



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.

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GAO: BUSH ADMINISTRATION VIOLATED LAW BY RESTRICTING SCHIP

The Bush administration violated federal law last year when it restricted states' ability to provide health insurance to children of middle-income families, and its new policy is therefore unenforceable, lawyers from the Government Accountability Office said last week. The ruling strengthens the hand of at least 22 states, including New York and New Jersey, that already provide such coverage or want to do so, and it significantly reduces the chance that the new policy can be put into effect before President Bush leaves office in nine months. At issue is the future of the State Children's Health Insurance Program, financed jointly by the federal government and the states. Congress last year twice passed bills to expand the popular program, and Mr. Bush vetoed both. State officials of both parties say the policy, set forth in a letter to state health officials on Aug. 17, has stymied their efforts to cover more children at a time when the number of uninsured is rising and more families are experiencing economic hardship.

In a formal legal opinion issued last Friday, the accountability office said the new policy "amounts to a marked departure" from a longstanding, settled interpretation of federal law. It is therefore a rule and, under a 1996 law, must be submitted to Congress for review before it can take effect, the opinion said. However, Jeff Nelligan, a spokesman for the federal Centers for Medicare and Medicaid Services, said, "G.A.O.'s opinion does not change our conclusion that the Aug. 17 letter is still in effect." The letter told states what steps they needed to take to be sure the children's health program would not displace or "crowd out" private coverage under group health plans. The White House cited the policy as a justification for rejecting a proposal by New York State to cover 70,000 additional youngsters. What happens next is not clear. New York, New Jersey and several other states have filed lawsuits challenging the Bush administration policy. In addition, Congress may consider legislation to suspend the directive.

Under the August 17 directive, states cannot expand the Children's Health Insurance Program to cover youngsters with family incomes over 250 percent of the federal poverty level (\$53,000 for a family of four) unless they can prove that they already cover 95 percent of eligible children below twice the poverty level (\$42,400). Moreover, in such states, children who lose or drop private coverage must be uninsured for 12 months before they can enroll in the Children's Health Insurance Program, and co-payments in the public program must be similar to those in private plans.

The legal opinion was requested by Senators John D. Rockefeller IV, (D-WVA) and Olympia J. Snowe, (R-ME). In view of it, they urged the administration to rescind the August directive. The administration told states they must comply with the directive by August of this year or else they face "corrective action." Compliance could mean cutting back programs. The Justice Department contends that the letter is "merely a general statement of policy with nonbinding effect," But Gary L. Kepplinger, general counsel of the accountability office, said administration officials had treated it as "a binding rule."

Source: The New York Times, Associated Press, 4/21/08.

FORMER SENATORS READY TO TACKLE HEALTH CARE

Former Senate majority leaders Bob Dole, a Republican, and George Mitchell, a Democrat, may be facing their biggest challenge to date — reforming the nation's health care system. The two senators said last week they would be joined by two other former Senate majority leaders, Democrat Tom Daschle and Republican Howard Baker, in crafting a series of health policy recommendations that would be delivered in 2009 to a new president and Congress. There have been scores of recent efforts in Washington to investigate and fix the nation's health care woes. Yet, the number of uninsured continues to grow, as does the cost of care. Lawmakers and President Bush disagree so much on how to stop those trends that little gets accomplished. Much the same happened under the Clinton presidency. The four former majority leaders — two Republicans and two Democrats — are betting

they can help lead a breakthrough. "We've got everything but votes," Dole said. "We do have some friends and we do have some ideas." The senators will each oversee forums on four key pillars for reform: improving quality and value, improving access, ensuring a strong role for consumers, and finding a way to finance it. They will get technical advice from Dr. Mark McClellan, who recently oversaw the Centers for Medicare and Medicaid Services under President Bush, and Chris Jennings, former health adviser to President Clinton. John Rother, director of policy and strategy at the AARP, said the effort, while one of many, has promise.

Mitchell served as majority leader when President Clinton put forward a plan that guaranteed a generous, minimum package of health insurance to all Americans. He said mistakes were made, but he preferred not to spend Wednesday dwelling on them. "It's very useful to know one's history, but it's not useful to live in it," Mitchell said. Dole and Mitchell said they will wait until after the presidential election to make their recommendations. They don't know how long their project will last, but they know the recommendations will have a better chance if delivered next year. "You fiddle around for one or two years, you know what happens," Dole said. "You've been around here long enough."

Health care has been a more prominent issue among the Democratic candidates this year. Sens. Hillary Rodham Clinton and Barack Obama both said they have a goal of providing universal coverage. The biggest difference is that Clinton would require everyone to get health insurance while Obama would not. Clinton says her plan is the only one that is truly universal because people won't get coverage unless they are required to, similar to auto insurance. Clinton played a key role in crafting the health plan that stalled in 1994. Meanwhile, Republican candidate John McCain is calling for ending the favorable tax treatment of employer-sponsored insurance. In its place, he would provide a tax credit of \$2,500 for individuals and \$5,000 for families.

The senators also stressed that they will be the ones responsible for the recommendations. While advisers will provide technical expertise, they wanted to make it clear they will have final say on what's in the package. Both Daschle and Mitchell are Democratic super delegates. Daschle is supporting Obama. Mitchell is undecided. The two voiced optimism about the prospects for making major improvements to the health care system, in part because the call for change grows with each passing year, and in part because they have confidence in their ability to fashion a compromise acceptable to all sides. Dole said President Reagan, the conservative icon, advised lawmakers that if they could get 70 percent of what they wanted in an agreement, they needed to take it. At the same time, they know that finding a compromise could prove painful for all sides. "There's no easy fixes or it would have been done already," Dole said.

In 2007, the four senators established the Bipartisan Policy Center, an organization dedicated to addressing tough policy challenges in a pragmatic manner. They decided health care was one of the major issues they wanted to tackle. Daschle will lead the project's first health care forum on April 24 in Washington D.C. The health care project will be funded by the Robert Wood Johnson Foundation. The foundation awards grants to improve health care in the U.S.

Source: Reuters News Service, 4/20/08.

HEALTH CARE DEBATE PRODUCES SHARP DIFFERENCES IN PRESIDENTIAL CANDIDATES

The *Wall Street Journal* has examined how health care will produce some of the sharpest differences between Democrats and Republicans in the presidential election as the candidates respond to increasing economic anxiety about many issues. Democratic candidates Sens. Hillary Rodham Clinton (N.Y.) and Barack Obama (Ill.) want to use government as a lever to expand health insurance to more U.S. residents. Both candidates would use the federal government to establish a marketplace in which residents could purchase private or public health insurance, with subsidies for lower-income residents, and would prohibit health insurers from rejecting applicants because of pre-existing medical conditions. The most significant difference in the proposals involves the question of whether to mandate that all residents obtain health insurance. Clinton would implement such a mandate, but Obama would require coverage only for children.

Meanwhile, presumptive Republican nominee Sen. John McCain (AZ) who has said he doesn't believe it is the job of government to ensure that all citizens are insured, would seek to give people more control over their health insurance through the free market. The centerpiece of his plan is severing the link between health insurance and employment. McCain would replace a tax break for employees who receive health insurance from employers

with a tax credit of \$2,500 for individuals and \$5,000 for families for the purchase of private coverage. He has said that Clinton and Obama want government to take over the health care system.

The Obama campaign has begun to air a television advertisement in Pennsylvania that claims Clinton might garnish wages to enforce the individual health insurance mandate in her health care proposal. According to the ad, "Hillary Clinton is attacking, but what's she not telling you about her health care plan? It forces everyone to buy insurance, even if you can't afford it." In response, a group that supports Clinton has begun to air a TV ad in Pennsylvania that claims the Obama health care proposal would not provide health insurance for all residents. During a speech on Saturday in Bethlehem, Pa., Clinton said that Obama has "misrepresented" her health care proposal. She said that "the last thing we need is somebody spending as much money as he has downgrading universal health care." In addition, Clinton said, "We need to achieve universal health care -- not create political opposition to universal health care," adding, "That's what Republicans do."

Source: The Wall Street Journal, 4/19/08.

FEDERAL PROPOSAL FOR HEALTH CARE I.T. TO BE PUT FORTH

Members of the New Democrat Coalition last week announced a proposal that would use a New York City health care information technology program as a legislative template for a federal template. At a media conference on Capitol Hill, coalition members appeared with New York City Mayor Michael Bloomberg and city Health Commissioner Thomas Frieden to discuss the proposal, which they said would improve health care quality, increase efficiency and reduce medical errors. Under the New York City program, about 200 primary care providers use electronic health records, and program officials hope to expand use of EHRs to 1,000 providers by the end of 2008. The coalition seeks to nationalize interoperable health care IT and have 75% of providers use the technology by 2018. According to the coalition, the proposal involves three areas for implementation: infrastructure, which would include codification of the HHS Office of the National Coordinator for Health Information Technology; standards; and finances. The proposal would require the first report to Congress of standards for public programs -- such as Medicare, Medicaid and SCHIP -- by Jan. 1, 2010. Rep. Allyson Schwartz (D-PA), a coalition member, said that the proposal also would include privacy standards to address concerns about confidentiality often linked with the use of health care IT. At the media conference, Bloomberg said that the proposal would mark the "largest of its kind in the nation." He said, "New York City is spending some \$30 million in a public-private initiative to bring electronic health records to community health centers and doctors' offices serving more than one million patients." Bloomberg added, "We do think our system merits replication." Frieden said, "Done correctly, an electronic health record can be more secure than a paper record," adding, "You can document who's looked at it, when, what they've done, there's an audit trail for all of the steps, you can work with the practice to make sure they control passwords or access."

Source: CQ Healthbeat, 4/18/08.

HOUSE BILL WOULD DELAY IMPLEMENTATION OF NEW MEDICAID REGULATIONS

The House Energy and Commerce Committee on Wednesday voted 46-0 to pass a bill (HR 5613) that would delay implementation of seven new Medicaid regulations for one year. The legislation, sponsored by committee Chair John Dingell (D-MI), would delay implementation of the regulations until April 1, 2009. Under the regulations, proposed by the Bush administration, states could not use federal Medicaid funds to help pay for physician training. The regulations also would place new limits on Medicaid reimbursements to hospitals and nursing homes operated by state and local governments and limit coverage of rehabilitation services for individuals with disabilities and mental illnesses. In addition, the bill would provide \$25 million annually for efforts to fight Medicaid fraud. Before the passage of the legislation, the committee by voice vote approved a manager's amendment sponsored by Dingell that would make several changes, one of which would revise the implementation of a program to verify electronically the assets of Medicaid beneficiaries. Dingell said of the seven Medicaid regulations, "There is little support outside the four corners of HHS for these actions." Committee ranking member Joe Barton (R-TX) said that both the House and Senate have the votes to override a

presidential veto, although he predicted that President Bush would not veto the bill as threatened. HHS Secretary Mike Leavitt on Tuesday sent a letter to committee members that said senior White House advisers will ask Bush to veto the bill. Barton said, "I don't think the veto threat was appropriate, and I don't think it will be successful if vetoed because the votes simply aren't there." In addition, he said, "I hope that in the time period while the moratorium is in place, we can work together not just on a committee level, but with the administration, to find a way to fine-tune some of the regulations and see if they can go into effect at some point in time." Dingell was quoted as saying, "I hope the president will take a look at the vote we're going to get on this matter and decide maybe a veto is unwise."

Source: National Journal Congress Daily, 4/17/08.

AVERAGE PRESCRIPTION CO-PAYMENTS DECREASED IN 2007

The average prescription drug copayment for patients in 2007 decreased by 25 cents to \$13.20 -- the first such decrease in at least five years -- as the average total cost of such medications increased from \$55.01 in 2002 to \$55.93 in 2007, according to a report released on Wednesday by pharmacy benefit manager Express Scripts. For the 2007 Drug Trend Report, Emily Cox, senior director of research at Express Scripts, and colleagues examined prescription claims data from customers. Express Scripts processes more than one million prescription claims daily. The report attributed the decrease in the average prescription drug co-pay to an increase in the number of customers who have switched to generic medications. According to the report, 64% of prescription claims in 2007 involved generic medications, compared with 42% in 2002. In addition, the average co-pay for preferred brand-name prescription drugs increased by \$4.52 to \$19.18 between 2002 and 2007, and the average co-pay for non-preferred brand-name medications increased by \$11.28 to \$28.44 during the same period, according to the report. By comparison, the report found that the average co-pay for generic prescription drugs increased by only 86 cents to \$7.57 between 2002 and 2007.

Source: The Associated Press, 4/18/08.

Of Physician Interest

HHS APPEALS DECISION REQUIRING RELEASE OF MEDICARE PHYSICIAN CLAIMS DATA

The U.S. Department of Health and Human Services filed an appeal last week in the U.S. Court of Appeals for the District of Columbia, challenging an August 2007 court decision that requires the department to release Medicare claims data on more than 40 million beneficiaries and 700,000 physicians. In August 2007, the U.S. District Court for the District of Columbia ruled that HHS must release Medicare physician claims data for Illinois, Maryland, Virginia, Washington state and Washington, D.C. In the case, Consumers' CHECKBOOK/Center for the Study of Services filed a lawsuit to obtain access to the data. HHS argued that the release of the data would violate the privacy of physicians. However, the court rejected that argument because Medicare claims account for only a portion of the incomes of physicians. According to the court, the release of the data would "help the public make more informed Medicare decisions" and provide "more information of how government funds are spent." Consumers' CHECKBOOK plans to post the data online for public use. Researchers could analyze the data to determine the number of times physicians perform certain procedures and to compare the mortality rates among patients of certain physicians, and health insurers could use the data to improve their analyses of physician quality. Consumer groups, employers and health insurers support the decision, and physician groups oppose the decision. The American Medical Association, which has petitioned to join the HHS appeal, maintains that the data could be misleading because they do not take into account differences in patients treated by different doctors.

Source: The Associated Press, 4/18/08.

Of Regional Interest

LOUISIANA

Proposed Cut Would Affect Medicaid. The budget-cutting targets sought by House leaders could lead to reduced access to health-care services by the poor, elderly and disabled, the state Department of Health and Hospitals warned in a letter to lawmakers last week. Health and Hospitals Secretary Alan Levine said the 5 percent cut in operational expenses contemplated by House budget-writers would translate to an \$86 million reduction in state general-fund spending, which would grow to \$302 million once federal matching funds are factored in. Most of the agency's \$8.5 billion budget goes to the Medicaid program, which serves the poor, elderly and disabled. Financing for Medicaid is shared between the state and the federal government, with Louisiana's share coming to about 30 percent. Levine's letter to Rep. Tom McVea, R-St. Francisville, who is chairman of the health subcommittee of the House Appropriations Committee, did not say which services the agency would cut, but instead presents several options for the panel to consider as it reviews state spending for the 2008-09 budget cycle. The options include slowing the rate of growth in home-care services for people with severe disabilities, reducing the length of the average stay in the state's charity hospitals or cutting detox services in the state's Office of Addictive Disorders. Levine's letter said that cutting the Medicaid rates paid to doctors, hospitals and other health-care providers will reduce access and potentially lead to higher long-term costs as more people seek care through expensive emergency-room visits. McVea had not seen Levine's letter Thursday afternoon, but said he would not be inclined to cut Medicaid if it means sacrificing the federal match as well. "We don't want to take wheelchairs away. We don't want to disenfranchise those people that need Medicaid. I don't think you're going to see that," McVea said. However, House Speaker Jim Tucker, R-Algiers, said he remains committed to cutting the budget and that the House can't achieve its targets without cutting into Medicaid. The \$6.2 billion program grew by more than \$1 billion last year, when the Legislature raised the rates paid to doctors, nursing homes, hospitals and other providers. "Nothing's off the table at this point," Tucker said. House leaders have said their goal is to reduce the amount of one-time money being plugged into the state's operating budget by about \$250 million.

Source: New Orleans Times-Picayune, 4/2/08.

TEXAS

Cuts to Subsidies for Physician-Owned Hospitals Possible. Several Texas lawmakers are fighting a proposal to slice the price tag of the multibillion-dollar farm bill by curbing Medicare payments to physician-owned hospitals. A conference committee of Republican and Democratic House and Senate members is negotiating a compromise farm bill to send to President Bush. Bush has been threatening a veto if the final bill that pays for crop subsidies, agricultural and nutrition programs exceeds his spending limits. The House and Senate bills would cost about \$280 billion. The conference committee is considering limiting payments to hospitals based on rates of ownership by physician. One proposal is to require a hospital only be 40 percent owned by physicians to qualify for Medicare reimbursement. The spending proposal also would limit expansion by physician hospitals and the rate of ownership in a hospital by one physician. The proposal rekindles a dispute between physician-owned and community hospitals over whether the doctor-owned hospitals syphon away patients with insurance or Medicare coverage or who can afford better health care. Rep. Sam Johnson, R-Plano, ranking Republican on the House Ways and Means Committee's health subcommittee, and Rep. Joe Barton, R-Ennis, the top Republican on the Energy and Commerce Committee, sent a letter opposing the proposal to members of the agriculture conference committee Friday. "Such a limitation should not be used precariously to offset agricultural spending in a bill that does nothing to address rising health care costs or ensure patient's access to care," the lawmakers wrote. "This provision, put simply, pays for farm bill spending at the expense of all Americans." The lawmakers said the measure would restrict patient choice and jeopardize quality of care in communities and states with few hospitals, doctors and other health care professionals.

The American Hospital Association issued a news release saying studies show physician-owned hospitals treat fewer patients who are sicker or poor, and reduce patient access to emergency and trauma care. However, the Texas lawmakers are questioning a Congressional Budget Office estimate that the limits on physician owned hospitals could save \$2.4 billion over 10 years. Previously the office estimated minimal savings from such limits, the lawmakers said. Republican Sens. John Cornyn and Kay Bailey Hutchison signed the letter. Other Texans who signed the letter are Republican Reps. Pete Sessions of Dallas, Michael Burgess of Flower Mound, Ralph Hall of Rockwall, Mike Conaway of Midland, Jeb Hensarling of Dallas, Ron Paul of Lake Jackson, Kay Granger of Fort Worth, Mike McCaul of Austin and Louie Gohmert of Tyler. Democrats Sheila Jackson Lee of Houston and Silvestre Reyes of El Paso also signed.

Source: *The Associated Press*, 4/18/08.

ARKANSAS

Medicaid in Arkansas is OK, DHS Reports. The Medicaid program provides health care for the poor, and is a huge expense for all states, including Arkansas, so when the Beebe administration announced a major cutback in funding for Medicaid and other state programs, images leapt to mind of hordes of poor Arkansans being denied medical care. However, according to a spokesman for the Department of Human Services, which administers Medicaid in Arkansas, the situation is not dire. "It's certainly not a gloom-and-doom picture at this point," Julie Munsell said. The administration has said that declining state revenues require major cuts in state spending for the fiscal year that begins July 1, possibly as much as \$41 million in the amount that was budgeted for Medicaid. But, Munsell said, "We have \$220 million in the Medicaid trust fund to absorb any challenges we face." The trust fund gets its money mostly from the soft drink tax and the bed tax paid by nursing homes. By law, the fund can be used for Medicaid only. "It's a rainy-day fund, and fortunately we haven't had to tap it in a couple of years," Munsell said. Because of the projected reduction in the state's general revenue, DHS will watch Medicaid usage even more closely than usual, Munsell said. However, because Medicaid has been ruled an "entitlement" by the courts, she said, "We don't have many options in rolling back services." "There've been times in the past when we wanted to eliminate services provided by Medicaid, and we've been enjoined by the courts," she said. But the state can make changes in the package of services, she said. For example, if Medicaid had been covering six prescription drugs a month, and the state wanted to scale that back to four, it could. While some might consider that a minor change, it would be large to a poor person who needed all six of the drugs. Still, Munsell said, "Medicaid is not as much of an issue as some of our other programs." She mentioned children and family services, and aging and adult services. These do not have reserves like Medicaid, and to keep them running acceptably, money will have to be diverted from elsewhere in the DHS budget. Fortunately, DHS has authority to move resources from one area to another where the resources are needed more, Munsell said. She was confident the necessary adjustments could be made.

Source: *Arkansas Times*, 4/17/08.

UTAH

Health Care Task Force Seeks Real Life Stories. The Utah Health Policy Project wants to add real-life stories of how Utahns are dealing with rising costs and declining access to health care services in the state. A special legislative task force assigned to design a total renovation of the state's health care system will meet for the first time later this month. The group will be inundated with statistics illustrating facts such as health insurance premiums increasing by 66 percent but wages increasing by only 13 percent in recent years. And they'll have every economic indicator that shows premium costs increases will actually surpass annual house hold income within the next 20 years if something pretty drastic isn't done — and soon. "This is the first real opportunity to fix the system," Judi Hilman, executive director of UHPP said Tuesday. "But even more important, this is the first real opportunity for individual consumers to have a real say in how the reform plays out."

People are feeling so alienated by government machinations, economic forces and just the whims of life in general that the only thing they are certain of is that they'll be overmatched by whatever is coming down the road, said Hilman, who has seen at least two previous reform efforts come and go.

This can't be a piecemeal effort this round, she said. "This time it can't just be up to the governor or to lawmakers or to somebody else. I just can't stress enough that if there is something about the system that doesn't work or some way you can think of that will make it work better, we need to hear from you."

Hilman said any story is important enough, whether someone was on Medicaid and is now self-sufficient, a business owner who has dropped health care benefits or someone who wants to start a small business but can't because he or she can't afford to pay for even a part of the premium for employees. "Anything that matters to the individual needs to be told and passed along to the task force," Hilman said. "These stories are critical to setting the table of how we're going to expand access, how we'll make it affordable, how we'll increase quality and how we'll contain costs." Some other states are further along in the process and some that offer workable models, such as Washington State, Maine and Vermont, she said. "But whatever system is built has to be uniquely our own with as many voices heard as possible, or it simply will fall apart," she said.

Source: Deseret News, 4/10/08.

OKLAHOMA

Oklahoma Divided Over Use of Medicaid Funds for Undocumented Immigrants. The CEO of the Oklahoma Health Care Authority and a state lawmaker remain split on whether using state Medicaid funds to provide prenatal care services to undocumented immigrants will jeopardize federal funding for the program. The department last fall approved a rule allowing undocumented pregnant women to receive prenatal care as long as their infants become citizens upon birth. States are required by federal law to pay for emergency labor and delivery services of undocumented women, who do not qualify for other Medicaid services. The rule took effect at the start of the year. Under the rule, undocumented women receive coverage for prenatal care services that are needed to protect the health of the fetus. The women still do not qualify for full Medicaid benefits, according to officials. At least 12 other states, including Texas and Arkansas, have similar regulations. State Rep. Randy Terrill (R) contends that the rule should have been reviewed and approved by legislators and not the health authority. He said, "As a result, the Oklahoma Health Care Authority may soon be committing Medicaid fraud by billing the federal government for services provided to [undocumented immigrants] that the Legislature never authorized." He said that providing federally funded prenatal care services to undocumented immigrants sets a dangerous legal precedent because it does not clearly define the concept of "personhood" versus "citizenship." Terrill added that the rule could cost the state millions of federal dollars. Terrill and state Rep. John Wright (R) have filed a measure to overturn the department's rules. A state immigration law, written by Terrill, states that the department cannot provide medical services to an undocumented immigrant over age 14. However, Mike Fogarty, CEO of the department, said that the law does not specify if the regulation applies to prenatal services, adding that the agency "has specific federal approval and encouragement to reimburse health care providers for prenatal care services to unborn children regardless of their mother's documentation status." The federal SCHIP program defines a child as an individual from conception to age 19. In addition, the program defines child health assistance as including prenatal care services, Fogarty said. "The Bush administration recognized the positive public policy associated with providing prenatal care for these babies and began encouraging states to adopt this option in 2002."

Source: The Oklahoman, 4/20/08.

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