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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. Congress will be in August recess soon.

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DEMOCRATS PLAN TO PUSH DOMESTIC BILLS BEFORE AUGUST RECESS

House and Senate Democrats are planning a busy finale this week before the August recess, with plans to push through a raft of bills to secure major domestic victories as lawmakers head home. However, some think the agenda may be overly ambitious and could set the Democrats up for Republican criticism for falling short of their promises.

Yet some leaders have raised the specter of working through Saturday, August 4, to get all the legislation done. Majority Leader Harry Reid (D-NV) said after completing work on a \$38 billion homeland security bill, the Senate will attempt to pass an expansion of the \$35.5 billion State Children's Health Insurance Program (SCHIP). It will also take up a conference report implementing the bipartisan 9/11 Commission recommendations and a sweeping overhaul of ethics and lobbying rules. "That's an amazing lineup, for those four things to pass in two weeks," said Sen. Charles Schumer of New York, who heads the Democratic Senatorial Campaign Committee. "I haven't seen that many two-week periods where that much gets done."

The 9/11 Commission bill and the ethics bill are in their final legislative stages, and sending those measures to President Bush's desk next week could help Democrats fulfill two promises that were a part of their 2006 campaign platform. Still, passage of all those measures is anything but assured. Republicans have thwarted many Democratic accomplishments in the narrowly divided Senate by throwing procedural roadblocks and slowing down the chamber's progress. Senate Republicans are planning an alternative to the SCHIP bill, while Sen. Jim DeMint (R-SC) is likely to filibuster the ethics bill because of his concerns over earmark disclosure requirements.

The House has a line-up that would include more than one major bill for each of the four full days that members are expected to be in session next week. In addition to doing their part on 9/11 recommendations and the ethics bills, Democratic leaders want to finish conference work on the water resources and development act. They also want to pass the agriculture and defense spending bills, as well as an energy bill and SCHIP.

Democratic leaders acknowledge that the schedule is difficult, especially if Republicans mount attacks on the floor. Democrats have said that the Republicans are courting political danger if they oppose recommendations supported by relatives of the 9/11 victims or children's health insurance. Yet, Republicans aren't showing much sign of accommodation on the major issues, and say it is Democrats who are out of step with the public. Brian Kennedy, spokesman for House Minority Leader John Boehner (R-OH), said he wouldn't bet on Democrats getting their priorities passed in time for the break.

Source: The Hill, 7/28/07.

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. This issue looks at the plans of Democratic front-runner **Sen. Hillary Clinton** and former New York City Mayor Republican **Rudy Guiliani**.

Senator Clinton laid out a major plank in her framework for providing affordable, quality health coverage for all Americans: her 7-step strategy for lowering spiraling costs. She has pointed out that the rising cost of health care is threatening working families, American businesses, and the nation's economic competitiveness. Premiums have almost doubled since 2000 - up 87 percent - four times higher than wages. Citing the statistic that if left unattended, health care spending will double to \$4 trillion per year over the next 10 years, Senator Clinton stressed that the necessary commitment to cover all Americans will require massive reform.

Senator Clinton has proposed a series of initiatives that she claims will cut the spiraling rate of growth by one-third over time. Her health care modernization strategy achieves this by targeting the drivers of health care costs, including (1) emphasis on preventive care, (2) a move to maximized use of health care technology, (3) a plan to address unmanaged chronic illnesses such as diabetes and heart disease, which account for over 75 percent of health care spending, (4) address what she sees as the over-utilization of medical interventions that provide little added value and the under-utilization of those that do, (5) and excessive insurance, drug, and malpractice costs. Senator Clinton says that her proposals would reduce costs and improve quality in the health care system. Taken together, her campaign argues that they would lower national health spending by at least \$120 billion dollars a year. She has also promised a vague "common sense" approach to medical liability reform.

Source: Clinton Campaign, 7/30/07.

Rudy Guiliani has said he supports more market-based approaches to solving the health care crisis. His plans offers two key reforms. First, he would allow both individual and group benefits insurance plans to be deductible: Putting individual insurance on a level playing field with group insurance will allow people to seriously compare the features and benefits of group versus individual insurance and make informed decisions. Second, his plan would offer more choices by offering a national market where people can choose from providers across state lines. Currently, individuals must decide on a plan deemed acceptable by their own state: Rather than force people to buy plans approved by their state, he says his plan would allow people to shop anywhere, pointing out that one reason why health insurance in some states is very expensive is because they can't do so now. These market based reforms rely on the individual to decide which plan best suits their needs rather than a universal system where the government provides a one size fits all program.

Source: Guiliani Campaign, 7/30/07.

SOME HOUSE MEMBERS PROPOSE UNIVERSAL COVERAGE

A bipartisan group of House members, including Democratic Reps. Brian Baird of Washington and Earl Blumenauer of Oregon, introduced a bill last week to provide health care coverage to all Americans through a pool of private insurance plans. The so-called Healthy Americans Act mirrors a plan introduced by Sen. Ron Wyden, D-OR, and would provide affordable, private health care coverage for all Americans, except those covered through Medicare or the military. Coverage would be guaranteed, even if someone loses a job, and would be equal to that of members of Congress, lawmakers said. "Many Americans are just a pink slip or economic downturn away from losing not just their job, but their health insurance. This bill guarantees that won't happen," Baird said. The United States is a leader in medical innovation and technology, "yet access to quality and affordable health care remains out of reach for far too many," Baird said. "The Healthy Americans Act aims to level the playing field and guarantee affordable, high quality coverage for all Americans and their families."

Besides Blumenauer, the bill also is co-sponsored by Reps. Jim Cooper, D-TN, and Jo Ann Emerson, R-MO. "The time has come to fix the health care system and the Healthy Americans Act makes way for comprehensive reforms that would offer all Americans affordable insurance," Blumenauer said. Under the program, individuals would be able to choose from a variety of plans offered in their state. State-based health agencies would guide individuals through the enrollment process by providing information about each plan. For the first four years of the new system, employers who provide health insurance benefits for their workers would be required to convert their health care premiums into higher wages that employees would then use to buy insurance. The Senate plan, co-sponsored by Sen. Robert Bennett, R-UT, would only require the employer stipend for two years. The plan would allow workers to carry their health insurance from job to job without penalty, Wyden said. More efficient administration — coupled with greater competition among health care plans — should allow better coverage while not increasing costs above what the government is now paying for health insurance, he said.

Source: Associated Press, 7/25/07.

DEMOCRATS SEEK TO MAKE SCHIP VETO-PROOF

Confident Senate Democrats are attempting to attract a veto-proof 67 votes for their politically popular children's healthcare bill. Six GOP senators supported the \$35 billion reauthorization of the State Children's Health Insurance Program, or SCHIP, during committee consideration, adding to the bill's momentum. The measure is expected to be debated on the Senate floor before the August recess. GOP leaders plan to offer an alternative that keeps new SCHIP funding closer to President Bush's proposal, but the irresistible cause of healthcare for low-income children is proving difficult to strongly oppose. "Enrolling nearly 6.6 million children and lowering the uninsured rate by nearly 25 percent, SCHIP has been a success," five senior Republicans, led by Senate Minority Leader Mitch McConnell (R-KY), wrote to the GOP conference on Tuesday. "We support the reauthorization of SCHIP." Conceding the success of the program, Republicans contend that the SCHIP

reauthorization would open the door to eventual government-run healthcare, invoking the specter of Sen. Hillary Rodham Clinton's (D-NY) failed universal coverage effort in the 1990s.

GOP leaders also point to what Sen. Judd Gregg (R-NH), ranking member of the Budget Committee and a cosponsor of the leadership's alternative, calls a "budget gimmick": the low estimate of SCHIP spending in the bill's final year, allowing the entire package to be offset under pay-as-you-go rules. Finance Chairman Max Baucus (D-MT) dismissed the GOP alternative, which also includes long-held Republican goals of tax-free health savings accounts and small business health plans, at a cost of about \$9 billion. "This so-called alternative would leave a lot of low-income uninsured kids with no alternative at all for health care," Baucus said in a statement. "They shouldn't call their proposal CHIP. It's really 'CLIP' – a Children Losing Insurance Plan."

Democrats have yet to openly predict vote counts for the SCHIP measure, but the 60-vote margin likely needed for passage appears well within reach. Republicans facing difficult reelections in 2008 are considered prime candidates to join the bipartisan SCHIP alliance. Two in that group, Sens. Pat Roberts (Kan.) and Gordon Smith (Ore.), have already come on board, and Sens. Susan Collins (Maine), Norm Coleman (Minn.), John Sununu (N.H.), John Warner (Va.) and others in cycle will be closely watched. One Finance aide expressed confidence — contingent upon the defeat of Democratic amendments to expand the bill and Republican amendments to shrink it.

Getting to 67 votes would send a strong signal to the White House, where Bush has vowed to veto the Senate measure despite Republican entreaties. Bush has promoted his plan for preferred tax treatment of certain health insurance plans as a companion to SCHIP, but the Senate GOP rebuffed that proposal in their alternative. A strong showing in the Senate also could lend momentum to the \$75 billion House SCHIP bill, which includes cuts to private Medicare providers and has aroused hotter partisan tensions. House Republicans released their own SCHIP alternative yesterday, with Democrats offering condemnation similar to that in the Senate. The Senate bill offsets SCHIP expansion with a 61-cent hike in the tobacco tax, potentially alienating anti-tax conservatives in states that rely on the children's health program. Still, Democrats believe they can fend off Republican attempts to expand the debate beyond the popular program at hand.

Meanwhile, tobacco companies are continuing to encourage grassroots lobbying of lawmakers as floor debate approaches, said John Singleton, spokesman for Reynolds American. The industry also is pointing to what it believes is a contradiction between the SCHIP bill and Sen. Edward Kennedy's (D-Mass.) plan, now pending in the Health, Education, Labor and Pensions Committee, to regulate tobacco through the Food and Drug Administration. Kennedy's bill aims to cut down the number of American smokers, Singleton said, "and at the same time, we're looking at this SCHIP bill, which says they want 61 cents per pack to fund what is clearly going to be a growing healthcare program."

Source: The Hill, 7/26/07.

STUDY: NEW RULES LED TO MEDICAID DECLINE

Medicaid rolls declined in many states after Congress imposed new documentation requirements, but most of the drop-off appears to be among people eligible for coverage — not illegal immigrants. A law that took effect July 1, 2006, requires states to obtain evidence of citizenship and nationality when determining whether people are eligible for Medicaid. The Government Accountability Office surveyed states on the impact of the new rules. Twenty-two of 44 states reported enrollment declines, the GAO said Tuesday, and most of those states said the decline was due to delays in coverage or a loss of coverage for eligible citizens. Meanwhile, 12 states said the requirement had no effect on enrollment. Ten others didn't know. Medicaid is the state and federal program that provides health coverage to the poor.

In responding to the report, the federal agency that oversees Medicaid raised concerns that states did not provide data to document their conclusions. The GAO acknowledged that its review basically represents the perspective of state Medicaid officials. "(They) stated the requirement has resulted in enrollment declines and has posed administrative burdens to states and individuals," the report said. "Further, our survey results indicate that the effects states experienced in the first year may continue at least to some extent in the future. Leslie Norwalk,

the former acting administrator for the Centers for Medicare and Medicaid Services, challenged the GAO's conclusions in June. She left the agency last week as a permanent administrator was expected to come on board. "These conclusions are largely based on anecdotal statements or vague feelings by some states that all declines in enrollment must be based on the new requirements," Norwalk said. "In fact, enrollment generally ebbs and flows across states such that at any given time one would expect declines in some states, increases in other states and unchanging levels in others."

Beginning in 1986, Congress required that beneficiaries attest that they are citizens or legal immigrants eligible to participate. But, Congress took the proof of eligibility a step further last year by requiring documentary evidence. The Centers for Medicare and Medicaid Services projected that the new documentation requirements would save the federal government and the states about \$90 million this year. However, the GAO also disputed that estimate, saying Medicaid officials "did not account for the increased administrative expenditures reported by the states, and the agency's estimated savings from ineligible, non-citizens no longer receiving benefits may be less than anticipated."

Overall, 35 states reported increases in the time spent processing enrollment applications. Looking at one unidentified state, GAO noted that the state processed an average of more than 150,000 applications a month in the eight months following the new documentation requirements. In that state, assuming an extra 16 minutes per application that would have added at least 40,000 hours of staff time per month. Rep. Henry Waxman, D-CA, requested the GAO's analysis. He said the report should lead to changes concerning documentation requirements. "States should be able to decide for themselves whether the costs of the current one-size-fits-all documentation policy are in the best interests of their citizens," Waxman said.

Source: The Associated Press, 7/26/07.

Of Physician Interest

PHYSICIAN SHORTAGE DISPROPORTIONATELY AFFECTS RURAL & URBAN AREAS

A nationwide physician shortage is affecting rural and inner-city residents the most and is being exacerbated by restrictions put in place on foreign doctors who want to practice in the U.S. after the Sept. 11, 2001, terrorist attacks. According to the American Medical Association, more than 35 million people live in underserved areas, and it would require 16,000 physicians to immediately alleviate the shortage of doctors in those areas. One government estimate indicates the U.S. could require as many as 24,000 physicians in 2020 to fill the shortage. To help relieve the shortage in some areas of the U.S., including the Mississippi Delta region and Appalachia, the federal government through a number of state and federal work programs began issuing J-1 visa waivers, which allow foreign physicians to work in rural areas for three to five years and could allow them to seek permanent residency. The majority of J-1 waivers come from a 13-year-old program sponsored by Sen. Kent Conrad (D-ND) that issues 30 waivers per state per year. That program is set to expire in 2008.

Since 2001, the government has implemented higher fees, harder tests and stricter rules on determining "underserved" areas, making it more difficult for foreign physicians to attain the visas and obtain permanent residency. According to the Government Accountability Office, the number of physicians in training with J-1 visa waivers declined by nearly half over the last 10 years, from 11,600 in the 1996-1997 academic year to fewer than 6,200 in the 2004-2005 academic year. In addition, HHS in 2003 took control of a Department of Agriculture foreign doctor program and has approved 61 J-1 waivers since that time. The Health Resources and Services Administration have said they are not receiving many applications because the applicant pool keeps reducing in size.

Source: Medical News Today, 7/25/07.

Of Regional Interest

LOUISIANA

Health Care System Continues to Impede New Orleans Recovery. Efforts to address problems with the "shattered" New Orleans health care system in the aftermath of Hurricane Katrina might prove the most important to the "economic revival" of the city. Before the hurricane, the health care system served as the largest employer in New Orleans after tourism and retail stores and paid much higher wages. However, since the hurricane, the number of jobs in health care has decreased by 16,800, or 27%, in part because of a shortage of nurses and other medical workers. In addition, only one of the seven general hospitals in New Orleans has opened fully since the hurricane; two have opened partially, and four remain closed. Problems with overcrowding and fewer health practitioners "hit hardest on the poor and the newly uninsured, but they also affect doctors and patients, politicians and entrepreneurs, the displaced and the returned -- and everyone at any level who has the misfortune to turn up in a jam-packed emergency room," the Times reports. Community clinics are struggling as well, but Donald Erwin, founder of St. Thomas Community Health Center, said "The fact that clinics are now collaborating -- and recently qualified for federal financing -- is a new and welcome development in what can seem like a bleak medical landscape. Andy Kopplin, executive director of the Louisiana Recovery Authority, said that efforts to address problems with the New Orleans health care system are "critical for both the short and the long term." He said, "Short-term, having confidence that the health care residents need will be available and accessible is vital for folks who are returning," adding, "Long-term, it's important for employers -- and health care is a huge business in New Orleans."

Government officials and community leaders have begun floating plans for the future of the city's medical system, for a state-of-the-art hospital, for a cutting-edge system to cover the uninsured, even for a bio-innovation center that would be an engine for economic growth, but the question is what will happen in the meantime, which is likely to be many years long.

Source: Medical News Today, 7/27/07.

TEXAS

Prevention Falls Short. As more states and municipalities move toward education and outreach for children in abuse and neglect situations, and often with dramatic results, Texas remains woefully behind the times. Faced with an alarming spike in fatalities four years ago, Texas lawmakers responded by cutting funding for prevention by 26 percent. This year, with a budget of \$913 million, CPS will spend \$1 out of every \$100 on prevention, according to an analysis by Madeline McClure, director of Tex Protects, the advocacy division of Austin nonprofit Prevent Child Abuse Texas. By comparison, far more will be spent on paying caseworkers, whose focus is removing children from homes where they're thought to be at risk. In 2006, CPS removed 12,205 children statewide, 908 of them in Bexar County. Dozens end up sleeping in CPS offices because they have nowhere else to go. Meanwhile, the number of deaths attributed to abuse or neglect continues to rise. Last fiscal year, a record 227 children died statewide. The problem is social as well as systemic. Despite declines in teenage pregnancy across the country, Texas has the highest rate of teen pregnancy, according to the Annie E. Casey Foundation, a national child advocacy group based in Baltimore. Mounting reports of horrific abuse and an increasing number of child deaths prompted Gov. Rick Perry to order an investigation of CPS three years ago.

Source: Associated Press, 7/26/07.

ARKANSAS

Gov. Beebe Continues to Tout Plan for Health Care in Arkansas. Arkansas Gov. Mike Beebe said the ARHealthNet program enables small businesses to provide affordable health care to workers. Beebe believes the plan will help businesses with up to 500 workers provide health care coverage to employees who otherwise may not be able to get coverage. Beebe said the state program is available to the first 15,000 people who sign up. He thinks broadening the number of people who have health insurance will help everybody in the state. “Hopefully it will grow,” Beebe said about ARHealthNet. The program is geared toward low-income and other workers at small businesses. According to the program’s Website, more than 378,000 Arkansas residents between 19 and 64 don’t have health insurance. In order to qualify, businesses must agree to cover all eligible uninsured workers and have at least one employee who meets the income guidelines. Also, the business must not have offered health insurance coverage for at least a year, according to an informational brochure handed out during the governor’s press conference. Annual services under ARHealthNet include six physician office visits and seven inpatient days. There’s a maximum annual benefit of \$100,000. Spouses are covered under the program, but not children. There’s a \$100 annual deductible and a 15 percent co-insurance required after the deductible. The maximum out-of-pocket is \$1,000 annually, including the deductible. Beebe said although the coverage may not be a “Cadillac plan” it’s a good program that produces a healthier and more productive work force. He said the percentage of uninsured children in Arkansas has dropped to 10 percent, but he said until now there’s been nothing to tackle the problems workers face getting affordable health care when they work at small businesses. Traditionally small businesses don’t have the “buying power” to provide affordable health care to employees, said Beebe. Beebe said ARHealthNet complements programs provided by health insurers. “We’re not in competition with the private sector. This is to augment and supplement,” said Beebe. Dr. Joe Thompson, Arkansas surgeon general, said two-thirds of Arkansas small businesses don’t offer health insurance. He said ARHealthNet is a “safety net, a stepping stone, if you will” to providing affordable health care for employees.
Source: Associated Press, 7/20/07.

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