Advocacy

Advisory

Vol.9 No. 7, April 7, 2009

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HOT TOPICS FOR ADVOCACY IN THIS ISSUE

THIS ISSUE of the Advocacy Advisory will focus on topics of current interest to health care, including ongoing federal and state issues related to patient access, covering the uninsured, and reimbursements. The CHRISTUS position is consistent that health care dollars must be preserved in programs such as Medicare and Medicaid, as both of these programs these serve a vital function as part of the health care safety net for the uninsured and underserved population.

Putting Care Within Reach:

As one of the largest Catholic health care systems in the United States and because of our solid reputation among policymakers at all levels of government, CHRISTUS Health is uniquely positioned to lead in the effort to achieve meaningful and significant health care reform for this nation. Our efforts will be targeted at achieving objectives in support of the goal of universal coverage, and will include continuing to build effective relationships with legislators and members of the new Obama administration, equipping CHRISTUS leadership and associates with the tools needed to engage and participate in this important national debate, and working to build consensus and collaboration among other health care providers.

The national political scene promises change in 2009 and early indicators are that it will be a favorable time in which to work to achieve our goals. However, there remain significant challenges that CHRISTUS will work to help overcome as a primary feature of our campaign of **"Putting Care Within Reach."** Success will require a profound commitment at every level of CHRISTUS Health, as we all work together in our individual communities and on a system-wide basis to promote a message of hope, change, and quality health care for every American.

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- Congress to Reconcile Separate Budget Resolutions After Recess
- Health Care Reform Debate Begins In Wake of Budget Process
- HHS Confirmation Delayed
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CONGRESS TO RECONCILE SEPARATE BUDGET RESOLUTIONS AFTER RECESS

House and Senate Democrats will return from their recess to a budget battle centered on an $8 billion gap in discretionary spending and differences over whether to use special rules to push healthcare reform through the Senate. Though resolutions in the House and Senate both call for about $3.5 trillion in spending and are largely similar to President Obama’s blueprint, a handful of major differences must be hashed out during a House-Senate conference. The biggest sticking point will be whether to use reconciliation instructions to prevent a GOP filibuster on legislation overhauling the nation’s healthcare system. The House budget includes the instructions, while the Senate budget does not.

Reconciliation rules, which direct committees to pass legislation by a certain date, are approved as part of the budget resolution. That means they need only 51 votes to win Senate passage. Most contentious legislation needs 60 Senate votes to move forward. Senate Republicans and a handful of centrist Democrats, including Senate Budget Committee Chairman Kent Conrad (N.D.), have opposed using reconciliation for healthcare, warning that doing so would make it harder to win bipartisan support for future bills. The other major sticking point between House and Senate negotiators will be over discretionary spending levels. The House would spend $533 billion on non-defense programs in 2010, while the Senate has proposed $525 billion.

The gap amounts to less than 2 percent of the proposed spending levels, but small gaps in spending have loomed large in the past. Last year, Democrats in Congress and President Bush could not agree on appropriations bills despite a difference of about 2 percent. Other differences between the House and Senate plans could quickly fall by the wayside. For example, a Senate amendment backed by centrist Democrats that lowers the estate tax rate and increases exemptions may be discarded in conference. The measure wasn’t in the House budget and didn’t have support among Senate Democratic leaders and the White House, noted James Horney, a former budget aide to Senate Democrats and now the federal fiscal policy director at the Center on Budget and Policy Priorities. The amendment also required that the relief be offset, something lawmakers are often reluctant to do. Overall, the House and Senate budgets are similar to Obama’s proposal. On paper, the chief difference is that the congressional budgets would reduce the deficit in 2014 to less than $600 billion. Critics say the House and Senate use various budget tricks to hide future costs, including an assumption that the Alternative Minimum Tax will be applied.

Both resolutions contain deficit-neutral reserve funds for future healthcare reform legislation. The House resolution, unlike the Senate's version, includes instructions for budget reconciliation, which would fast-track healthcare reform legislation. Republicans failed to support either resolution. Providers have been pressing for the inclusion of long-term care in any kind of healthcare reform measure. The White House issued a statement saying that the House vote is "another step toward rebuilding our struggling economy." The Senate budget reportedly differs from Obama's in that it contains fewer specifics on how to fund healthcare reform, among other initiatives. Senate Majority Leader Harry Reid (D-NV) said the Senate's budget reflects the fundamental priorities proposed by Obama. A two-week congressional recess begins this week.
Source: The Hill, 4/6/09.

HEALTH CARE REFORM DEBATE BEGINS

In the wake of the largest federal budget in history, the real debate now begins over whether leaders will try to push through health care reform now or seek greater bipartisan support for what is one of the Obama administration’s key priorities. One of the most difficult decisions that budget negotiators will face is whether to bypass regular legislative rules to allow health care reform to pass the Senate by a simple majority using a fast-track procedure called "reconciliation." "I hope we don't have to use it, and I hope it encourages Republicans to come to the table and offer real ideas and accept some they don't like, because that's what compromise is about,"

said Sen. Sherrod Brown, Democrat from Ohio. "If they don't cooperate enough, then we go through reconciliation."

The procedure would eliminate the filibuster and allow legislation to pass with only a simple majority, not the three-fifths supermajority needed to end a filibuster. Democrats have 58 seats - a comfortable margin, but two seats short of the 60-seat supermajority. House Democratic leaders for weeks have insisted that keeping the fast-track option open is essential to avoid Republican obstructions on health care legislation. Thomas Mann, a congressional specialist with the Brookings Institution, a liberal-leaning Washington think tank, said that - given the success Republicans have had blocking Democratic measures this year - an argument could be made that Democrats would be "nuts" not to include reconciliation in a final budget resolution. Democrats "are not about to let health care reforms die as a consequence of a unified Republican filibuster," Mr. Mann said. "I am convinced it will survive the budget conference and be part of a final resolution." However, simply threatening to use reconciliation often is enough to force the minority party to accept concessions it otherwise may not consider, political experts have said.

Source: The Washington Times, 4/4/09.

HHS CONFIRMATION DELAYED

Governor Kathleen Sebelius of Kansas appeared last week to be headed for confirmation as health and human services secretary, but several Republican senators objected to an immediate vote, so the Senate is unlikely to take up the nomination until later this month. Ms. Sebelius sailed through a hearing of the Senate Finance Committee on Thursday without encountering any difficult questions about her income taxes or her views on abortion. The committee chairman, Senator Max Baucus (D-MT), said he looked forward to swift approval of Ms. Sebelius. However, Republicans later asked that the committee defer action, meaning that the full Senate would probably not vote before lawmakers leave town on Friday for a two-week spring break. Senators of both parties submitted dozens of written questions to Ms. Sebelius on Thursday and want to review her answers before voting. She said her success in dealing with the Republican majority in the Kansas Legislature and her experience as state insurance commissioner had prepared her to work with Congress in overhauling the health care system. Senator Charles E. Grassley (R-IA) and senior member on the Finance Committee, said Ms. Sebelius had “addressed some tax irregularities.” Neither Mr. Grassley nor other committee members suggested that the tax problems disqualified her. Ms. Sebelius disclosed last week that she and her husband had recently paid $7,040 in back taxes and $878 in interest after discovering “unintentional errors” in their returns for 2005-7.

Seven conservative organizations, including the Family Research Council and Concerned Women for America, issued a statement last week that criticized Ms. Sebelius for supporting abortion rights. The statement, which opposed her nomination, said the governor “may not pay her own taxes but has no qualms about using tax dollars to pay for others’ abortions.” However, senators did not press Ms. Sebelius to explain her record on abortion. Her views on the issue appear to be generally similar to those of President Obama, who as a presidential candidate endorsed a woman’s right to an abortion. Lawmakers did, however, repeatedly ask her about various proposals to expand health insurance coverage and rein in health costs.

Ms. Sebelius affirmed her support for creating a new public insurance plan, which would compete with private insurers. The public plan would provide an additional option to consumers, Ms. Sebelius said. In some metropolitan areas, she said, consumers have few choices because one or two insurance companies have overwhelming shares of the market. More than 30 states offer their own employees a choice between traditional private insurance and a public health plan financed and underwritten by the state, Ms. Sebelius said. In Kansas and other states, she added, this approach “operates very effectively” and “there has been no destruction of the marketplace.”

Source: The New York Times, Associated Press, 4/4/09.

STUDY FOCUSES ON MEDICARE RE-ADMISSION RATES

The nation spends billions of dollars a year on patients' return visits to the hospital — many of which are readmissions that could be prevented with better follow-up care, according to a study published last week in the *New England Journal of Medicine*. As many as a fifth of all Medicare patients are readmitted within a month of being discharged, according to the study, and a third are re-hospitalized within 90 days. Half the patients who returned to the hospital within 30 days of undergoing treatment other than surgery apparently did not see a doctor before they went back. The high rate of hospital readmissions is "one of the fruits of an increasingly fragmented health care system," said Dr. Stephen F. Jencks, a former Medicare official who is an author of the study, which analyzed Medicare claims information for 2003 and 2004. He estimated that the cost of the unplanned return trips was $17 billion in 2004 alone.

Policy analysts say that while high return rates have long been a problem, controlling those costs is increasingly urgent. The Obama administration, as it seeks money to provide health care for more Americans, has already identified hospital readmissions as a source of potential cost-cutting. The president's budget calls for $26 billion in savings from readmissions over 10 years, which includes lowering payments to hospitals with high number of patients who are re-admitted.
Source: The New York Times, 4/3/09.

HOUSE BILL REQUIRES DISCLOSURE BY INSURERS

Health insurers would be required to disclose any limits or exclusions of benefits to plan participants under a bill passed overwhelmingly by the U.S. House of Representatives last week."Many consumers or employers shopping for health care coverage are led to believe that care for a broken arm, for example, is the same regardless of how the injury happened but that is not the case," said Republican Representative Michael Burgess, a physician who sponsored the legislation. He said people who ride motorcycles, horses or snowmobiles or participate in other sports can find that an injury suffered while engaging in those activities is not covered by their health insurance policy." Trip and fall at home and break your arm -- no problem. Get bucked off a horse while on vacation with the family and break your arm - you may be slapped with the bill," Burgess said. "This is simply unfair." The bill, approved 422 to 3, would let insurers exclude coverage for those kinds of injuries, but would require them to inform plan participants of any coverage limitations when they sign up. The House passed the same bill late last year, but it was never taken up by the Senate. Burgess said he hoped the Senate would consider it this time around. Insurance industry coverage and billing practices are being reviewed as part of the overall health care reform focus in Washington.
Source: Reuters News Service, 4/1/09.

Of Physician Interest

MORE PHYSICIANS OPTING OUT OF MEDICARE

Two trends are converging: there is a shortage of internists nationally — the American College of Physicians, the organization for internists, estimates that by 2025 there will be 35,000 to 45,000 fewer than the population needs — and internists are increasingly unwilling to accept new Medicare patients.

In a June 2008 report, the Medicare Payment Advisory Commission, an independent federal panel that advises Congress on Medicare, said that 29 percent of the Medicare beneficiaries it surveyed who were looking for a primary care doctor had a problem finding one to treat them, up from 24 percent the year before. And a 2008 survey by the Texas Medical Association found that while 58 percent of the state's doctors took new Medicare patients, only 38 percent of primary care doctors did.
Source: The Associated Press, 4/1/09.

Of Regional Interest

ARKANSAS

State Attempts to Cope With Rural Health Care Shortage. Despite stepped-up state and federal efforts to recruit doctors to rural communities through student loan forgiveness programs and seed money, the calling often goes unanswered. Federal and state government standards leave Arkansas classified a medically underserved area (MUA), according to the number of physicians, clinics and services available per 1,000 people. Benton and Washington counties are partially underserved, while Carroll and Madison counties and the majority of the state is deemed to be fully underserved. Arkansas widely recognizes that there just are not enough doctors to serve rural populations. According to the Arkansas Department of Health, western Washington County has one doctor for every 4,500 residents, while Madison County has one doctor for every 3,500 residents. Northern Crawford and Johnson Counties also reported one doctor per 5,000 residents. Between 1980 and 2001, the state recruited 134 physicians through a grant program in hopes of drawing more doctors into underserved rural areas, according to Bill Rogers, director of the state's Office of Rural Health. He said the grant program was put on hold from 2002 and 2008, because a lack of funding from the state, but in 2009 four doctors have received the $55,000 grant to be paid over a four-year period. Rogers said the agency completed a study in 2002 that showed an 85 percent retention rate in the doctors who kept their practices in rural areas. Sen. Blanche Lincoln, D-Ark., agreed that health professionals trained in Arkansas are more likely to stay here. The problem, she said, is that more training slots are needed for doctors, nurses and physical therapists in Arkansas higher education. She said not enough doctors are choosing primary care specialization and the Senate finance committee is working to realign those payments at a higher level. She also advocates expanded nursing and geriatric care programs that could help bridge the gap for some rural communities. Financial incentives are an important factor in attracting medical professionals, she added.
Source: Arkansas Democrat-Gazette, 4/3/09.

LOUISIANA

Levine Wants Federal Rules Eased. Louisiana's health chief sought federal relief last week from rules that would require the state to put up hundreds of millions in extra funding for Medicaid. The state would have to pay $700 million more annually to match the federal-state Medicaid financial participation rate proposed, state Department of Health and Hospitals Secretary Alan Levine wrote the interim federal health chief. Levine said that does not count the loss of health-care stimulus dollars that are part of federal recovery efforts. The problem emanates from a federal formula that Levine contends, "has become artificially skewed by the infusion" of hurricane recovery dollars into the calculation of per capita income. States' Medicaid match rates are determined by a formula that includes a three-year average of per capital income. Louisiana's match would go from 28 percent to 36.9 percent by the 2011 federal fiscal year because of the inclusion of hurricane recovery dollars. Levine asked U.S. Department of Health and Human Services interim secretary Charles Johnson to consider leaving the state's matching as it is today "until the temporary impact of Hurricanes Katrina, Rita, Gustav and Ike work their way through the three-year formula." Levine also broached the idea of adjusting the formula to not take "one-time,

extraordinary infusions into account in establishing per capita income." "We believe it is fair to suggest that our (matching rate) could be 'locked in' at a rate comparable to our historic averages for a period long enough to allow the formula to normalize," Levine wrote. Levine said he wanted to set up a time to meet with Johnson or his designee and acting Centers for Medicare and Medicaid Services administrator Charlene Frizzera.
Source: The Advocate, 4/7/09.

NEW MEXICO

Governor Signs 2010 Operating Budget. Take-home pay of state workers and educators will drop starting in July under a bill signed into law by New Mexico Gov. Bill Richardson this week to reduce government spending next year and help balance the budget. The new law will save the state $40 million during each of the next two years by reducing what government pays into public pension funds. Employees - from school teachers and judges to state agency workers - will make up that amount for pension programs by contributing an extra 1.5 percent of their salaries. For teachers earning an average salary of $47,000, the higher pension payments will mean a $27 reduction in biweekly pay - roughly $700 a year. Richardson signed the pension measure along with a nearly $5.5 billion budget bill and legislation to allocate almost $140 million for more than 70 capital improvement projects across the state. Richardson and state legislative leaders said the shift in pension contributions - an extra $80 million by workers over the next two years and a corresponding reduction by government - will help avert possible furloughs as the state struggles with budget problems. "We are, I think, among the most proficient states in terms of protecting our state employees at the same time balancing our budget," Richardson said at a news conference.
Source: The Associated Press, 4/7/09.

OKLAHOMA

Uninsured Continue to Rise in Number; Strains Community Health Centers. For the increasing number of uninsured Oklahomans, county health departments and trips to hospital emergency rooms are not practical. That number is estimated to be at 640,000 and rising, as more and more Oklahomans find they cannot pay for health care. Low-income patients increasingly seek out small, free health clinics and community health centers, known as Federally Qualified Health Centers. Community health centers, or CHCs, receive federal grants through the Health Resources and Services Administration's Bureau of Primary Health Care. The centers see uninsured patients whose income is below 200 percent of federal poverty level. *Insure Oklahoma* is a new program to help low-income residents pay health insurance premiums. The increasing number of people seeking alternative services such as CHCs is both historic and alarming, observers note.
Source: NewsOK, 4/4/09.

TEXAS

Budget Moves to Texas House. A Texas House committee approved a $178 billion state budget Tuesday, a 5 percent increase over the previous two-year budget but about $4 billion less than the Senate version. The unanimous vote by the House Appropriations Committee moves the budget to the full House, where it is expected to be taken up late next week. The budget includes about $11 billion in spending from the federal stimulus package. That federal boon has helped lawmakers deal with a projected shortfall between the amount of state revenue available and the spending needs they identified. Neither version of the bill taps the state's savings account, the Rainy Day Fund, which is expected to have $9.1 billion if left untouched over the next two years. The Senate bill includes language to expand Medicaid managed care to rural areas of the state. The rider would move clients under the Primary Care Case Management model to an Exclusive Provider Organization arrangement. This would cause a serious negative impact on the Upper Payment Limit program. Converting from

PCCM to EPO would generate almost $7 million in new tax revenues for the state; however, UPL payments to state hospitals will decrease by more than that amount, and non-state public hospitals could see losses up to $200 million, resulting from a loss of some $120 million in federal Medicaid funds. The impact to CHRISTUS Health is estimated at $22 million. Federal law prohibits Medicaid UPL payments for clients cared for under a capitated model. Hospitals are allowed to receive UPL payments for treating Medicaid fee-for-service and PCCM clients. *Source: Houston Chronicle, Texas Hospital Association.*

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UTAH

One Third of Utahns Uninsured in Last Two Years. An estimated one-third of Utahns under age 65 went without insurance at some point in the past two years. The picture of Utah's uninsured drawn in a report just released by the national group Families USA is substantially bleaker than the one given by the state health department from last month. Locally, health officials say less than 12 percent of nonelderly Utahns were uninsured last year. "The huge number of people without health coverage in the United States is worse than an epidemic," Ron Pollock, executive director of the nonpartisan health care consumer group, said in a teleconference. "At this point, almost everyone in the country has had a family member, neighbor or a friend who is uninsured." In Utah, the toll number of uninsured totaled 784,000 in 2007 and 2008, according to the Families USA report, which focused on Americans under 65 because the elderly are eligible for Medicare. Most of Utah's uninsured, at 84 percent, were working full or part-time. More than half were Latino. About half made $42,000 or less for a family of four. In addition, 72 percent went without coverage for at least six months. Pollack blames escalating costs of health care -- rising four times faster than earnings since 1999 -- which are driving small businesses to drop health care coverage. Utah businesses are eliminating coverage faster than other states. The figures do not fully reflect the recession, which started nationally in December 2007. Utah's economy started to decline last fall.

Many of the uninsured are increasingly seeking help at clinics that offer free or low-cost care. However, to balance the budget, the state Legislature chopped by $500,000 the amount of money it provides in grants to agencies that provide primary care to un- and under-insured Utahns. The cut, totaling nearly one-third of the former budget, will mean fewer people will get help starting in July. Forty-nine agencies received funding for the current year to provide services ranging from mental health counseling to controlling diabetes and tuberculosis. At the same time, Utah's federally funded community health centers received an extra $3 million as part of the American Recovery and Reinvestment Act. The money must be used to maintain or expand services and is expected to help 14,500 new patients, including 9,300 uninsured Utahns. Center directors say they will use the money to open extra hours, transport rural patients to clinics and hire more providers.
Source: Salt Lake City Tribune, 4/7/09.

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