 000 ARKids First children who lacked a primary doctor, said another panelist, Kathy Grisham of Community Clinic at St. Francis House in Springdale. Before Community Clinic became a federally qualified health center in 2005, it wasn't seeing any ARKids First children for general medical care, Grisham said, adding that it only treated children under the ARKids coverage's dental provisions. That changed with its new status, which in part allowed it to seek federal grants. The Arkansas Advocates forum was hosted by the Northwest Arkansas Hometown Health Improvement Project, a coalition of health agencies and medical providers. The Fayetteville forum was one of seven the group is holding across the state, the others being in West Memphis, Jonesboro, Little Rock, Mena, Russellville and El Dorado.

Source: Arkansas Democrat Gazette, 12/4/08.

LOUISIANA

Louisiana Medicaid Spending Close to Reaching Maximum. Louisiana Medicaid spending soon will outpace education, law enforcement, infrastructure and other state budget items if growth of the program is not contained, state Department of Health and Hospitals Secretary Alan Levine said last week at the annual meeting of the Council for A Better Louisiana. Medicaid provides health coverage for about 25% of the state's residents. Furthermore, Louisiana currently spends 16% of state revenue on Medicaid, up from 10% in 2004, and it is expected to account for 21.5% of state revenue spending by 2011, Levine said. He said that the federal government is projecting an 8% annual Medicaid growth rate in the future, which means next year the state will need an additional $450 million in state and federal funding to sustain the program at current levels. In addition, Louisiana is within $50 million to $70 million of reaching the $1.5 billion limit for federal participation of uninsured care costs, after which the state must pay 100% of the cost, he said. Based on the estimated growth in uninsured care, the state would have to raise $300 million to $600 million annually in addition to the normal Medicaid program growth if the cap is reached, according to Levine. Levine touted Gov. Bobby Jindal's (R) Medicaid overhaul plan -- which would change the way that providers are reimbursed and create incentives for improving health and penalties for deficiencies -- as the solution to curb spending in the program.

Source: Baton Rouge Advocate, 12/8/08.

NEW MEXICO

Report Card Gives New Mexico Failing Grade in Emergency Care. New Mexico is failing to provide sufficient access to emergency health care at a time when more people are losing jobs in the faltering national economy, according to a national report card on the state of emergency medicine. The state ranked 49th in the nation in access to emergency care and received an F on the report card released Tuesday by the American College of Emergency Physicians. The access category was the most important of five in the organization's study, which did not measure care in individual emergency rooms, but rather government support for that care.

Overall, the organization gave New Mexico a D for support of emergency health care, also ranking the state 49th. Massachusetts earned the highest grade, B, while Arkansas, with D-minus, ranked last among the 50 states and the District of Columbia. Some 22 percent to 24 percent of New Mexicans lack health insurance, according to different studies, but Dr. Alfredo Vigil, the state's health secretary, said 30 percent to 35 percent of people seen in emergency rooms don't have insurance. "The financial burden of that care is massive," said Vigil, who also noted that for the most part, health care in America is in the hands of private business, both for-profit and nonprofit. The study also recorded New Mexico's high rates of uninsured residents as well as its shortage of nurses and specialists. It said the state has one of the highest uninsured populations in the country, with 24.8 percent of adults and 17.9 percent of children lacking health insurance. The state ranks 50th in registered nurses - a category which has gotten worse since the last report in 2006. It faces a shortage of neurosurgeons, ranking 49th nationally per capita; ear, nose and throat specialists (45th); plastic surgeons (38th); and orthopedists and hand surgeons (35th). New Mexico ranks 43rd in the number of staffed inpatient beds and last for pediatric specialty centers. Vigil said the report held no surprises and that he hopes it helps raise awareness among citizens, legislators and members of Congress about the seriousness of the problem.
Source: Associated Press, 12/9/08.

OKLAHOMA

Proposal to Self-Fund Health Care Getting Attention. Oklahoma has about 600,000 uninsured people and the number is increasing. According to Oklahoma Healthcare Recovery Act research in 2003, the estimated negative economic impact on the state was well over $6.1 billion in unrealized income and business activity with 55,000 unrealized jobs and $816 million in unrealized federal dollars. State hard dollar costs are $1 billion plus. It is a safe bet the numbers have gone up. Insure Oklahoma is working but only 15,000 have been covered. Business owners need affordable options for insuring their work force. Providers need help in cost reimbursement for uninsured who cannot pay. The strain on a fragile economy is huge. The cost of a shared payer plan — state, federal, employer and insured — for 200,000 is $400 million. A comprehensive solution is difficult, but some are pushing the state to consider a self-funded plan with indigent care reserve. Large companies self-fund massive health care plans. Businesses with more than 200 employees realize cost benefits by self-funding. Premiums paid to insurers can be premiums lost. By self-funding, an employer avoids premiums and shoulders the risk of paying insurance claims up to a certain point. Purchased reinsurance covers claims over an agreed amount. A self-funded plan gives the employer control in setting policy requirements, deductibles, co-pays and coverage. Unused funds at year end can roll over. By investing $1 billion in an insurance fund that includes $234 million for third-party administrator fees, many believe Oklahoma can self-fund. Businesses or individuals would pay $1,200 a person annually for premiums and $420 for each child. Funds would be reserved for indigent care to reimburse providers where no insurance exists or to match Medicaid. The proposal would include setting the deductibles at $1,200 per individual and $300 per child.
Source: NewsOK, 12/5/08.

TEXAS

Study: Illegal Immigrants Cost State $677 Million. The state of Texas and local hospital districts spent an estimated $677 million to provide health care to illegal immigrants in a year, a new study says. The survey, issued by the Texas Health and Human Services Commission, said that most of the money — $597 million — was spent by local hospital districts for the immigrants' care during the state's fiscal year that ended on Aug. 31, 2007. Lawmakers from both parties said they were not surprised by the millions spent and expressed hope that the report, required by the 2007 Legislature, will help prompt Congress to pass comprehensive immigration reform legislation. State Rep. Garnet Coleman, D-Houston, said the study only tells half of the story. He noted that the immigrants contribute to government coffers by paying sales and property taxes. The report said that in the fiscal year ending Aug. 31, 2008, the state spent $80 million under the Texas Emergency Medicaid program, which

pays hospitals to provide life-saving care, including labor and delivery services, to patients living here illegally. The state also paid $1.2 million to provide services to undocumented immigrants in family violence shelters. Federal law requires hospitals and ambulance services to provide care to anyone needing emergency treatment regardless of their citizenship, legal status or ability to pay. State Rep. Warren Chisum, R-Pampa, the House Appropriations Committee chairman, said the report puts a number on health care costs that the state cannot do anything about. "Show it to our congressman, I guess. Tell him, 'Merry Christmas,' "Chisum said. "This is something we can look at the federal government and say, 'You guys ought to do a better job of guarding your borders or at least pay for 'em if you're going to allow them to come over here.' "One of the most prominent critics of illegal immigration, Rep. Leo Berman, R-Tyler, said he is glad that Congress is getting the report.
"I'd like to bill the United States government," he said, "and have them pay Texas for the cost of the benefits that they require us to provide to illegal aliens."But a report issued two years ago by then-Comptroller Carole Keeton Strayhorn said undocumented immigrants helped to support the state's economy. She said illegal immigrants in 2005 paid $1.58 billion in taxes while the state spent a total of $1.5 billion. Strayhorn said local governments spent $1.3 billion on indigent health care.
Source: Houston Chronicle, 12/11/08.

UTAH

Medicaid Spared in Budget. The budget Governor Jon Huntsman has proposed assumes Congress will move quickly to send fiscal relief to the states to bolster Medicaid. And Utah Health Policy Project's Judi Hilman says that's a safe bet, which could help maintain services for Utah's most vulnerable population. But, the governor's budget could face challenges in the Legislature."Some legislators have said, well that's just temporary relief. We can't count on it. We have to cut Medicaid anyway. Not true, if you consider that broader context of Congress and this administration's willingness to tackle health system reform."Hilman says Medicaid must be preserved and even expanded to meet the 10 percent growth in people seeking help. She sees Medicaid as the essential foundation to Utah's health reform process, because it offers affordable health care. Increasing affordability is one of the three components of the state's health system reform effort. The other two address quality of care and accessibility. Incoming Senate President Michael Waddoups ranks health care as one of his top priorities for this next legislative session. But, he acknowledges that Medicaid might wind up on the chopping block. "We'll do Medicaid funding the best we can. But if we have to cut back in education, if we have to cut backing transportation, there's a very strong likelihood we may have to cut back in public services to those on Medicaid or other public service programs," Waddoups says. "You can't have a significant cut-back in revenues and not have everybody feel part of it." Like Hilman and other health advocates, Senator Waddoups is looking to Congress for help solving the health care crisis. He says health reform will come primarily from the federal government, not Utah.
Source: Utah Policy Report, 12/8/08.

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