



# *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 within the 110<sup>th</sup> 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. However, the measure is still less than solid because of a threatened presidential veto. 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.

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### **PRESIDENT BUSH THREATENS VETO OF SCHIP MEASURE**

**P**resident Bush, bracing for a series of battles with Congress over spending, threatened this past week to veto a bill expanding SCHIP, calling it “a step toward federalization of health care.” The program expires September 30, and Congress is on the verge of renewing it by providing coverage to an additional 4 million children over the 6.6 million already enrolled — at an additional cost of \$35 billion over five years. Mr. Bush says the bill would expand a program aimed at helping the poor beyond its original intent. The veto threat is just one of nearly a dozen the White House has issued recently aimed at a variety of bills including measures on education spending and financing for medical research. With the fiscal year ending September 30, Mr. Bush and

Congressional Democrats are headed for a showdown over spending similar to the one that preceded the government shutdown of 1995.

On Capitol Hill, lawmakers have yet to complete action on any of their 12 major spending bills. But even if they do, Mr. Bush will not sign them; he has issued veto threats on 10 of the 11 appropriations measures passed so far by the House. At his news conference on Thursday, Mr. Bush sought to get out ahead of the Democrats by painting them as big spenders and himself as a responsible steward of taxpayers' money. He urged Democrats to pass a temporary extension of the health insurance program, and accused them of playing politics with children's health care by waiting until the program was about to lapse to send him legislation they know he will veto. "In other words," Mr. Bush said, "members of Congress are putting health coverage for poor children at risk so they can score political points in Washington."

Democrats, meanwhile, are trying to force Mr. Bush into the uncomfortable position of vetoing a bill covering 10 million children before any spending bills reach his desk. They are casting the president as the compassionate conservative who forgot his compassion." They thought they were going to get a fight on spending appropriations, and what they're getting is 10 million children's health care," said Representative Rahm Emanuel, the Illinois Democrat who is chairman of the House Democratic Caucus. "September 30 is the deadline on kids' health care. We're going to meet that deadline and he's going to get a chance to side with 10 million kids or not." If Mr. Bush's emphasis on fiscal restraint is angering Democrats, it is pleasing conservatives in Mr. Bush's own party, who have long accused the president of allowing government spending to run amok. That criticism is percolating again in Washington this week from an unlikely source: Alan Greenspan, the former chairman of the Federal Reserve, who in a new book has accused Mr. Bush of putting Republican politics ahead of fiscal responsibility.

In calling for Congress to pass a "clean, temporary extension" of the current State Children's Health Insurance Program, Mr. Bush argued that the Democratic bill would raise taxes and allow children whose families earn up to \$83,000 a year to enroll. The Democrats propose paying for the measure by raising the federal excise tax on cigarettes. However, the chief Republican sponsor of the bill in the Senate, Senator Charles E. Grassley of Iowa, said Mr. Bush "is getting bad information." He said Mr. Bush's reference to the \$83,000 limit was drawn from a proposal put forth by New York State to receive an exemption from the program's restrictions, which the administration recently denied. Mr. Grassley said he appealed to the president directly Thursday morning, telling him that a long-term extension of the current law would leave children uncovered, and that the \$5 billion increase in the program the president has proposed is not enough to cover more children.

"Drawing lines in the sand at this stage isn't constructive," Mr. Grassley said, adding, "I wish he'd engage Congress in a bill that he could sign instead of threatening a veto, and I hope he'll still do that." Democrats were more pointed. Senator Robert Menendez, Democrat of New Jersey, accused Mr. Bush of a "stubborn and uncompassionate stance," while Representative John D. Dingell, the Michigan Democrat who is the longest-serving member of the House, called Mr. Bush's stance "shameful."

The House and the Senate have approved the legislation in different forms, and for the last month they have been trying to reconcile their differences. Though they have not announced the fine points of their final bill, they have agreed on its major provisions and are expected to approve it next week, in time for the Sept. 30 deadline. However, it is unlikely that the approval will come with a veto-proof margin. The bill Mr. Grassley backed in the Senate passed 68 to 31, with one vote more than the 67 necessary to override a presidential veto if all 100 senators are voting. The House version passed 225 to 204, well short of the two-thirds majority necessary for an override. This means Democrats and the White House will almost certainly have to work together on some kind of extension if Mr. Bush issues his veto, because neither side will want to take the blame for letting the children's health program lapse.

*Source: The New York Times, Associated Press, 9/21/07.*

## 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 contender **Sen. Joseph Biden** and Republican **Fred Thompson**.

**Senator Biden** has put forth a plan that he headlines as the "Four Practical Steps toward Health Care for All." He proposes four essential steps as the foundation to a comprehensive plan:

- 1) *Reduce the cost of health care* by focusing on prevention, improving management of chronic illnesses, investing in information technology that will improve efficiency and thereby lower administrative costs, requiring uniform billing and claims, negotiating for prescription drug costs, meeting the need for new health professionals in the workforce.
- 2) *Coverage for all children* by expanding the SCHIP program and allow families to but into the program further.
- 3) *Lower health care costs for employers* by establishing a federal loss pool to reimburse employers for catastrophic care costs.
- 4) *Encourage reform in the insurance industry*. To help people afford health insurance, Joe Biden would: allow insurers that offer individual policies to access the reinsurance pool if they agree to use community rating to underwrite their policies and agree not to turn people away because of pre-existing conditions or risk of them; and protect against genetic discrimination by prohibiting employers and insurance companies from collecting or using genetic information when making decisions about hiring, providing health coverage, or discriminating in the pricing of an insurance policy.

Source: *Biden Campaign, 9/21/07.*

**Fred Thompson** has said he is committed to a health care reform program that "realigns programs and creates a system around individual consumers and patients by providing more information and more opportunities to choose affordable health care options." His plan lacks many specifics, but in general terms, Thompson wants the nation to shift to a system that promotes cost-effectiveness in prevention and chronic care management, that modernizes and streamlines care by use of information technology, and "increases competition and consumer choice while streamlining regulations through free-market solutions." Thompson has said he advocates a plan that will provide access to affordable, portable, health insurance without creating new government mandates or raising taxes.

Source: *Thompson Campaign, 9/21/07.*

## CONGRESS RE-VISITS MEDICAID IDENTIFICATION LAW AS PART OF SCHIP LEGISLATION

Congress is working to soften the impact of a year-old law that is designed to keep illegal immigrants from getting Medicaid benefits but is inadvertently disqualifying many U.S. citizens from the health insurance program for the poor. Retooling the law, which requires Medicaid patients to prove their citizenship, is one small part of federal legislation to extend the State Children's Health Insurance Program beyond its September 30 expiration date. As pointed out previously, House and Senate negotiators are hammering out the last details of an SCHIP agreement this week, despite President Bush's threats to veto the legislation.

In working out an SCHIP deal, House and Senate negotiators also are seeking agreement on changes to the Medicaid documentation law, which passed last year in the Deficit Reduction Act. The law requires Americans asking for Medicaid benefits to prove they are citizens by producing certain government-produced documents, such as birth certificates or passports. States report the new requirement has created roadblocks for

many qualified applicants. Plus, state officials say, it has cost them millions of dollars to comply with and has caused backlogs and confusion among administrators and applicants. To qualify for Medicaid, applicants were previously allowed to provide either official documents or unofficial ones, such as baptism certificates or birth announcements, to prove citizenship. In some cases, states approved enrollees after they swore under oath that they were citizens. Only U.S. citizens and certain legal immigrants, who must prove they're authorized to be in the country, qualify for Medicaid.

At this point, Congress is weighing competing fixes to the documentation requirements. The House voted to let states go back to the old rules, but only for children, not adults. The Senate, on the other hand, would give states another option for verifying citizenship: checking identification electronically with the federal Social Security Administration. However, the Senate's version would also make SCHIP enrollees go through the same checks as Medicaid recipients, a step they have not had to take under the current law. The backtracking comes because states report they're spending more money to comply with the documentation law but have found very few illegal immigrants receiving benefits. Officials attribute at least part of the decrease to enrollees being unable to produce the necessary documents or unwilling to deal with the hassle of reapplying.

*Source: Stateline.org, 9/21/07.*

## VATICAN EDICT ON FEEDING TUBES DEBATED

**E**nd-of-life care for Catholics is in the spotlight again following the Vatican's statement last week that feeding tubes should not be removed from patients in a vegetative state.. Prominent Catholics have traditionally split over the issue. Religious uncertainty was so pronounced that the U.S. Conference of Catholic Bishops wrote to Rome in April 2005 requesting a response to two questions. Is the administration of food and water to a patient in a vegetative state morally obligatory, the bishops asked, and does it make a difference if a patient is permanently unconscious? Last week, the Vatican's highest theological body responded. Yes, giving food and water to a patient artificially is a basic means of maintaining life and therefore morally obligatory in most circumstances, it wrote. And no, this obligation doesn't change if a patient has no hope of recovery. That settles where Rome stands, but it leaves open a host of practical and religious questions. From a practical standpoint, Catholic health-care institutions -- including 615 hospitals and 511 skilled nursing homes across the U.S. -- may now have to alter practices. Until this latest Vatican pronouncement, medical centers had followed what was previously understood to be the church's guidance: There was a bias in favor of using feeding tubes in profoundly compromised patients, but the devices could be withdrawn if patients or their families insisted there was cause to do so.

This flexibility has deep roots in Catholic medical ethics, which do not prescribe a set of rules that all patients must follow. Instead, religious tradition calls for each patient to weigh the pros and cons of potential treatments. If the burdens -- physical discomfort, emotional distress, financial stress -- outweigh the benefits, treatment is considered "extraordinary" and can be refused. If the benefits exceed the burdens, the care is defined as "ordinary" and must be continued, said James Walter, director of the bioethics institute at Loyola Marymount University in California.

Now, however, Rome has said feeding tubes must be considered "ordinary" care for patients in a vegetative state except when there are significant physical complications, such as ongoing infections or when a patient can no longer assimilate food and water. This means that people who have living wills specifying that they not be kept alive in a vegetative state cannot be certain their wishes will be respected in Catholic medical institutions. Nationally, as many as 25,000 U.S. patients are believed to be in a vegetative state. From now on, Catholic facilities will need to inform families in advance that they cannot acquiesce to the patient's or the family's wish to remove a feeding tube when the person is in a vegetative state. If families object, a transfer to another medical institution will have to be arranged. The logic is that "no matter how serious the patient's brain damage or disability, this is still a human being with full human dignity and we must provide basic care," said Richard Doerflinger, deputy director of pro-life activities for the U.S. Catholic Bishops.

*Source: Catholic Health Association of the United States, 9/20/07.*

## SURVEY SHOWS MORE THAN ONE-THIRD WENT WITHOUT HEALTH INSURANCE OVER LAST TWO YEARS

More than one-third of the U.S. population under the age of 65 went without health insurance for all or part of the last two years, according to the nonprofit Families USA group, using data from last month's U.S. Census Bureau report. Researchers found that 47 million Americans went without health insurance for all of 2006. Families USA broke down that figure and calculated that 89.6 million people under age 65 -- 34.7 percent -- went without health insurance at some point during 2006-2007. It used a projection for the remaining months of this year.

"The huge number of people without health coverage over the past two years helps to explain why health care has become the top domestic issue in the 2008 presidential campaign," Ron Pollack, executive director of Families USA, said in a statement. "The expansion of health coverage in America is no longer simply a matter of altruism about other people but a matter of intense self-interest." Budget crunches mean states have tightened eligibility for programs such as Medicaid, the public insurance plan for the poor and disabled, and for programs covering children. Surveys also suggest that many of those going without insurance are middle-class and employed. The Families USA report found that nearly two-thirds of people who lacked coverage at some point went uninsured for six months or more, and half went uninsured for nine months or more. **Texas had the most people without insurance** -- 45.7 percent of the non-elderly population.

The report found that more than 79 percent of those without insurance were in families in which at least one person had a job, 70.6 percent were themselves employed full-time, and 8.7 percent were employed part-time. "The number of uninsured has reached crisis proportions that must be addressed by the President and Congress to ensure that health coverage is available and affordable for all," Pollack said.

Source: Reuters News Service, 9/20/07.

## Of Physician Interest

### ETHICAL GUIDELINES OUTLINED FOR HEALTH CARE REFORM

A new consensus report published in the ethics journal *The Hastings Center Report* outlines a basic ethical framework necessary for health system reform. The report, "Improving Access to Health Care: A Consensus Ethical Framework to Guide Proposals for Reform," highlights key ethical obligations and recommendations to guide health system reform proposals in order to improve access to care. The report was authored by members of the Ethical Force Program, a multi-stakeholder collaboration led by the American Medical Association's (AMA) Institute for Ethics. "By all accounts, health care in America faces many ethical challenges - one of the most notable being that 47 million people are without health insurance," said Paul Schyve, MD, chair of the Ethical Force Program Oversight Body and senior vice president at The Joint Commission. "One of the barriers to change has been the lack of consensus on the fundamental principles that should govern reform of the American health care system. This report provides a shared ethical framework for health reform agreed upon by individuals who represent the perspectives of patients, practitioners, employers, politicians, and the public."

In the report, the group outlines four fundamental ethical obligations that are mandatory for successful access to health care in a just society. According to the ethical framework:

- Every member of society must have an adequate array of core health care benefits.
- The contents and limits of health care benefits must be established through an ethical process.

- The health care system must be sustainable.
- The health care system must ensure that its stakeholders have clear responsibilities for which they are accountable.

"The ethical framework is based on shared American values, such as equality of opportunity, justice and compassion for our most vulnerable," said Mark A. Levine, MD, member of the Ethical Force Program Oversight Body and chair of the AMA's Council on Ethical and Judicial Affairs. "These are values that everyone can embrace, yet until now, they haven't been organized and articulated in such a way as to help drive health system reform. That's what this report can do." The release of the Ethical Force Program report comes only a few weeks after the launch of the AMA's "Voice for the Uninsured" campaign, a three-year, multi-million dollar campaign to spur action to cover the uninsured. The AMA is reaching out to voters and candidates to talk about the problem and the AMA's solution, and encouraging Americans to vote in 2008 with the issue of the uninsured in mind.

*Source: American Medical Association, 9/20/07.*

## Of Regional Interest

### LOUISIANA

*Reforms from Louisiana Health Care Redesign.* Louisiana has traditionally ranked at the bottom of the pile in health rankings. However, after nearly two years of study by the state's health care redesign collaborative, the state created legislation this past session that revamps health care delivery to Medicaid and low-income, uninsured patients, part of which is beginning to come to fruition. The reform dubbed Louisiana Health First focuses on what's called the "medical home" system of care with a primary care provider coordinating the patient's care with the patient's specialists and other providers. It utilizes health information technology to allow the providers to share information as they manage the patient's condition. The coordination will enable care to be focused on preventative treatment of the patient, cutting down on medical costs in the long run, said Dr. Fred Cerise, earlier this month when he was still serving as the state's secretary of Health and Hospitals that oversaw the reform. Last week, Cerise stepped down to oversee operations of the LSU public hospitals and medical education programs. "We know that we've got to do a better job of coordinating care because patients often have a primary provider, a specialist provider and then hospital provider and beyond," Cerise said. "There are expectations you can put in place up front and measures to see if it's working." The current system of health care is uncoordinated - not worthy of the term "system," Cerise said. "What exists today in Louisiana and most areas of the country is an uncoordinated, hard to call it a system, with a number of access points of care where providers are reimbursed for a fee-for-service world," said Cerise. It's also set up for the convenience of the provider, Cerise said.

While the legislation gets its legs, the state is ready to roll out the first phases of the reform in Lake Charles and New Orleans where health care gaps are most evident following the 2005 hurricane season. It's estimated that it will cost \$226.9 million with \$64 million of the funds coming from state monies to begin the medical home model of care in those two areas. It could cost \$946.6 million to implement the medical home model statewide. But the legislation requires an annual appropriation approval from the legislature. The two areas will serve as the pilots for the reform with implementation phased in to the rest of the state in 2009, Cerise said. "It's going to take time to phase in enrollment," Cerise said. "Once up and running, we anticipate it's going to be a couple of years to get substantial number of people enrolled in these programs. We want to make sure we can get this done." The plan calls for changes in the way that physicians are reimbursed with added incentives for those who track patients, which will take approval from the Centers for Medicare and Medicaid Services. But that will take time to implement, along with time to recruit physicians, Cerise said. Now, the providers will track patient care.

"With electronic records, you'll track your people with disease and know that you've taken the appropriate preventative measures, so that you're more proactive in managing people's care," Cerise said. A key challenge is improving information technology at some health care facilities, which is costly. The projects must meet the criteria of the state - home system of care, health information technology, and other standards, said Kristy

Nichols, director of the DHH's Bureau of Primary Care and Rural Health. "A common problem for providers, especially those trying to provide care for the uninsured is that they don't have funding for technology enhancements or when they want to expand and provide more services to communities in need," Nicholls said. The LSU hospital in Shreveport is teaming up with DHH and rural hospitals in north Louisiana to create an information network.

*Source: The Daily Advertiser, 9/18/07.*

## TEXAS

*Physician Rates Lowered for Fifth Time.* Medical Protective, Texas' oldest primary medical professional liability insurer, has announced it will reduce its average rates for Texas physicians by another 7.3%, effective January 1, 2008. This will be the fifth reduction in the last three years, cumulatively reducing malpractice premiums for Texas physicians by an average of over 30%. This is believed to be a direct result of comprehensive medical malpractice reform becoming law in the state and is an important indicator of the financial impact such legislation can achieve. Texas has become a model of study for other states seeking similar medical malpractice liability limits.

*Source: Business Wire, 9/18/07.*

## ARKANSAS

*Insurance Commissioner Announces Settlement.* State Insurance Commissioner Julie Benafield Bowman announced that United Healthcare has agreed to pay an assessment of up to \$20 million to Arkansas and other states over alleged violations of claims payment services, according to an Arkansas Insurance Department news release. Arkansas, Connecticut, Florida, Iowa and New York led the negotiations for the settlement. Claims handling and other state administrative practices were reviewed through state-led market conduct examinations, according to the release. Arkansas is expected to receive more than \$224,000, according to the release. United Healthcare also agreed to implement a detailed, three-year improvement plan for its claims payment system. If the company fails to meet set benchmarks, an additional \$20 million assessment could be levied against the company, according to the release.

*Source: North Arkansas Bulletin, 9/18/07.*

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