



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 110th Congress – including an examination of the outlook for health care issues:

- 1) The State Children’s Health Insurance Program (SCHIP) might be the most important piece of legislation to be addressed this year. SCHIP requires re-authorization during this congressional session. Unless Congress changes the budget baseline rules for SCHIP, funding will remain frozen at FY2007 levels for the long term. President Bush included a freeze in his proposed budget. Many states that were looking at increasing their coverage to more children are putting their programs on hold until additional funding is assured. In addition to the funding issue, many of the children who are eligible for coverage under SCHIP in many states did not get enrolled. Remediating this situation requires additional hearings and most likely, additional funding.
- 2) The Medicare drug program is also on the table for discussion – some lawmakers believe that Medicare needs to be able to negotiate with drug manufacturers for best prices, but others believe that the best prices are available now and the introduction of formularies would work to increase costs. Most agree that there should be a move in the program to the use of generics.
- 3) Reimbursement rates for physicians are an important issue. The primary concern involves the annual effect of the Sustainable Growth Rate (SGR). Many on Capitol Hill believe this must be dealt with a long term manner rather than addressing the 5-6% deficits required under the SGR each year.
- 4) Health Information Technology – Congress is looking for a funding mechanism for hospitals and physicians to purchase HIT necessary to track quality measures, support electronic health records, and collect data that will be useful in determining new quality measures as time goes on.

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 and renewed examinations of the Medicare prescription drug plan.

- HOUSE PASSES FIVE YEAR SPENDING PLAN
- THE FUTURE OF UNIVERSAL HEALTH CARE

- WHITE HOUSE PROPOSES IMMIGRATION MEASURE
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HOUSE PASSES FIVE YEAR SPENDING PLAN; \$50 BILLION FOR SCHIP

House Democrats passed a five-year spending plan this week that offers something to almost everybody but leaves many questions unanswered — much like the plan passed last week by the Senate. The House plan, approved 216 to 210, envisions a balanced budget by 2012. It would provide an additional \$50 billion over five years to fund SCHIP for low-income children, \$7.9 billion more next year for education and social service programs and \$3.5 billion more than President Bush has requested for veterans programs. The plan would also reject Mr. Bush’s proposal to reduce the projected spending on Medicare and Medicaid entitlement programs by more than \$250 billion. But both the House and Senate budgets implicitly require tax increases in the years ahead. Neither offers any guidance about where the needed extra revenue would come from. Almost all of Mr. Bush’s tax cuts are now set to expire at the end of 2010. Democrats have said they want to extend most of them, but they have adopted tough “pay-as-you-go” requirements that will require Congress to pay for new spending and additional tax cuts with tax increases or savings in other areas. “After years of reckless budgets and skyrocketing debt, Democrats have brought fiscal sanity back to Washington,” said Representative Rahm Emanuel of Illinois, chairman of the House Democratic Caucus. The plan, Mr. Emanuel said, “funds the right priorities for our country and puts middle-class families first.” Republicans said the Democratic budget would lead to huge tax increases without doing anything to slow the explosive growth of entitlement programs like Medicare and Medicaid. “No matter how they spin it, no matter how they dodge it, they will raise taxes,” said Representative Paul D. Ryan, (R-WI), in debate on the House floor. “Numbers don’t lie. This budget, this Democratic budget, gives us the largest tax increase in American history.” Democrats easily defeated, by a vote of 268 to 160, a substitute proposal by Mr. Ryan that would have exempted tax cuts from the new budget rules and would have reduced projected spending on Medicare and Medicaid by \$279 billion over the next five years.

The Democrats’ plan would postpone most of the hard decisions on how to finance their priorities. Instead of instructing the tax-writing committees to raise taxes or cut spending, the plan includes a long list of “reserve funds” to pay for new programs. The “reserve funds” are not actually funds, but rather expressions of commitments to use funds for particular purposes if more money becomes available. The list of reserve funds includes \$50 billion over five years for doubling the Medicaid health care program for low-income children; \$50 billion for a one-year freeze of the alternative minimum tax; \$20 billion over five years for additional farm programs; and a less well-defined fund for middle-class tax cuts. One immediate hurdle for Democrats is the proposed freeze on the alternative minimum tax. Originally created to catch millionaires who took too much advantage of tax breaks, the tax is about to affect 20 million households because it is not adjusted for inflation. The one-year freeze alone will cost \$50 billion, and the cost of a freeze would rise sharply with each additional year.

The cost of extending Mr. Bush’s tax cuts is even higher. As now written, the Democratic budget assumes a gusher of more than \$400 billion in the two years after Mr. Bush’s tax cuts are set to expire. Representative John M. Spratt, (D-SC) and chairman of the House Budget Committee insisted that the plan would protect Mr. Bush’s tax cuts at least through the end of 2010 and would “leave until the future” the decisions about what happens to them after that. Supporters of the Democratic plan said it was a step toward greater fiscal

discipline. Mr. Bush and Republican lawmakers have opposed applying any “pay as you go” rules to tax cuts and Mr. Bush’s tax cuts have largely been financed with higher government borrowing. Indeed, total government spending has climbed far faster under Mr. Bush than it did under President Clinton, while tax revenue has climbed far more slowly. All told, federal debt has grown by almost \$4 trillion since Mr. Bush took office.

Source: *The New York Times*, 3/30/07.

THE FUTURE OF UNIVERSAL HEALTH CARE TAKES SHAPE AMONG PRESIDENTIAL CONTENDERS

Of the 300 million people in the U.S., roughly 15% don't have health insurance. One big reason: Small businesses, which employ over half of America's private sector workers, can't afford it. That means they also can't attract the talent they need to grow. For years the unholy grail, from a political standpoint, has been "universal health care." While giving everyone access to regular medical care is a nice thought, figuring out how to pay for all that care--without jacking taxes through the roof--is a policy nightmare. Now, it seems, we may be moving closer.

Starting this July, all Massachusetts state residents must purchase health insurance or face a tax penalty. And in more than a dozen states around the U.S., local legislators now are actively wrestling with universal health care schemes. In Massachusetts, small companies will have the option to buy health insurance through a state-regulated agency that aims to soften premiums by spreading risks and administrative costs. Employers that don't offer health coverage will pay a penalty per employee. Meanwhile, individuals will have better access to affordable health care, easing the burden on small employers. All of this, lawmakers say, could spell some relief for entrepreneurs. That's the theory, but there are plenty of kinks. One is basic math. If employers decide they would rather eat the penalty rather than shell out the incremental costs for health coverage, then they are in worse shape from a financial standpoint than before. The same calculation goes for individuals. At bottom, the Massachusetts plan--and others like it--is more of a nudge than a clear-cut solution. Still, it's something.

What's more, the notion of universal health coverage seems to be garnering support from both sides of the aisle. That's a big shift from just a decade ago when President Clinton (and now Sen. Hillary Clinton) took heat for proposing--and failing to deliver--what was roundly considered a "big government" solution to the health care. Now even conservatives are giving universal health care some lip service. Massachusetts passed its plan under a Republican governor (and a Democratically controlled state legislature). Earlier this year Gov. Arnold Schwarzenegger of California unveiled his own aggressive plan that would cover even illegal immigrants. And it's not just the coasts. Governors in New Mexico, Colorado, Louisiana, Oregon, Wisconsin, Kansas and Illinois, among others, have trotted out universal health plans, while other states like Michigan, North Carolina and Ohio have commissioned outside consultants to crack the financial logistics. Earlier this year both Republican and Democrats in New Mexico's state legislature introduced proposals for universal coverage. Neither passed, but "I took it as a real testament that both [sides of the House] are very interested in pushing this forward," says Pamela Hyde, New Mexico secretary of human services.

So how do legislators expect to pay for this dream? Insurance regulations differ in each state (as do the numbers of uninsured), complicating the calculations. No matter how you slice it, though, tax hikes are probably part of the plan. "Every politician wants you to tell them that you can provide coverage to everybody and spend less money, but analytically you shouldn't be counting on that," says Linda Blumberg, principal research associate at the Urban Institute, a non-partisan tax policy think tank. Massachusetts, with 550,000 uninsured residents, is doing its best to keep a lid on taxes. The first step of its plan--crafted under former Gov. Mitt Romney, now running for president--is getting all of those who are eligible for Medicaid (the federally administered program aimed at poor citizens) to sign up. The goal: to ease the burden on state-funded emergency rooms by giving the poor more access to preventative care.

The second step involves linking residents with lower-cost insurance plans via a state-regulated entity called the Connector. Those with incomes up to 300% above the poverty level (or about \$50,000 in annual income for a family of three) will receive sliding-scale subsidies to purchase one of four basic plans from four insurance carriers. Also through the Connector, small firms with fewer than 50 employees will be able to choose from a broader array of plans from seven carriers. (Mammoth insurer UnitedHealth Group submitted a bid but didn't make the cut.) If employers still choose to skimp on health benefits, all residents will have access to those

same small-company plans. To attract talent in lieu of insurance premiums, employers can open Section 125 plans that allow employees to use pre-tax wages to buy their own health insurance.

What will all of this cost? Initial estimates from the Massachusetts government last year: \$1.8 billion--much of it in subsidies. Legislators said they wouldn't raise income taxes to cover the bill, though now they admit the costs could be higher than projected.

Here is the financial plan. First, redistribute funds slated for Medicaid. When it passed universal health care legislation a year ago, Massachusetts was sitting on some \$400 million in unused federal Medicaid funds. The next honey pot: \$600 million used to run free clinics at hospitals. With more preventative care, the theory goes, the less clogged those clinics should be. But that's still not enough. To raise more money, Massachusetts plans to charge firms with more than 10 employees a fee of up to \$295 per worker if they don't offer health insurance. (Merely opening that Section 125 plan is not enough.) Finally, pile on another \$300 million from existing "general state funds."

California--with nearly 6.6 million uninsured (19% of the population, vs. 11% for Massachusetts)--has even bigger funding issues. Gov. Schwarzenegger is calling for a 4% payroll tax on companies that don't "play"--and another 4% tax on doctors and hospitals. Worse, employers would only have access to one plan, vs. the wide array at the Massachusetts Connector.

All of this assumes that "play or pay" even flies with regulators, of course. Earlier this month, a federal court overturned Maryland legislation requiring Wal-Mart to buy health insurance for workers. Reason: such a mandate violates the Employee Retirement Income Security Act. (Massachusetts' more modest proposals aren't expected to face similar challenges.) How long might this universal health care revolution take? Legislators in Massachusetts spent more than three years honing their plan before laws were passed. California, which is further along than most other states, is well behind that.

Ultimately, policy experts agree, the federal government will have to step in. So far John Edwards is the only presidential candidate to announce a comprehensive plan for universal health coverage. Meanwhile, Romney argues the problem should be solved at the state level.

Source: Forbes, 3/29/07.

WHITE HOUSE PROPOSES IMMIGRATION MEASURE

A White House plan devised in weeks of closed-door meetings with Republican senators would grant work visas to undocumented immigrants but require them to return home and pay hefty fines to become legal U.S. residents. The draft immigration legislation is the first stab by the White House and Republican senators to address the presence of 11 million to 12 million illegal immigrants living and working in the country and the reliance by employers on illegal workers. The White House draft plan was circulating earlier this week around Capitol Hill and among groups with an interest in immigration legislation after elements of it was leaked late Wednesday. Under the plan, undocumented workers could apply for three-year work visas, which the plan dubs "Z" visas. They would be renewable indefinitely but renewal would cost \$3,500 each time. The undocumented workers would have legal status with the visas, but to get a green card, making them legal permanent residents, they'd have to return to their home country, apply at a U.S. embassy or consulate to re-enter legally and pay a \$10,000 fine. The plan also tries to make border security a priority by requiring 18,300 Border Patrol agents and 370 miles of physical fencing be in place, as well as electronic monitoring of the southern border ongoing before a temporary worker program could start. The plan is far more conservative than the one the Senate approved last year with bipartisan backing and support from President Bush. That plan, whose principal architects were Sens. John McCain (R-AZ), and Edward M. Kennedy, (D-MA), allowed illegal immigrants to stay in the U.S., work and apply to become legal residents after learning English, paying fines and back taxes and clearing a background check. Critics dismissed that bill as an amnesty. Supporters of immigration reform say the draft plan shows the White House is serious about getting a bill completed this year. But immigration advocates were disappointed with the product and see it as a step backward. "For us it's a no go," said Angela Kelley, deputy director of the advocacy group National Immigration Forum.

A plan to make more green cards available to skilled workers by limiting visas for parents, children and siblings of U.S. citizens and one that would prohibit temporary workers from bringing family members is one of the plan's

more controversial provisions. "President Bush said family values don't stop at the Rio Grande. Evidently they do," said Kevin Appleby, director of Migration and Refugee Policy for the U.S. Conference of Catholic Bishops. Kennedy appeared at a news conference in support of immigration reform with evangelical leaders, including Richard Land, president of the Southern Baptist Convention's Ethics & Religious Liberty. The leaders said they plan to exhort their congregations to push lawmakers and take other steps to get an immigration reform bill passed. Family unification, said Kennedy, "has been an essential aspect of immigration policy since the history of this country" and letting immigrants work their way toward legalization is a framework for previous immigration bills that has received substantial support. "You don't compromise on the morality of these issues," Kennedy said. "We're not going to."

However, Sen. John Cornyn (R-TX) said he favored gearing immigration toward the higher skilled and educated who he said would help the country. The immigration plan is the result of about a month of meetings among White House officials, Homeland Security Secretary Michael Chertoff, Commerce Secretary Carlos Gutierrez and Republican senators. Democrats recognize they need Republican support to get an immigration bill passed this year and have been counting on Bush to deliver Republican votes. A House bill introduced last week by Reps. Luis Gutierrez (D-IL), and Jeff Flake (R-AZ), also attempts to appeal to conservatives. It provides six-year work visas to undocumented immigrants and requires them at some point during that period to exit the country and re-enter using their work visa.

Source: Associated Press, 3/29/07.

REPORTS EXAMINE WAYS TO RE-VAMP CMS PAYMENT

Reports released earlier this week evaluated the Center for Medicare and Medicaid methodologies for converting its inpatient hospital payment system from being charge-based to one that is cost-based and which more fully reflects the severity of a patient's condition. RTI International found that converting to cost-based weights might lead to distortions in the value of diagnosis-related groups, where low-cost DRGs are overvalued and high-cost ones are undervalued. There's also the issue of "charge compression," which refers to the practice of assigning a lower markup to relatively high-cost items and a higher markup to lower-cost items. RTI determined that charge compression could underestimate or overestimate cost estimates for specific DRGs, biasing the weights. Separately, a working paper from RAND Health found that a severity-adjusted classification system developed by 3M Co. does the best job of paying for patients appropriately and explaining or differentiating DRGs based on cost. The RAND paper compared five systems that could be used to classify discharges into severity-adjusted DRGs with the CMS' current DRG system. The paper found that all five systems would reduce the amount of cost variation within DRGs, and that each of the five systems did a better job of explaining differences in cost across Medicare discharges than the current system. Although 3M's consolidated, severity-adjusted DRGs system rated highly in these categories, its drawbacks are that it is a proprietary system that is very difficult to understand.

Source: Modern Healthcare, 3/27/07.

CORRECTION TO NUMBER OF NATION'S UNINSURED

The government's estimate of the number of people in the U.S. without health insurance fell by nearly 2 million people last week, but not because anyone got health coverage. The United States Census Bureau said it had been overstating the number of people without health insurance since 1995. The agency blamed the inflated numbers on a computer programming error. The agency reissued figures for 2004 and 2005 last Friday. It plans to issue new numbers for every affected year in August, when the 2006 numbers are scheduled for release. Health insurance statistics are widely cited in debates over the nation's healthcare system, expected to be a major issue in the 2008 presidential election. The revised estimates show that 44.8 million people, or 15.3% of the population,

had no health insurance in 2005. The original estimate was 46.6 million, or about 15.9% of the population. "The total impact is small," said Ruth Cymber, the agency's director of communications. She said similar reductions are expected for previous years, leaving historical trends unchanged. In 2005, the percentage of people without health insurance was at its highest point since 1998, according to the original numbers. Workers discovered the programming error when they were updating the computer system.
Source: The Associated Press, 3/27/07.

Of Physician Interest

SUPPORT FOR HEALTHCARE INFORMATION TECHNOLOGY

The American Medical Association (AMA) today expressed support for advancing health information technology (HIT) in physician offices, while urging Congress to make privacy and security of patient information a top priority and called for funding assistance to implement HIT into physician practices. The AMA submitted its stance in a statement to the House Committee on Small Business Subcommittee on Regulations, Healthcare and Trade. "We share the widespread optimism over the promise that HIT holds for transforming patient care if properly developed and carefully integrated into the existing health care delivery system," said William G. Plested, MD, AMA President. "If carefully structured, HIT has the potential to raise the overall quality and safety of patient care." Protecting patients' privacy and security is a top concern of physicians, and the AMA encourages Congress to make those issues a top priority when creating an HIT infrastructure. "Safeguarding the privacy and confidentiality of patient information is a professional responsibility that physicians take very seriously," said Dr. Plested. "When a patient's private and sensitive health care information can be made public with the touch of a button, it is imperative that adequate privacy and security standards and protections be developed." A common barrier to HIT implementation in physician practices, especially smaller practices, is the significant cost. The AMA strongly urges Congress to consider direct means to assist physicians, such as grants, low-interest loans, increased reimbursement for the use of HIT, accelerated depreciation for HIT investments, tax credits, and other economic incentives. A study by Robert H. Miller found that initial electronic health record costs were approximately \$44,000 per physician with ongoing costs of about \$8,500 annually. A report by the Congressional Research Service estimates similar per physician cost, with HIT start-up costs ranging from \$16,000 to \$36,000. "The decreasing revenue from public and private payers, high medical liability insurance premiums, and state and federal mandates, makes the cost associated with implementing HIT a significant impediment for physicians," said Dr. Plested.
Source: American Medical Association, 3/28/07.

Of Regional Interest

LOUISIANA

Lawmakers Call For Task Force. The Louisiana congressional delegation this week called for the creation of a technical working group comprising state, federal, private and community-based health-care providers to end a stalemate over how to provide coverage for the uninsured. In a letter to U.S. Department of Health and Human Services Secretary Mike Leavitt and Louisiana Department of Health and Hospitals Secretary Dr. Fred Cerise, the nine-member bipartisan delegation requested the working group to agree on statistics in dispute. "We believe that to move forward, all parties must agree on basic statistics, such as the uninsured population in both the greater New Orleans area and statewide," said the letter from the office of U.S. Sen. David Vitter, R-La. Among the statistics are:

- The estimated number of uninsured people statewide by income level.

- The portion of federal disproportionate share hospital money Louisiana has received annually from 2004 to the present, specifically, how much of this allocation is paid by the federal government and how much is matched by the state.
- The maximum amount of disproportionate share hospital money available to Louisiana under current federal rules and the state/federal breakdown.
- Actual disproportionate share hospital expenditures for the current and previous three fiscal years, including where and how it was spent.
- A clear accounting for what has been sent from the federal government to Louisiana for health care in the current and previous three fiscal years.

A fundamental disagreement about the statistics has prevented both health-care redesign and the building of a health-care hospital from moving forward, the letter said.

State officials want to rebuild Charity Hospital, which was destroyed in Hurricane Katrina. Federal officials want to use money dedicated to the state for private insurance for the uninsured. State officials have balked at the move, saying it would leave about 400,000 residents uncovered.

“As a state, we must invest in a system that has as its core preventative, coordinated, community-based care, not just treatment of ills as they arise,” the letter stated.

Neither Cerise nor Leavitt could be contacted about the letter Monday. Leavitt was traveling in Central America. Cerise was also traveling, DHH spokesman Bob Johannessen said. However, he said, the state has been working with federal officials on the numbers.

The working group’s private sector health-care leaders would be drawn from the Coalition of Leaders for Louisiana Healthcare, which is already working on the issue.

Source: The Advocate, 3/27/07.

TEXAS

Texas PricePoint Launched. Texas hospitals have launched a Web site that allows consumers to learn the sticker price for common medical procedures ahead of time. Texas PricePoint provides details about most of the hospitals in the state, as well as a breakdown of each hospital's usual charges and the duration of patient stays for hundreds of treatments. It's intended as "a consumer education tool" that makes data now collected by two state agencies more readily available to patients, said Patricia Kolodzey, the Texas Hospital Association's director of advocacy and public policy. "Employers are trying to push more accountability to their employees on the purchasing of their services," Kolodzey said. "This is a good first step for Texas to put some information out there, to allow the consumer -- whether they have insurance or whether they do not have insurance -- to actually look at some of the hospital information."

The Web site, which now relies on 2005 statistics, allows consumers to determine which local hospitals do the most business in a particular procedure, which has the lowest average daily charge and how long patients typically are hospitalized. PricePoint doesn't offer details about the price markdowns available at specific hospitals, nor does it include charges for outpatient procedures, and although it doesn't contain descriptions about the quality of medical care at each hospital, the site does link to a federal government site that offers some of that information. It also includes statistics for each hospital such as:

How much of the hospital's revenue comes from Medicare and Medicaid patients.

How many of its charges go unpaid by charity patients and people who fail to pay their bills.

How severely ill its Medicare patients generally are.

The hospital association expects to unveil an updated version of the Web site this summer that would add several features, including the ability to compare several hospitals side by side.

Source: Fort Worth Star Telegram, 3/28/07.

UTAH

Utah to Pay Back Money to Federal Government. Utah will repay the federal government some \$625,000 it over-billed for medical costs during a three-year period. The Utah Department of Health has agreed with a federal audit that the state sought reimbursement for administrative costs for health care at a much higher rate than it should have, according to the report issued Thursday by the inspector general of the U.S. Health and Human Services Department. That department is headed by former Utah Gov. Mike Leavitt. The audit comes after the state itself realized a mistake in its billing from July 1, 2002 through Sept. 30, 2005 under Medicaid's managed health care program. Utah previously paid up to \$6 million back to the federal government after its own probe into billing practices, according to the Health Department's director of Health Care Financing, Michael Hales. "People administering that program weren't aware of the policy or didn't make the change at the time," Hales said. The money was paid out of the program's budget, which annually costs about \$110 million, Hales added. The \$625,000 reimbursement will come out of the same fund, which can handle the cost because of a 7 percent drop in people signing up for Medicaid benefits in the last year. No services will be cut because of the repayment and it will not affect the number of people currently covered.

Source: Salt Lake City Tribune, 3/28/07.

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