



# *Advocacy*

## **ADVISORY**

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### *In this edition:*

- Congress Delays Vote on Appropriations
- Senate Finance Addresses Medicare Payment Delay
- Widening Gap Seen in Access to Healthcare
- Stem Cell Experts Urge Lifting Ban for Research
- Regional Updates

### **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.

#### **IN THIS ISSUE:**

- CONGRESS DELAYS VOTE ON APPROPRIATIONS BILL THAT WOULD IMPACT MEDICAID; HURRICANE RELIEF
- SENATE FINANCE ADDRESSES MEDICARE PAYMENT DELAY
- LAWMAKERS SUBMIT BILL TO STOP SCHIP ENROLLMENT DIRECTIVE
- FEDERAL OFFICIALS TESTIFY ABOUT DISASTER PLANS AND HOSPITAL DEFICIENCIES
- WIDENING GAP SEEN IN ACCESS TO HEALTHCARE
- STEM CELL EXPERTS URGE LIFTING BAN FOR RESEARCH EFFORTS
- REGIONAL UPDATES

## CONGRESS DELAYS VOTE ON APPROPRIATIONS BILL THAT WOULD IMPACT MEDICAID; HURRICANE RELIEF

The Senate Appropriations Committee on Thursday delayed a scheduled mark up of a \$193 billion supplemental war appropriations bill that includes a provision to block for one year seven new Medicaid regulations proposed by the Bush administration, as well as additional funds for the Food and Drug Administration. Committee Chair Robert Byrd (D-WVA) decided to move the mark up to May 15 at the request of Senate and House leadership after dissension forced House Democrats to delay until next week bringing the supplemental bill to the floor. The Senate version of the bill includes \$275 million for FDA, \$400 million for NIH to fund about 700 research grants, \$437 million for the construction of poly-trauma centers administered by the Department of Veterans Affairs and \$350 million for hospitals in Louisiana and Mississippi as part of relief from Hurricane Katrina. In addition, the legislation includes a provision that would ban construction of new physician-owned specialty hospitals. The provision also would require the 100 to 200 specialty hospitals currently in operation to disclose their ownership interests to patients. According to a Senate Republican aide, the provision would save \$2.4 billion over 10 years, in large part through decreased growth in the number of medical procedures billed to Medicare. The bill might face a Republican filibuster because of its price tag, raising the possibility that the Senate would turn to the House bill but if Democrats can round up the 60 votes needed to fight off GOP objections, the Senate will send a bill with war funds and domestic spending back to the House.

Senate Finance Committee ranking member Chuck Grassley (R-IA) on Thursday asked Byrd and Senate Appropriations Committee ranking member Thad Cochran (R-MS) to remove the Medicaid provision and the specialty hospital provision from the Senate version of the bill. In a letter to Byrd and Cochran, Grassley wrote that the provisions "should only be considered by the Finance Committee," which has "done significant work on this issue over the years including holding hearings and conducting investigations." However, Senate Finance Committee Chair Max Baucus (D-MT) supports the inclusion of the provisions in the legislation, according to a Senate aide.

*Source: Kaiser Daily Health Policy Report, 5/9/08.*

## SENATE FINANCE DISCUSSES MEDICARE PAYMENT DELAY

Senate Finance Committee Chair Max Baucus (D-MT) said last week that a Medicare package that would delay for 18 months a 10.6% cut to physician fees would cost between \$15 billion and \$18 billion over five years, prompting committee members to begin discussions on how to offset those costs. Sens. Olympia Snowe (R-ME) and Kent Conrad (D-ND) said that committee members continue to examine reducing payments to private insurers that administer Medicare Advantage plans as a potential offset for the bill. MA plans, on average, are paid an estimated 113% of what traditional Medicare pays per patient. Last year, when Congress passed a six-month delay for the Medicare fee cuts, Republicans -- particularly from rural areas where the plans are popular -- objected to cuts to the MA program. House Ways and Means Health Subcommittee Chair Pete Stark (D-CA) on Wednesday said he expects Baucus to cut indirect medical education payments under MA that are given to insurers that provide coverage in areas with teaching hospitals. Baucus said no decisions were made on Wednesday, but he did not rule out cutting IME payments. "There are lots of different options on the table," Baucus said, adding, "Just don't know yet." Observers report that members of Congress are generally in favor of stopping the scheduled physician fee cuts, but finding a broadly acceptable offset has been the primary stumbling block to moving a bill forward.

The Bush administration has asked Congress to approve legislation delaying the fee cuts, which are scheduled to take effect on July 1, by June 16 to avoid delays in payments that would result in additional administrative costs. CMS estimated that passing legislation by June 16 would help reduce the possibility of

disrupted payments or reprocessed claims that would result in extra administrative costs," Christina Pearson, a spokesperson for HHS, said. Baucus said that Senate Majority Leader Harry Reid (D-NV) has pledged floor time for discussion of the legislation in early June. Baucus said that he would try to meet the June 16 deadline but would be finished by the end of the month. However, House members are nervous regarding the Senate's timing, according to some observers. "The concern here is if the Senate acts so late and sends us a bill in late June and expects us to rubber-stamp it, they're in for a rude awakening," Rep. Shelley Berkley (D-NV) said. Congress could go beyond the deadline, but some doctors have vowed to see fewer Medicare beneficiaries if payments are reduced, and a disruption in payments could have a similar effect.

*Source: National Journal Congress Daily, 5/8/08.*

## LAWMAKERS SUBMIT BILL TO STOP SCHIP ENROLLMENT DIRECTIVE

**R**eps. Frank Pallone (D-NJ) and Carol Shea-Porter (D-NH) have introduced a bill that would block a CMS directive that set tighter requirements for enrolling children from higher-income families in the State Children's Health Insurance Program. "At a time when the number of uninsured children is steadily rising due to the economic recession, Congress must overturn the Bush administration's mean-spirited and illegal children's health directive," said Pallone, chairman of the House Energy and Commerce health subcommittee, in a written statement. The legislation was introduced a day after the CMS issued a letter to state health officials offering more flexibility in the way states could carry out the terms of the directive. The CMS clarified that states would be able to suggest other strategies than what were in the original directive to prevent "crowd-out," where higher-income families substitute public coverage for private coverage. The directive issued last August required states to first enroll 95% of children in families earning less than 200% of the federal poverty level—\$42,400 for a family of four—before they can seek to enroll children in families earning more than 250% of the federal poverty level. The directive's original purpose was to prevent crowd-out, but many states have said that it would be too difficult for them to meet that goal of covering 95% of the lower-income children. "Based on conversations with states, we are convinced that a number of states have already reached this goal," acting CMS Administrator Kerry Weems said in a written statement. The Government Accountability Office last month said that the CMS overstepped its authority when it tightened these enrollment requirements for SCHIP.

*Source: Modern Healthcare, 5/8/08.*

## FEDERAL OFFICIALS TESTIFY ABOUT DISASTER PLANS AND HOSPITAL DEFICIENCIES

**T**wo Bush administration Cabinet members testified last week before the House Committee on Oversight and Government Reform, acknowledging gaps in the capability of U.S. hospitals to deal with a mass-casualty terrorist attack or other disaster, but they said a congressional effort to block pending Medicaid cuts will not correct the problem. Homeland Security Secretary Michael Chertoff and Health and Human Services Secretary Michael Leavitt said lawmakers could target funds at the shortcomings more directly, such as by financing the stockpiling of hospital beds, ventilator units or medicine, if needed. Stopping a White House plan to tighten Medicaid would not necessarily improve the nation's "surge capacity" to handle an attack on the scale of the 2004 train bombings in Madrid, they said. "There are deficiencies in our surge capacity. I just don't believe Medicaid dollars is the source of funds that ought to be directed or looked to link to that solution," Leavitt testified. This testimony came two days after the committee's chairman, Rep. Henry Waxman (D-CA) released a survey showing that hospitals in seven major U.S. cities would be overwhelmed in case of a Madrid-scale attack. In that incident, 191 people were killed and as many as 270 patients were sent to a single hospital within hours.

President Bush has threatened to veto House legislation that would impose a one-year moratorium on changes sought by HHS to Medicaid, the federal insurance program for the poor. Congressional budget analysts say that the reimbursement changes would lower federal spending by \$17.8 billion over five years. State officials have said the impact would be greater, including cuts to physicians at teaching hospitals and to urban public

hospitals whose emergency rooms are already strained. Waxman said Chertoff's and Leavitt's departments were "irresponsible" because they had not analyzed the impact of cuts on emergency rooms. "Why would HHS withdraw billions of federal dollars from the hospitals that provide the most comprehensive emergency care to the most seriously injured?" he said. "It is a substantial breach in what I think is our mutual responsibility to make sure we can deal with a homeland security attack." Leavitt said HHS will report by the end of the year the results of a national survey of surge plans and capabilities. He said a survey is underway of hospitals' ability to electronically track and report the number of available beds on one hour's notice. Leavitt also defended the proposed Medicaid changes, saying they are designed to stop states from using federal funds for hospitals as a substitute for state funding. "This is about states not paying their fair share," Leavitt concluded.

Source: *The Washington Post*, 5/8/08.

## WIDENING GAP SEEN IN ACCESS TO HEALTHCARE

About \$45 billion is spent on public insurance programs and uncompensated care for full-time workers and their families each year, and yet low-wage workers have access to fewer critical medical services, according to two recent studies by the Commonwealth Fund. Nineteen million full-time workers and their dependents were uninsured in 2004, compared with 16 million in 1999. And 11 million workers and dependents in 2004 were enrolled in public programs such as Medicaid and the State Children's Health Insurance Program, up from 6 million in 1999, according to the study entitled, *Who Pays for Healthcare When Workers are Uninsured?* by Sherry Glied and Bisundev Mahato of Columbia University. Public insurance enrollment rose fastest among those employed by large firms, the authors said. The gap is widening for not only insurance coverage between low- and high-wage workers but access to care, the researchers said in a companion study titled, *The Widening Healthcare Gap Between High and Low-Wage Workers*. The study revealed that higher-wage workers had their blood pressure checked at least once, up from 77% in 1996. By contrast, 66% of lower-wage workers had their blood pressure checked in 2003, down from 70% in 1996.

Source: *Modern Healthcare*, 5/2/08.

## STEM CELL EXPERTS URGE LIFTING BAN ON RESEARCH EFFORTS

Leading research experts urged Congress last week not to close off any avenue for stem cell experimentation. The House Energy and Commerce Health Subcommittee held the hearing in anticipation of legislation being prepared by Reps. Diana DeGette (D-CO) and Michael Castle (R-DE) that would lift the federal ban on funding for new lines of embryonic stem cells, and create an ethical oversight mechanism for all research in the area. Recent developments using adult stem cells have brought calls to substitute adult stem cell research for work using embryonic stem cells. Democrats on the panel blamed the Bush administration for limiting research on embryonic stem cells. A 2001 executive order limited research to existing stem cell lines, lines scientists say are wearing out and are not always as good as new embryonic stem cells would be. But opponents of embryonic stem cell research say the embryo has to be destroyed in the process and that destroys human life. Stem cells can transform into many different types of cells, leading to the possibility of research that could find cures for many types of diseases. DeGette said her 14-year-old daughter is a diabetic, and she does not care if a cure for that disease comes from embryonic stem cells, adult stem cells or some other source. Democrats apparently were looking to create a record and set a framework for a new president in January who could reverse Bush on stem cell research. "The fact is Americans want stem cell science to advance," said House Energy and Commerce Health Subcommittee Chairman Frank Pallone (D-NJ), whose state has forged ahead with stem cell research in the absence of federal funding. "They want us as legislators to do everything we can to help unlock the potential of embryonic stem cells in the quickest fashion possible and bring new life saving therapies to the patients who need them."

House Energy and Commerce Health Subcommittee ranking member Nathan Deal (R-GA) expressed the view of many opponents of embryonic stem cell research by pointing to advances in adult stem cell science. "Adult stem cell research has resulted in many discoveries," Deal said. "We must consider whether we should take funding away from other research that has shown promise." But the scientists, including National Institutes of Health Director Elias Zerhouni, suggested that one type of research should not obscure others. "From a purely scientific view, it is essential to pursue all types of stem cell research simultaneously, including human embryonic stem cell research, since we cannot predict which type of stem cell will lead to the best possible therapeutic application." *Source: National Journal Congress Daily, 5/8/08.*

## Of Physician Interest

### AMA OUTLINES GUIDELINES FOR ELECTRONIC PRESCRIPTIONS

The American Medical Association shared for the first time last week an outline of what physicians would accept as part of electronic prescribing legislation. The proposal comes amid growing momentum to include an e-prescribing mandate in the Medicare physician pay fix that senators are crafting. Until now, the AMA has been considered the largest barrier to enacting e-prescribing legislation that would link the technology's use to Medicare reimbursement. The AMA has cited concerns over the cost of adopting and implementing the technology. But lawmakers have seen it as increasingly attractive, given that the expected reduction in medical errors could provide them with enough money to meet pay/go requirements.

AMA board member and emergency physician Steven Stack today called on lawmakers to give physicians two years to adopt the technology before Medicare would be required to start docking their payments for paper prescriptions. The leading congressional proposal on the table gives physicians through 2011 to implement e-prescribing in their offices before Medicare would face financial penalties. Stack also said any proposal should include exceptions for small practices and physicians in rural areas as well as emergency situations in which physicians may have to prescribe medications outside their normal offices. Hospitals and other healthcare facilities should be motivated to provide e-prescribing technology for physicians, Stack said.

The AMA also wants Congress to direct the Centers for Medicare and Medicaid Services to release final e-prescribing standards by the end of 2009. CMS issued three standards last month and plans three more. Stack said their completion is critical to establishing interoperability to ensure the technology does not become obsolete. Congress must also remove a barrier in place under the Drug Enforcement Administration's prohibition on e-prescribing controlled substances, Stack said. The AMA estimates that controlled substances account for 20 percent of all prescriptions. AMA has raised concerns about the cost of implementation, and while Stack mentioned those concerns again today, the physicians' group did not back a specific dollar amount that Congress should give physicians to adopt e-prescribing.

*Source: National Journal Congress Daily, 5/9/08.*

## Of Regional Interest

### ARKANSAS

*Arkansas Surgeon General Discussed State of Health.* Last week, the University of Central Arkansas and Arkansas Business hosted a symposium titled "Benefiting Arkansas: Health Issues for Employers" at Reynolds Performance Hall. Dr. Joe Thompson, surgeon general of the state of Arkansas and director of the Arkansas Center for Health Improvement, was among the speakers at the symposium. Thompson discussed the increase in health care cost, which leads to a lack of coverage for many Arkansans. He also said costs could be reduced by individuals making lifestyle choices that lead to better health. He said the proportion of uninsured Americans (47

million) continues to increase, and health care costs continue to exceed other growth areas. In Arkansas, 520,000 are uninsured, he said. Premium increases and inflation continue to outpace worker earnings, and co-pays have increased as well, he noted. The number one cause of bankruptcy is directly tied to non-covered medical expenses, he said. Factors that drive up health care costs include changing demographics, illness burden, medical research, technological advancements and consumer expectations, he said. In Arkansas, employer-sponsored insurance is the primary source of health care, Thompson said. Children are beginning to be covered by the public sector under ARKids First. The state also covers more than half of pregnancies through Medicaid. Of Arkansans over 65, 99 percent are covered by Medicare, he said. The median family in Arkansas lives at 200 percent of the federal poverty level, he said, which is where many of the state's 520,000 uninsured fall. Thompson said individual choices can influence health care costs. He addressed the issues of tobacco use and obesity. In 1990, he said, 10 to 14 percent of adults were obese in most states. In 2006, the numbers had increased with 15 to 29 percent of adults being obese. Obesity leads to earlier death, more chronic disease and drives up health care rates, he said. The average annual total cost of health care for a person with no risks is \$2,382, he said. Being obese, smoking or being physically inactive makes the cost go up. The average cost for a person with any one of the three risk factors is \$3,427. The cost continues to go up as a person ages as well, Thompson noted. He said national and Arkansas childhood obesity trends over the past three decades have increased from 5 percent to 18 percent, however, Arkansas is the one state in the nation that has halted the progression in the last year. Thompson concluded by saying Arkansas must find innovative ways to achieve health care access that is affordable. "There is no magic bullet," he commented. UCA President Lu Hardin also addressed the crowd; saying health care will be one of the top two issues in the presidential election, along with the war in Iraq. He said the country needs to have definitive aid that recognizes small business, as well as bipartisan support, or the nation will find itself in a health care crisis. Hardin noted health care premiums make up \$7 million of the university's \$150 million budget, and he is looking into self-insuring.

*Source: Associated Press, 5/8/08.*

## LOUISIANA

*Legislature Weighing Tax Cuts and Budget.* During this past week, the Ways and Means Committee, chaired by Rep. Hunter Green (R-Baton Rouge) began debate on **SB 87** by Sen. Buddy Shaw (R-Shreveport), which is passed would cut income tax obligations by 10 percent per year, and disappearing entirely by 2017 at an eventual cost to state coffers of \$4 billion per year. In its original form, the bill would have eliminated over \$300 million in personal income tax by revising some of the income tax brackets impacted by the Stelly Plan. However, the bill was amended in the Senate to give taxpayers an even greater tax break by gradually eliminating the state income tax altogether. Economists are concerned that the reduction in state revenue would force program cuts at some future point, thereby potentially endangering many social service programs and Medicaid/SCHIP. Indeed, the most vulnerable area for such cuts would be healthcare. In related news, the Revenue Estimating Conference met last week and certified over \$460 million more in new revenue available for the current budget, as well as an additional \$360 million for the one beginning July 1. These estimates come on top of literally billions of additional surpluses and excess revenues that the REC has certified over the last two years. Prior to the REC meeting, Governor Jindal said he wanted any recurring excess revenues certified for next year's budget to be used to plug the remaining \$400 million hole caused by the last administration using \$800 million in one-time revenues to balance the 2007 state budget. Jindal eliminated half of that total in the budget proposal he submitted to the Legislature, and the \$360 million in additional excess revenues recognized would fill almost the entire remaining hole. Paradoxically, that \$360 million is also coveted by those who would like to substantially reduce the personal income tax. The governor's proposed use of \$360 million to eliminate the one-time revenues funding in the proposed budget would force the tax cut proponents to cut spending significantly in order to fund their tax cut.

## NEW MEXICO

*More New Mexico Residents Enroll in Medicaid and Other Programs.* More New Mexicans are enrolled in health insurance programs for low-income families, but 21 percent of the state's residents remain without medical coverage. Some 277,500 New Mexico children were enrolled in Medicaid or the State Children's Health Insurance Program as of December 2007, according to the state Human Services Department. The agency said that was an all-time high. In addition, 144,047 adults were enrolled in Medicaid as of last December. Combined with the 16,528 adults enrolled in State Coverage Insurance as of February, that also is an all-time high, the HSD said. The department credited an aggressive outreach and enrollment campaign over the past two years for the jump. "Reaching out to New Mexicans in their communities has proved to be successful," said Human Services Secretary Pamela Hyde. "However, there are more uninsured New Mexicans who are eligible but not enrolled." Betina Gonzales McCracken, a spokeswoman for the department, said last week that New Mexico ranked 49th in the nation for health insurance, according to a current population survey released last August by the U.S. Census. The ranking was based on 2006 data from a three-year average. The state's 21% uninsured rate translates to 400,000 New Mexicans without health insurance, McCracken said. However, the survey was done when the state had barely started or had not yet started several programs to help, she said. "Perhaps we'll see some better numbers" in the next survey this August, McCracken said. Last fiscal year, HSD had a \$2.7 billion budget, counting both state and federal dollars, for Medicaid, SCI and other medical assistance programs. The budget for those programs is \$3.1 billion in the current fiscal year, which ends June 30. But, McCracken said, "with the cost of medical care and medical premiums going up ... it's more expensive to cover New Mexicans each year." The State Children's Health Insurance Program generally serves children whose parents earn too much to qualify for Medicaid, the federal health insurance program for the poor, but who cannot afford private insurance. Family health care premiums paid by New Mexico workers whose employers offer health insurance rose 26 percent from 2001 to 2005, more than twice as fast as the 12 percent increase in income in the same period, according to a study released Tuesday by the Robert Wood Johnson Foundation.  
*Source: Albuquerque News, 5/1/08.*

## OKLAHOMA

*Survey Finds Steady Rise in Nursing Home Care Costs.* The cost of nursing home care in Oklahoma has risen by 21 percent in the past five years, but actual costs remained lower than most other states, according to a recent study by Genworth Financial, a global financial security company. Nursing home costs have risen 17 percent nationally since 2004, according to the study's findings. "There are all sorts of reasons for the increase in costs, from fuel costs to hiring competent staff," said Rebecca Moore, executive director of the Oklahoma Association of Health Care Providers. Despite the percentage increase over the past five years, actual nursing home care costs in Oklahoma remain relatively low when compared with other states. According to the study, one year, in a private nursing home in Oklahoma costs \$51,607, well below the national average of \$76,480 per year. Still, the reports shows that the gap between Medicaid reimbursement and the actual cost of having nursing home care continues to widen, said Moore. "There is no way private pay can make up those differences," she said. Because of cuts in Medicaid reimbursements, Oklahoma nursing homes are losing \$13.23 per day per resident, Moore said. Seventy percent of 18,511 nursing home residents in 324 homes statewide qualify for Medicaid. State officials are working to increase Medicaid reimbursements to provide quality care for nursing home residents, but constant changes in federal regulations are also proving costly for nursing homes, Moore pointed out. Much of the 21 percent increase may also be attributed to the ice storm that hit Oklahoma in December 2007. Running generators and performing clean up operations following the storm was costly.  
*Source: Tulsa News, 5/8/08.*

## TEXAS

*State Experiences Large Increase in Insurance Premiums; Highest Uninsured Rate in Nation.* Texas families saw their health insurance premiums soar 40 percent in five years — 10 times faster than their incomes increased, according to a report being released today by a national foundation that promotes health care improvement. Nationally, Texas ranked third — behind Oklahoma and Idaho — in premium increases from 2001 to 2005, according to the report on employer-offered insurance by the Robert Wood Johnson Foundation in Princeton, N.J. At the same time, Texas ranked No. 1 in the percentage of residents without insurance. In 2005-06, that figure was 27 percent and the state had 5.5 million of the nation's 47 million uninsured people. Health care advocates said they were not surprised by the relationship between high health insurance premiums and a high number of uninsured people. But they said they found the difference between the growth of insurance premiums and the increase in the state's median income over the same period — 4 percent — to be alarming. People without coverage often get expensive emergency room care, and those costs get passed on as higher premiums to people with insurance. The foundation's report — *Squeezed: How Costs for Insuring Families are Outpacing Income* — prepared by University of Minnesota researchers, didn't study why premiums increased almost 30 percent nationally, to an average of \$10,728 in 2005 from 2001. In Texas, premiums jumped from an average of \$8,255 to \$11,533. "This study makes plain what every working parent knows — that providing insurance coverage takes a bigger bite from the family budget every year," said Dr. Risa Lavizzo-Mourey, president and CEO of the foundation. Factors that drive higher costs include expensive medical technology, less healthy lifestyles and an aging population, said Brian Quinn, a program officer at the foundation. The foundation did not examine insurance company profits, he said. The Texas Department of Insurance did not have that data readily available Monday afternoon but noted that premiums doubled from 1997 to 2004.

*Source: Austin American Statesman, 5/1/08.*

## UTAH

*Low Cost Clinics Vital for Utahns.* Utah's community health centers offer the uninsured an alternative - a prevention-centered approach advocates believe improves residents' health, reduces costs and should play a key role in the state's health care reform efforts. The debate continues in the state, as not everyone is in agreement with this assessment. The Association for Utah Community Health has said it will advocate for approximately \$22.6 million in state funds to care for an additional 100,000 uninsured Utahns. The 29 centers in 10 counties function like a private family practice, but include more benefits, including pharmacy, dental and mental health care. They care for patients regardless of their ability to pay. Of their 98,331 patients last year, 61 percent had no insurance. However, others believe the state is currently doing enough. For now, Rep. Steven Urquhart, R-St. George, wants to see what the centers can do with \$500,000, allocated during last year's legislative session, to cover only 2,000 – 3,000 uninsured.

*Source: Salt Lake City Tribune, 5/12/08.*

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