November 18, 2005

**Budget Reconciliation**

After postponing consideration of the budget reconciliation legislation (H.R. 4241) three times, early on Friday, November 18, by a vote of 217-215, the House of Representatives approved a version of a 5-year budget plan. The bill is designed to save the federal government slightly less than $50 billion by reducing spending in entitlement programs or raising revenues. The House bill includes $12 billion in savings specifically in the Medicaid program. These savings are achieved by tightening eligibility requirements, reducing benefits for those who are eligible and increasing co-payments, premiums and deductibles.

To achieve passage, the final version of the House bill does not include an earlier provision that would have raised co-payments from $3 to $5 for Medicaid recipients with annual incomes below the federal poverty level. However, these co-payments would now be able to grow with inflation. The House leaders also increased the amount of home equity that recipients could shelter to be qualified for long-term care under Medicaid. Instead of limiting these assets to $500,000, the House bill now would allow Medicaid recipients to hold up to $750,000 in home equity to qualify.

The House bill does not include any provisions that affect Medicare, and so the bill is silent about the Medicare physician payment.

The House and Senate conference committee has the difficult task of reconciling the many, substantial differences in both policy and financing that exist between the two bills. Congressional leaders hope to accomplish this before the end of the year.

**Appropriations**

In an extraordinary turn of events, on November 17, the US House of Representatives defeated the conference report to the Labor/HHS spending bill by a vote of 224-209. The conference document not only had made severe cuts in numerous programs, but it also had removed all earmarks from the bill.

Section 747, which includes dollars for family medicine training, received a 68.3 percent cut in funding (a drop from $88.8 million to $28.2 million) and all of Title VII health professions programs (non-nursing) received a cut of 67.5 percent (from $299.6 million to $97.4 million).

Other programs received similar or deeper cuts. Geriatrics programs and Rural Health Research were zeroed out. Area Health Education Centers (AHECS) received a 93.1 percent cut, while Rural Outreach grants were cut by 72.6 percent. The Agency for Healthcare Research Quality (AHRQ) did relatively well in comparison and received level funding.

On the same day, the House passed a continuing resolution to keep the government operating through December 17. The bill maintains Section 747 at its current FY 05 funding level.
On November 18, the Senate voted on two motions to instruct conferees to the Labor/HHS measure. The first one, offered by Appropriations Labor/HHS subcommittee chair Senator Arlen Specter (R-PA) and Ranking member Tom Harkin (D-IA), designated $2 billion of the bill’s funding as emergency spending, thus requiring no offsets. The motion passed overwhelmingly by a vote of 66-28. The next motion was offered by Sen. Richard Durbin (D-IL) and directed conferees to maintain funding for NIH at the Senate level. The motion passed 58-36.

Medicare Payment to Physicians
On Thursday, November 17, the House Energy and Commerce Subcommittee on Health held a hearing on how Medicare pays physicians. The Administrator of the Centers for Medicare and Medicaid Services (CMS), Mark McClellan, MD, Ph. D., testified that the Administration would support legislation to replace the pending reductions in payments with increases in 2006 and 2007. But he placed the burden entirely on Congress to find the funds to pay for these increases and noted that Administration support requires “differential updates for physicians who report valid consensus-based quality measures.”

Health Information Technology
On Friday, November 18, by voice vote, the Senate approved the Wired for Health Care Quality Act (S. 1418) that would promote the use of health care information technology. Senators Mike Enzi (R-WY), who chairs the Senate Health, Education, Labor and Pensions Committee, Edward Kennedy (D-MA), who is the senior Democratic member of the committee, Bill Frist (R-TN) and Hillary Clinton (D-NY) sponsored the bill. It would allow HHS to award grants to hospitals, group physician practices and other health care providers to help increase the use of health I.T. systems.
STATE ACTIVITY

Health Care for the Uninsured
States are attempting to address the growing needs of the uninsured. Governors and legislators in several states are reaching agreements to increase access by reforming health care programs and looking at tax increases. As employer-based coverage shrinks, lawmakers in capitals across the country are trying to address the needs of the uninsured.

Illinois
Gov. Rod Blagojevich (D) signed the All Kids bill with an effective date of July 1, 2006. The program will cover the 253,000 estimated uninsured children of working parents in Illinois.

Tennessee
TennCare may expand to enrollment based on a better than anticipated financial outlook. Included in the expansion will be maternal care and newborns as well as those requiring home health care services. Officials are looking to defer caps on medical service and hospital stays until next July by utilizing savings from realized from drug management policies and other funds.

Medical Liability
Kaiser Permanente Northwest and Oregon Health & Science University have agreed to send state regulators information on past malpractice lawsuits against their doctors. The policy reversal by two of Oregon's biggest health care players will help fill a decade-plus gap in the state's ability to track malpractice records. The state medical board uses malpractice claims and settlements as one tool to identify potentially dangerous doctors. Malpractice reports triggered about one in 10 of the board's 313 investigations of doctors last year.

Medicaid
On Tuesday, November 15, Governor Dirk Kempthorne (R-ID) released further details of his proposed Medicaid modernization plan. Gov. Kempthorne is pursuing a waiver which would allow Idaho to split its current Medicaid program into three separate programs: one for healthy low-income children and adults, one for disabled and special needs patients, and one for the elderly. Application for the program would be simplified through elimination of asset tests. Following acceptance for coverage, beneficiaries would receive a screening by a primary care physician to determine health status and thus which of the three (new) Medicaid programs in which they should be enrolled.

The healthy children and adults program, as well as the disabled and special needs program, aims to enhance the primary care case management and preventive screening services already employed in the state. The healthy children and adults program proposal contains incentives for healthy behaviors, disincentives for negative behaviors (like cost sharing for inappropriate ER utilization and missed appointments), personal health accounts (which can be used for cost-sharing requirements), and school-based prevention and wellness services, among others. The disabled and
special needs program will include cash and counseling and employment assistance components.

The elderly program aims to provide additional prescription drug benefits beyond those provided in Medicare Part D, offer “Aging Resource Centers” where seniors can find information on long-term and end-of-life care, and preserve and promote the existing Home- and Community-Based Services waiver.

The population of the healthy children and adults program combined with the disabled and special needs program amounts to about 93 percent of Idaho Medicaid’s current enrollment, or about 166,000 people. These are the two programs that explicitly aim to improve care and efficiencies through primary care case management.