MEMORANDUM

Note: Congress has adjourned and will return in two weeks, on April 24.

FY 2007 Federal Budget
Late on Thursday, April 6, leaders in the House acknowledged that they do not have the votes to pass their Fiscal Year 2007 budget resolution.

The deal fell apart when moderate Republicans demanded more discretionary funding, conservatives wanted more assurances about changes to the budget process to limit future spending, and appropriators became concerned that budget process changes would limit their power. Rep. John Boehner (R-OH), House Majority Leader, in this first leadership test, insisted that he would try to revive a deal after the two-week recess.

The House budget resolution is $10 billion below the level needed to maintain current services. Moderate Republicans in the House, led by Rep. Michael Castle (R-DE), are insisting on restoring $7 billion to the health and education accounts in an amendment that mirrors the one that successfully passed the Senate. Conservative Republicans want to maintain the cuts in discretionary spending and add additional cuts in entitlement programs, like Medicare and Medicaid. They are demanding that the resolution include instructions requiring committees to cut another $6.7 billion. The Ways and Means Committee, which has jurisdiction over most Medicare programs, is instructed to cut $4 billion from programs under its jurisdiction.

There is no legal requirement that Congress have a budget resolution. Without one, by mid-May the House and the Senate will vote on a "deeming resolution" that simply will set the overall discretionary amount. (The House and Senate may differ on that number.) Then the appropriators will start working off that number and begin passing bills. The same disagreements in play during this week's budget struggle will resurface again in the fall at the end of the appropriations process.

Negotiations over a final $70 billion tax cut package also faltered even as an agreement appeared within reach. Conservative Republican members of the House said late Thursday that they had a deal with leadership on tough new budget rules, but appropriators rebelled at proposals that would dilute their authority and vowed to defeat the budget resolution. They objected to a provision requiring Budget Committee approval of non-defense emergency spending. In addition to a new check on emergency spending, conservatives demanded leadership support for a package of new enforcement measures, including rules on earmarks, a line-item rescission measure and a sunset commission intended to target programs for elimination.
Health Information Technology
House Small Business Subcommittee on Regulatory Reform and Oversight

On Thursday, April 6, Rep. Todd Akin (R-MO), who chairs the subcommittee, convened a hearing on the economic costs and benefits of electronic health records. Witnesses included Christopher Normile, MD, a family physician from St. Charles, Missouri, who is part of a 2-physician practice that has implemented an EHR. Dr. Normile testified about his experience in using the EHR both in terms of significant start-up costs and the difficulties of regular maintenance.

The focus of the hearing vacillated between the view of fiscal conservatives that government does not have a role in supporting IT investments and the view of those who believe government should provide incentives and assistance to small businesses. The chairman asked the members of the panel if they thought market forces were enough to accelerate adoption of technology without the federal government. Everyone agreed the federal government needed to be a partner in creating incentives.

Rep. Phil Gingrey (R-GA), who is a physician, spoke as the lone witness on the second panel. Rep. Akin asked if legislation he is offering would help the small and solo practices and Rep. Gingrey admitted it would not, saying it was geared to groups of five or more doctors. Then, Rep. Gingrey noted that he thought his approach would be more helpful than the federal government offering assistance for which small practices could not effectively compete, given the resources of large groups. He talked about patient safety and long term cost savings, but seemed disinclined to use federal funds to obtain these savings.

House Ways and Means Health Subcommittee
At the same time, Rep. Nancy Johnson (R-CT), who chairs the Health Subcommittee, held a hearing on efforts to increase the use of health information technology. Two panels testified. The first consisted of David Brailer (HHS National Coordinator for Health Information Technology); Lewis Morris (Office of the Inspector General for HHS) and Simon Cohn (National Commission on Vital Health Statistics). The second was comprised of Ken Kizer (Medshpere Systems), Brent Henry (Partners HealthCare System), Joe Smith (Arkansas BCBS) and Gloryanne Bryant (Catholic Healthcare West).

Key discussions centered on the question of proprietary versus open source EHR. Generally, the Democrats on the subcommittee favored open source while Republicans believed private enterprise would be better able to respond to changing dynamics more rapidly.

Dr. Brailer, in addition to outlining the considerable ground that has been covered by HHS and specifically the Office for Health Information Technology, described a system in which the government would set the public standards and would require private entities to meet those standards. He reported that considerably more work is required to test and verify those benchmarks.

Ken Kizer spoke in support of an open source EHR and urged Congress to take three essential steps:
(1) Stipulate that open source would be the first source for acquisition of EHRs when federal funds were involved;
(2) Designate a small portion of funds to the Veterans’ Administration to develop public-private partnerships with companies who wanted to implement open source and do this for a five-year period; and
(3) Set a date certain by which use of EHR would be a condition of participation (Medicare), specifying certain elements of EHR that must be included.

There was some disagreement over the transition to ICD-10 with proponents suggesting that ICD-9 is insufficient to describe certain conditions especially for the purpose of pay-for-performance. Others said the transition is too complex and should be delayed.

Chairman Johnson appeared to agree with a point made by Rep Mike Thompson (D-CA) that the cost of implementing (and maintaining) health information technology is much more difficult for small and rural practitioners. The chair urged Dr. Brailer and others to look into this issue and see what changes needed to be made for these practices. She also urged Brailer to “look at the ‘Medical Home’ concept …as it is very important for Medicare beneficiaries, especially high cost patients, to have a family doctor.”

Association Health Plans
On Thursday, April 6, the Senate Finance Committee held a hearing to discuss legislative solutions to help small businesses provide health coverage, including the Health Insurance Marketplace Modernization and Affordability Act (S. 1955). Sen. Michael Enzi (R-WY), who chairs the Senate Health, Education, Labor and Pensions (HELP) Committee, introduced this bill to allow small businesses to join association health plans to buy less regulated coverage. Critics of the bill charge that it would lessen costs only for the healthier employees of a small business that joined an AHP while increasing them for sicker employees.

Senator Blanche Lincoln (D-AR) spoke for legislation she is proposing that would create a national purchasing pool to form a small-employers health benefits program similar to the Federal Employees Health Benefit program.

Upcoming in Congress
During the first week in May, the Senate is scheduled to consider several health-related bills, including:
• A measure to limit non-economic damages in medical malpractice law suits;
• A bill to expand access to association health plans to small businesses; and
• A proposal for Health Savings Accounts.

FamMedPAC
On Friday, April 7, on behalf of FamMedPAC, Government Relations Division staff participated in a DC fundraiser event for Rep. Sue Myrick (R-NC), who serves on the Energy & Commerce Subcommittee on Health. The topics discussed included the Medicare physician payment formula; medical liability reform; preparations for pandemic flu; implementation of the Medicare prescription drug benefit; and mental health issues. Mental health is a great passion for her and staff discussed the AAFP’s involvement
with streamlining the exceptions and prior authorization process, which is a particular problem for psychotropic drugs. Staff also brought up the Title VII reauthorization, which will be handled by this committee, after a brief segue from our funding problems with the program. While Rep. Myrick didn’t seem overly familiar with the issue, she said that she would be willing to help.

STATE GOVERNMENT RELATIONS

Special Report: Massachusetts Universal Health Insurance Legislation

Seeking to solve the problem of the uninsured, Massachusetts legislators in the House and Senate, as well as Governor Mitt Romney (R), offered competing proposals to address the issue. After two months in an often contentious conference committee, negotiators reached a compromise that both chambers promptly passed. The bill has now gone to Governor Romney for signature; he is expected to sign it into law sometime during the week of April 10.

The bill aims to cover some 90 to 95 percent of the state’s 500,000 to 600,000 uninsured (which, at 10.8 percent of the population, is among the nation’s lowest). It hopes to achieve this goal without a new tax or large budget expansion, relying mainly on existing funds in the budget (both state and federal) and fees levied on businesses.

Precise details of how the plan will roll out are not included in the bill’s language. The legislature is leaving the hammering out of finer details to regulators, meaning that while this hurdle was finally overcome, a good number remain.

Physician Payment
Roughly 15 percent of the funds in the bill are marked for physician payment. With some estimates placing the price tag of the bill as high as nearly $2 billion over the next three years, this is no small amount of money. However, the vast majority of that amount is tied to pay-for-performance. The bill does not explicitly mention quality measures, except for reductions in racial and ethnic health disparities.

Pay-for-performance measures will be determined by the Health Care Cost and Quality Council established by the bill. Information gathered on providers, insurers and facilities will be made publicly available. The data will include performance and cost measures.

The Council will consider reports from three other commissions (two newly formed, one reorganized) by the bill. The MassHealth Payment Policy Advisory Board will examine provider payment issues around MassHealth (the umbrella name for Massachusetts’ health programs, including Medicaid and SCHIP). The new Racial and Ethnic Disparities Council will examine the eponymous issues and make recommendations on improving towards the goal of elimination of health disparities. The bill reorganizes the Public Health Council and includes two physician seats (one specifically for primary care).

Benefits for Patients
The chief benefit for patients is better access to health care. The bill provides new and expands existing coverage options for patients. Among the notable provisions:

- Expanding MassHealth coverage to 300 percent of the Federal Poverty Level (FPL)
- Offering state-subsidized, waived-premium basic health plans to those below 100 percent FPL
- Offering state-subsidized plans with premiums on a sliding scale to those between 101 percent and 300 percent FPL
- Reducing premiums through greater availability of low-cost plans in the market; in other words, making more plans available at cheaper prices for those above 301 percent of poverty. (The latest estimate is that premiums for individual coverage will be about $325/month, double for families.)

The bill establishes a new Commonwealth Health Insurance Connector to help connect individuals and small businesses with affordable insurance products. The Connector will allow insurance portability, as well as the opportunity for more than one employer to contribute toward premiums.

**Insurance Cost Control**

The Uncompensated Care Pool will be phased out and replaced with a new Safety Net Care Pool. Business contributions to their employees’ health insurance will decline during the phase-down period. Business hopes that the bill will lead to a slower rate of increase in insurance premiums for their employees, if not a leveling off of those premiums.

The Commonwealth Health Insurance Connector, as with the individual market, will help link small businesses to affordable plans. Determinations of what “affordable” and “adequate benefits plans” are to be made by the Connector.

**Compliance Issues**

The bill, as some summarize it, makes it illegal not to have health insurance. It sets penalties on businesses and individuals that do not offer or have insurance.

Businesses with more than 10 employees that do not offer insurance will be assessed a fee of $295 per employee. The penalties will go into the Safety Net Care Pool that helps subsidize the low-cost plans. This fee is akin to the “Wal-Mart/Pay-to-Play/Fair Share” bills that have popped up around the country in the past few months.

The bill also includes what is called the “Free Rider” surcharge. If an employee uses free care more than three times in a year or all employees in a business use free care more than five times in a year, the employer will be responsible for 10 to 100 percent of the services’ costs. The state will exempt the first $50,000 per employer.

Individuals are required to accept the coverage their employer offers, to prevent crowd-out. However, waivers are available should the offered coverage be unaffordable for the employee. If an individual does not have coverage through the employer, has not purchased it through the market and has not purchased it through the state program, the state will withhold the first $150 of any tax refund. Individuals who go without
insurance a second year will be penalized at an amount that is twice the monthly premium of offered insurance.

Physicians are required to comply with reporting requirements set by the Health Care Cost and Quality Council. Those who refuse will be fined $1,000 per week, up to $50,000 per year.

**What's Next?**
While generally supportive of the bill, Gov. Romney indicated that he may exercise his line item veto authority to excise some of the business-related provisions. However, any line item vetoes can be overridden by the legislature. Since only 2 out of 195 legislators voted against the bill, chances that the legislature will sustain the veto are slim.

If the bill is enacted as currently written, it would be implemented in phases. All portions would become effective on January 1, 2008; however, the majority of the coverage provisions would go into effect July 1, 2007.