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HOT TOPICS FOR ADVOCACY IN THIS ISSUE

THIS ISSUE of the Advocacy Advisory will focus on topics of current interest within the 110th Congress – including an examination of the outlook for health care issues. Congress recently re-authorized SCHIP funding, an important victory for advocates of health care for the poor and underserved populations. There is discussion now on Capitol Hill regarding how best to fund this program. The CHRISTUS position is consistent that federal 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. Also under scrutiny at the federal level at this time are funding for stem cell research (recently vetoed by President Bush) and other right-to-life issues. Congress returned to its work this week following the July 4 recess.

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SCHIP CONFLICT LOOMS IN WASHINGTON

The top two senior Republicans on the Senate Finance Committee blasted the Bush administration on Thursday for threatening to veto a bill reauthorizing the State Children's Health Insurance Program, saying the bipartisan compromise being negotiated represents the best chance for a Republican role in the policy. "What the administration needs to understand is that if a bipartisan plan isn't achieved, then the Democratic-controlled

Congress will, at the very least, extend the current program with all the terrible policy provisions that have evolved, such as waivers for childless adults and coverage for higher-income kids," said a statement from Finance ranking member Charles Grassley (R-IA), and Health Care Subcommittee ranking member Orrin Hatch, (R-UT).

Other Senate Republican aides said Grassley and Hatch's opinion represents a minority of GOP members. GOP leaders are crafting a response to the Finance Committee plan that will hammer on the continued coverage for adults and what they consider unwarranted expansion in government-run health care, the aides said. Finance Committee members who have been involved in the SCHIP negotiations say the chairman's mark will include a phase-out of adult coverage under SCHIP, but other Republicans have indicated a phase-out will not satisfy them. The chairman's mark is expected to be released Friday in advance of a Tuesday markup. Negotiators have been mum about the details of the adult phase-out.

In negotiations, committee Republicans have managed to keep the reauthorization proposal from including several costly provisions, such as coverage for legal immigrants and expanded coverage for uninsured parents, Grassley and Hatch said. The administration is upset because the Finance Committee mark would authorize $35 billion in new spending for the program over five years. Grassley and Hatch countered that a straight extension of SCHIP could cost as much as an additional $24 billion. The other scenario is a $50 billion increase in spending for the program attached to a must-pass spending bill, the statement said. And while Grassley and Hatch support the White House's proposal for some type of healthcare tax provision, they said adding tax language to the SCHIP bill is "not realistic -- given the lack of bipartisan support for the President's plan."
Source: Congress Daily, 7/12/07.

PRESIDENTIAL CANDIDATES ON HEALTH CARE

Although it is still very early in the 2008 presidential race, the issue of health care has already taken center stage among many other major issues that will dominate the national debate. The following is a brief synopsis of each major candidate's position. In coming issues, we will focus individually on the candidates in an effort to cover each in more detail.

DEMOCRATS:

- Biden: Supports the expansion of health insurance for children and for catastrophic care, look to states for ideas on moving toward universal coverage.
- Clinton: Seeks national consensus before proceeding with universal health care plan. "I want to figure out how we provide universal health care without putting billions more into the system." Goal of universal coverage in eight years. Led an unsuccessful health care reform effort in 1993.
- Dodd: Has sponsored legislation to expand coverage for young, old and poor, and has expressed a goal of universal coverage; details and costs not specified.
- Edwards: Wants to achieve universal health coverage by 2012 with a system of expanded federal health insurance, family tax credits, and coverage requirements on employers, insurance companies and individuals. Has said this would require increasing taxes to pay for program's cost of up to $120 billion a year.
- Kucinich: Favors national health insurance program covering medical, dental, mental health and long-term care, as well as prescription drugs. "My plan doesn't provide for a role for for-profit insurance companies."
- Obama: A stated goal of universal coverage by 2012; details and costs not specified.
- Richardson: Priority is to insure all children under 5. Work with market and state to expand access for others. For New Mexico, favors expansion of health insurance through combination of private sector and government reforms instead of through state-sponsored universal health care.

REPUBLICANS:

- Brownback: Has offered a "market-based solutions, not government-run health care."
- Giuliani: "Market-driven" expansion of coverage, not government-sponsored universal coverage.

- Huckabee: Favors market solutions, state innovation. "We don't need universal health care mandated by federal edict or funding through ever-higher taxes."
- Hunter: Supported expansion of health insurance through tax breaks, not government-sponsored universal coverage.
- McCain: Has a record of promoting prescription drug coverage for elderly and expanded insurance for children, but not universal coverage.
- Romney: As governor, signed health care law aimed at ensuring universal coverage through a mix of subsidies, sliding scale premiums and penalties for those who do not get insurance. Says that plan might eventually become a national model.
- Tancredo: Market reforms instead of more federal spending to expand health coverage.

STUDY REVEALS HEALTH CARE CRISIS WORSENING

By 2020, America will be short 24,000 doctors and nearly 1 million nurses, the federal government predicts; now a major tax and consulting firm says the problem will be even worse. The health care workers will be spread unevenly across the country, according to a report released last Monday by PricewaterhouseCoopers. Meanwhile, current health care trends may be keeping would-be nurses and doctors out of the field, the report says.

The total number of nurses in the country is projected to begin decreasing after 2010. Many nurses will start to retire just as baby boomers begin turning 65 and needing more health care, according to a 2004 study from the U.S. Department of Health and Human Services. Forecasts for a registered nurse shortage range from 400,000 to more than 1 million. Texas, meanwhile, will face a shortfall of 27,000 registered nurses by 2010, according to the Texas Hospital Association. The average registered nurse vacancy rate at Texas hospitals already stands at 10.2 percent – 19 percent higher than in 2004.

Forecasts for physician supply and demand are more ambiguous than for nursing. Currently, one-third of all active physicians are over 55, according to a 2006 study from the Association of American Medical Colleges. Some experts predict that they may retire earlier than nurses because they are better prepared financially. The health and human services department predicts a net shortage of 24,300 physicians by 2020. The implications of such shortages extend throughout the trillion dollar U.S. health system, according to Pricewaterhouse. While hospital leaders now voice concern over the possible shortages, the study argues that these same executives have sided with short-term solutions over long-term changes since shortages have thus far been cyclical.

While shortages will create difficulties, an even greater problem will arise from the unequal distributions of physicians by specialty and geography, according to the Pricewaterhouse report. Only 20 percent of today's internal medicine residents are choosing to go into primary care internal medicine; the rest are going on to pursue higher paying subspecialties, according to PricewaterhouseCoopers' research. At the same time, problems educating and retaining new nurses contribute to the inadequate pool of nurses, the study found. Despite existing shortages, the number denied admission to nursing schools is high – rising more than six fold since 2002.

The reason? There is not enough qualified nursing faculty or clinical training sites, the report said. Instead, there are financial disincentives to offer nursing education, particularly among state schools, according to the study. More than 11,000 qualified nursing school applicants were turned away in Texas last year because of a lack of capacity, the Texas Nurses Association said. The barrier to enrolling more students here is not classroom space, but the lack of funds to hire needed faculty members, the nursing association said. The state has spent $39 million in special funding over the last three years, increasing the number of registered nursing graduates by 47 percent. The Texas Center for Nursing Workforce, a state organization that works to increase the number of nurses, said Texas had 6,700 graduates in 2006, up from 4,500 in 2001. However, an additional 47 percent increase will be needed by 2010, according to the center.

Organizations that focus on work/life balance for physicians and nurses will have a competitive edge in recruiting and retaining top talent, according to the study.

Source: The Associated Press, Dallas Morning News, 7/10/07.

FINAL RULE ISSUED ON MEDICAID DRUG PRICING

The CMS has issued a final rule that refigures the Medicaid drug-pricing formula, makes the pricing more transparent and requires states to collect specific data from physicians about the drugs they administer in their offices. Overall, the CMS said that the new rule, which was mandated by federal law, would help the Medicaid program and states save $8.4 billion over the next five years by paying more appropriately for prescription medications. Still, Medicaid expects to spend $140 billion for drugs over fiscal years 2007 through 2011.

In 2004, the Government Accountability Office and the HHS Office of Inspector General found that Medicaid payments to pharmacies for generic drugs were much higher than what pharmacies were actually paying for those drugs, the CMS said. “This new calculation method will allow Medicaid to pay more accurately for the medicines enrollees need,” CMS Acting Administrator Leslie Norwalk said in a written statement. However, the National Community Pharmacists Association said the regulation does not reflect actual pharmacy drug acquisition costs and said it would try to prevent its implementation.
Source: Modern Healthcare, 7/10/07.

PAY-FOR-PERFORMANCE SHOWS REDUCED COSTS

An experiment to gauge the efficacy of a pay-for-performance system showed that coordinating care and reducing hospitalizations can lower Medicare costs, CMS officials said on Wednesday. The study, which began in April 2005 and will run through April 2008, is an attempt by CMS to re-examine how Medicare reimburses physicians for care with a focus on quality, rather than the number of tests and procedures performed.

For the experiment, CMS analyzed hospital and physicians' bills for 224,000 patients being treated by 10 selected physician groups and compared them with bills from other doctors and patients in the same geographic areas. Doctors involved in the experiment were required to meet certain quality criteria, such as adhering to 10 clinical measures for diabetes care. For the second year, clinical measures for heart disease care will be added; in the third year, measures for hypertension and basic preventive care for all patients will be assessed.
Results of the experiment showed that all 10 physician groups participating in the program improved patient care during the first year. However, only two groups -- the University of Michigan Faculty Practice and the Marshfield Clinic in Wisconsin -- met the threshold to qualify for bonus payments. The two groups were paid a total of $7.3 million, in addition to standard Medicare payments for services, for saving the program $9.5 million. CMS has not yet calculated the overall savings of the experiment, but physician groups say that the experiment likely saved Medicare a combined $21 million.

All 10 of the physician groups are part of large organizations that have substantial experience in electronic health records or other systems known to improve patient care. The fact that eight of them did not meet the bonus threshold indicates how difficult it may be for Medicare to develop a payment system giving most doctors, many in smaller practices, a true financial incentive.
Source: The New York Times, 7/12/07.

Of Physician Interest

CALL FOR FISCAL NEUTRALITY IN MEDICARE ADVANTAGE

The American Medical Association has renewed its call for fiscal neutrality between Medicare Advantage and traditional Medicare, pointing out the gross inequity in payments between the two Medicare programs. "Right now the government is paying health insurance plans that administer Medicare Advantage, on average, 12 percent more per person than it spends on patients enrolled in traditional Medicare," said AMA Board Member Cecil Wilson, M.D. "With Medicare payments to doctors who care for seniors slated for a 10 percent cut next year, Congress must put the money used to subsidize the insurance industry to better use." At the AMA's Annual Meeting late last month, America's physicians sent a resounding message to Congress – eliminate the Medicare Advantage subsidy. AMA policy clearly states that subsidies to private plans offering alternative coverage to Medicare beneficiaries should be eliminated, and that these private Medicare plans should compete with the regular Medicare program on a fiscally neutral basis.

A report by the California Association of Physician Groups (CAPG), which represents some medical groups practicing in the managed care model, offers no conclusive reason why the government should continue overpaying Medicare Advantage plans. The CAPG report states that Medicare Advantage incentivizes California physician groups to provide proactive care, and gives an example of greater outreach for flu and pneumonia vaccinations. By that logic, California with its 35 percent of patients enrolled in Medicare Advantage plans should have above average vaccination rates. However, the most recent CDC data clearly show that adults aged 65+ in California receive flu shots in line with the national average. For the pneumonia vaccination, the number actually drops below the national average. In Maine – which has only 2 percent of Medicare patients enrolled in Medicare Advantage – the percentage of seniors who received both the flu and pneumonia vaccination is actually higher than in California.

"Eight in ten of America's seniors are enrolled in the traditional Medicare program," said Dr. Wilson. "Congress needs to do what's right for seniors by stopping harsh Medicare cuts to physicians that will make it very hard for physicians to care for new Medicare patients. The most viable way to do that is to level the playing field by eliminating the Medicare Advantage overpayment."
Source: American Medical Association, 7/10/07.

Of Regional Interest

LOUISIANA

Louisiana Incentive Program Explained. The Louisiana Department of Health and Hospitals has issued a release to clarify that medical professionals who participate in the Greater New Orleans Health Service Corps program do not need to dedicate 30% of their practice to treating Medicaid, Medicare and uninsured patients. DHH Secretary Fred Cerise said, "This was a misconception that was circulating among medical professionals," adding, "It is important that doctors and other health care professionals understand the requirements of the grant and not get wrong information that might keep them from applying." The program, developed by the state of Louisiana, is working to attract health care professionals to areas affected by Hurricane Katrina in 2005 by offering financial incentives, including student loan repayment and income guarantees. Since the hurricane, physician practices have flooded, some hospitals have closed and the number of uninsured residents has increased. To receive incentives, worth as much as $110,000, medical professionals must agree to practice in the area for at least three years. While

there is no quota, health care providers must agree to treat Medicare and Medicaid beneficiaries and accept payment on a sliding fee scale for uninsured patients based on their income to be eligible for the program. Priority is given to health care providers who accept and treat a high rate of Medicaid and uninsured patients for the duration of the three years.
Source: Kaiser Daily Health Policy Report, 7/11/07.

TEXAS

Expansion of SCHIP Would Mean $4.9 Billion More for Texas. Texas could receive an additional $4.9 billion in federal money over the next five years if Congress approves a proposal to reauthorize and expand the State Children's Health Insurance Program, a consumer group estimates. According to a recent report by Families USA, a consumer health organization, Texas could receive an average of almost $975 million in new federal funds annually for the next five years. The state is scheduled to receive almost $558 million in fiscal year 2008.
In Texas, almost 1.4 million children do not have insurance, and about two-thirds of them are eligible for state health insurance or Medicaid, the report said. If the program undergoes a major expansion, those children would be more likely to get coverage, said Ron Pollack, executive director of Families USA. Not expanding could cause about 1.5 million children across the country to lose coverage because of rising health costs, he said.
The report is based on data from the Centers for Medicare and Medicaid Services, and researchers used the current allocation formula to compute the estimated figures.
Source: The Associated Press, 7/11/07.

ARKANSAS

State Insurance Plan Tries to Attract Small Business. State officials promoted a new health insurance plan for small businesses this week, hoping to attract more companies to the 6-month-old program backed by the state and federal government. Despite the absence of Gov. Mike Beebe, whose flight was diverted from Pine Bluff because of morning thunderstorms, officials introduced the health insurance option ARHealthNet at Quest Corp., a Pine Bluff company that was one of its first clients. The insurance plan originated from Arkansas' tobacco settlement fund, and it focuses on businesses with more than two employees but fewer than 500. It aims to assist families making less than $40,000 a year. "We want to make sure that everyone knows that this is not a fully subsidized plan," said John Selig, director of the state Department of Human Services. "Obviously if the business can take care of its higher-end employees, the large number of workers who wouldn't be able to afford coverage can get help." Selig noted the benefits package, which does not include vision or dental, is a basic needs package that pays for 80 percent of the health coverage. The participating business would be required to take care of the remaining 20 percent, a price many companies have indicated a willingness to pay.
Although it does not cover major medical emergencies, ARHealthNet provides the basics for the average person needing health care. The package includes six physician visits a year, up to seven hospital stay days in a year and two prescriptions a month. Since launching at the beginning of the year, ARHealthNet covers about 700 people. The limit for the first year will be 15,000, and over the course of the first five years, up to 50,000 people employed by small businesses could be covered. When fully implemented, the state is expected to pay about $2 million annually for the program and the federal government about $10 million, Selig said. Based on information provided by ARHealthNet, for employees who meet the income criteria established for financial assistance the premium can range from $13 to $66 per month, with age as the primary determinant. The average cost per employee will be about $25 to $30 per month. Selig said many of the state's uninsured are employees of companies that could not afford the premiums from earlier insurance packages. Another benefit, Selig said, is that no pre-existing condition penalties are set.
Source: Associated Press, 7/11/07.

UTAH

State Simplifies Medicaid Process. Utah residents applying for Medicaid need now only interact with one state agency. Formerly, the 700 state workers who work on determining whether residents are eligible for Medicaid were split between the Health Department and the Department of Workforce Services. Over this last week, the group was consolidated under one roof. No one lost their jobs or took pay cuts under the merger, proposed by Utah Gov. Jon Huntsman Jr. as a way to save money and speed paperwork. The change means a $16 million loss for the Health Department, acknowledged Utah's Medicaid Director Michael Hales. But Hales is confident clients will benefit from the new "one-stop service environment." Previously, Workforce Services handled Medicaid applications for Utah residents also entitled to other aid, such as food stamps and cash assistance. Health workers handled those applying only for Medicaid. However, in 2006, more than 20 percent of Medicaid cases bounced between the two departments, creating confusion and delay. The merger is expected to be a major benefit for applicants, as it will improve service and speed access to needed benefits.
Source: Salt Lake City Tribune, 7/10/07.

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