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### NEXT WEEK IN WASHINGTON...

...the Senate will attempt to finish debate and vote on the *Family Smoking Prevention and Tobacco Control Act* (S. 982/HR 1256).

## 1. HEALTH CARE REFORM LEGISLATION BEGINS TO TAKE SHAPE

The Senate HELP committee released a 12-page summary of its health reform proposal. A two-page synopsis of the proposal prepared by AAFP staff follows this report. According to committee staff, the committee will begin consideration of legislation during the week of June 15.

Also in the Senate, the Finance Committee staff have indicated that the committee will release a draft bill on June 12; with its debate beginning June 17. However, that schedule appears to be slipping, since several Republican members of the committee have spoken about substantial objections to a draft of the legislation.

Meanwhile, the House Energy and Commerce Committee released a two-page summary of its health care reform legislation, which is included at the end of this report. According to Rep. Steny Hoyer (D-MD), the House Majority Leader, the three relevant committees in the House (Energy and Commerce, Ways and Means, and Education and Labor) will begin their consideration of health reform legislation in early July.

While President Obama has indicated he would like a bill to sign by October 1, speculation is that no legislation will be completed by at least Thanksgiving.

## 2. FDA TOBACCO REGULATION BILL IS STALLED BY DRUG RE-IMPORTATION

This week, the Senate started debate on legislation imposing federal regulation on tobacco products. The bill, the *Family Smoking Prevention and Tobacco Control Act* (S. 982/HR 1256) would give the Food and Drug Administration authority over tobacco, allow the agency to regulate the amount of nicotine in cigarettes and restrict marketing and advertising. The measure also would raise an estimated \$5.4 billion in fees from tobacco companies.

The progress of the legislation is endangered by Senator John McCain (R-AZ), who insisted on a vote on an unrelated amendment that would allow the re-importation of prescription drugs. The bipartisan re-importation amendment was offered by Senator Byron Dorgan (D-ND) and would allow the re-importation of drugs from Canada as a way to reduce drug prices for US consumers. Opponents worry it would hurt FDA's ability to keep drugs safe.

Supporters of the underlying legislation worry that adding this drug re-importation provision would make the tobacco bill unacceptable to those Senators who are not decided yet and thus make passage unlikely.

### **3. HHS SECRETARY TESTIFIES ON OBAMA FY 2010 BUDGET REQUEST**

On June 2, HHS Secretary Kathleen Sebelius testified before the House Appropriations Subcommittee on Labor, HHS, and Education. Although the purpose of the hearing was to discuss President Barack Obama's fiscal year 2010 HHS budget request, there was some discussion of health care reform and other issues.

Secretary Sebelius mentioned the release that morning of the [report of the White House Council of Economic Advisors](#) which found that reducing the annual growth rate for health care spending would provide broad economic benefits. The Secretary stressed the need for health system reform pointing out that 72 million Americans could be uninsured by 2040 if the reform is not enacted. She described the President's FY 2010 budget as building on the investments of the *American Recovery and Reinvestment Act* in health care overall and the Health Resources and Services Administrations' health care workforce programs in particular.

Chairman Dave Obey (D-WI) made it clear that he sees a need for a public plan option in health care reform. He also described the Committee's history of leaving decisions about NIH research to the scientific peer review process. Although the President's budget calls for targeting additional resources for research in cancer and autism, Chairman Obey insisted that the Committee would not support that Presidential request. Rep. Rosa DeLauro (D-CT), a cancer survivor, and others on the Subcommittee supported the Chairman's insistence that research allocations be made by the scientists at NIH.

Ranking Member Todd Tiahrt (R-KS) was emphatic about his concerns that health reform would lead to a single payer, government-run plan with comparative effectiveness research leading to rationing. Secretary Sebelius assured him that neither she nor President Obama is suggesting that we should do away with the private insurance system. She also pointed to a provision in the law that prohibits comparative effectiveness research to be used for cost containment.

Reps. Jesse Jackson, Jr. (D-IL), Barbara Lee (D-CA), and Mike Honda (D-CA) all mentioned the need to eliminate health disparities. Rep. Lee referenced the health disparities bill that she has worked on with Reps. Honda and Nydia Velazquez (D-NY). Sec. Sebelius pointed to the budget's investment in training minorities to be health care providers. Rep. Jackson also specifically mentioned the need for supporting Community Health Centers.

Rep. Patrick Kennedy (D-RI) offered his support for the medical home model and encouraged the inclusion of mental health services in this model. Rep. Betty McCollum (D-MN) complained that providers in Minnesota are not rewarded for their exceptionally high quality of care. Chairman Obey agreed and labeled Medicare reimbursement disparities as "outrageous."

### **4. FamMedPAC PARTICIPATES IN D.C. EVENTS; PLANS FUTURE EVENTS**

FamMedPAC participated in three events in Washington this week. Representatives of most of the physician specialty society PACs also met this week to plan future health care events, focusing on legislators who will be key players in the upcoming health reform debate.

- Government Relations staff attended a health care meeting with **Representative Steve LaTourette (R-OH)**, who serves on the House Appropriations Committee. Rep. LaTourette supported the Medicare legislation in the last Congress and the CHIP bill last February. FamMedPAC made a campaign contribution to Rep. LaTourette earlier this year. Rep. LaTourette was interested in hearing about the priorities for each of the physician organizations. He was aware of the need to increase support for primary care and noted that primary care would be the focus of the health reform debate. Several of the specialties brought up their concerns with any increase for primary care under Medicare resulting in a decrease in reimbursements for other specialties if the budget neutrality rules were applied.
- GR staff attended a health care breakfast for **Representative Gene Green (D-TX)**, who serves on the Health Subcommittee of the House Ways and Means Committee. Rep. Green made it clear that he not only supports primary care but also is committed to the inclusion of the medical home in the House health reform bill. Rep. Green touched on work force issues, saying he wanted to find ways to increase the number of primary care physicians. He said that while his daughter is an infectious disease specialist and his son-in-law is a gastroenterologist, he feels strongly that we need more primary care physicians and that they need better incentives. On coverage issues, he stated that he was not necessarily against an individual mandate, that it was only fair for everyone to buy into the system and be covered, and that the House bill would have a public plan option and that he was not against it. He noted that the House schedule was to complete work by the summer but he thought it would go into the fall. He also mentioned that he would work for an SGR fix. Rep. Green said he was aware of Sen. Rockefeller's new bill to make MedPAC an executive agency and said he was concerned that if MedPAC's recommendations automatically went into law, Congress was losing control of health care costs.
- GR staff attended a health care lunch, co-sponsored by FamMedPAC, for **Senator Ben Nelson (D-NE)**, who serves on the Appropriations Committee. Senator Nelson is a key swing vote on health care reform. He focused on the inclusion of the "public plan" health insurance option in any reform legislation. He noted that he earlier had said that he was opposed to this, but that his statements were misconstrued. He is opposed to a "single payer" system, but would keep an open mind toward a public plan as long as it did not compete unfairly with private health insurance or threaten the employer-based insurance system most Americans depend on. He thinks that health savings accounts, flexible spending accounts, and health insurance purchasing pools are good ideas that should be part of any health reform bill. He is anxious for a bill to be introduced so the real debate can begin. He thinks the schedule that Senator Baucus has laid out is ambitious, but feels that reform legislation will be voted on before the end of the year.

## **5. WEST VIRGINIA LEGISLATURE REVISES VETOED MEDICAL HOME LEGISLATION**

On Thursday, May 7, Governor Joe Manchin (D) vetoed legislation containing a medical home demonstration program. Gov. Manchin explained his veto was due to a technical matter that he believed would render the legislation unconstitutional. He vowed to sign the bill into law upon receipt of a corrected version. And that corrected version is on its way. The legislature promptly revised the bill and sent it back to the Governor on May 27.

The legislation defines the medical home as, "...a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patients'

families and communities. A patient centered medical home integrates patients as active participants in their own health and well being. Patients are cared for by a physician or physician practice that leads a multidisciplinary health team, which may include but is not limited to nurse practitioners, nurses, physician's assistants, behavioral health providers, pharmacists, social workers, physical therapists, dental and eye care providers and dieticians to meet the needs of the patient in all aspects of preventive, acute, chronic care and end-of-life care using evidence-based medicine and technology." The bill provides for the study of pilot programs to testing four different medical home models:

- a chronic care model (focusing on smaller practices),
- individual medical homes (focusing on larger practices),
- community centered medical homes (focusing on linking primary care practices with community health teams), and,
- medical homes for the uninsured (focusing on providing uninsured patients with primary and preventive care).

The WVAFP has been a strong champion for the medical home concept and supported this bill.

## **6. OHIO ESTABLISHES MEDICAL HOME DEMO AND PRIMARY CARE SCHOLARSHIPS**

The Ohio Academy of Family Physicians is championing a bill introduced on Tuesday, June 2, on which they worked closely with the author, Rep. Peggy Lehner. Of note in this bill are the opening lines of the medical home section: "The demonstration project shall be operated to evaluate the medical home model of care, as that model of care is defined by the American Academy of Family Physicians." The legislation aims to create a medical home pilot program in the Dayton, Ohio metropolitan area. The bill states that physician practices must, "be capable of adapting the practice during the demonstration project in such a manner that it is fully compliant with the minimum standards for a patient-centered medical home, as those standards are determined by the [N]ational [C]ommittee for [Q]uality [A]ssurance." The demonstration is limited to Dayton and Lucas County, "...physicians who are board-certified in family medicine, general pediatrics, or general internal medicine..." The program includes practice supports such as training, technical assistance, and reimbursement of not more than 75 percent of the cost of acquiring and learning to use appropriate medical home-related health information technology.

The bill also includes a primary care practice scholarship, called Choose Ohio First scholarships, for medical students who commit to three years of primary care practice in Ohio, accept a to-be-determined percentage of Medicaid patients, and identify specific medical home training opportunities during medical training. The bill further allocates \$1.4 million to the scholarship program over 2010 and 2011, while marking \$3.871 million to the medical home demonstration program over the same period. The scholarship funds go to a family practice account and are noted to be used for the purposes of advancing the medical home.

## **7. TEXAS PHYSICIAN LOAN REPAYMENT BILL PASSED**

The Texas House approved the Texas AFP's physician loan repayment bill, introduced by Rep. Al Edwards, D-Houston, by an overwhelming 122-21 margin late on the last Friday of the session, after the Senate had approved it 29-2 three days before. The bill was sponsored in the Senate by Sen. Juan "Chuy" Hinojosa, D-McAllen.

Throughout the session, the bill was opposed by a powerful group of tobacco lobbyists because funding for the new program will be generated by closing a loophole in the application of excise taxes on smokeless tobacco products. The change will raise an estimated \$105 million over the next biennium. About \$22 million of that will go to fund the new loan repayment program, which will provide up to \$160,000 for primary care physicians who agree to practice for four years in health

professional shortage areas.

The bill should bring as many as 225 physicians to health professional shortage areas each year, meaning in four years when the program is operating at full capacity, Texas will have 900 new physicians serving communities in need.

The bill is now on its way to the governor's desk. He has until June 21 to sign or veto bills, and those he chooses to neither sign nor veto become law after that date.

Administration of the new program will be the responsibility of the Texas Higher Education Coordinating Board and as soon as rules and an application process are in place, TAFP will help distribute that information to medical students and educational institutions.

#### **8. TEXAS GOVERNOR SIGNS INSTANT VERIFICATION OF BENEFITS BILL**

Gov. Rick Perry signed into law legislation by Rep. José Menendez, D-San Antonio, and Sen. Chris Harris, R-Arlington on May 30. The new law requires health plans to provide information to physicians at the point of care about what services are covered, the amount of the patient's co-pay and deductible and what the patient's out-of-pocket costs will be for services provided.

#### **9. OTHER ISSUES OF INTEREST TO FAMILY PHYSICIANS...**

- On May 29, HHS Secretary Kathleen Sebelius announced the appointment of Cindy Mann as director of the Center for Medicaid and State Operations, which oversees the federal part of Medicaid and CHIP. Mann was director of Family and Children's Health Programs from 1999 to 2001 at CMSO, where she helped implement CHIP. Mann also served as executive director of the Center for Children and Families at Georgetown University's Health Policy Institute.

## Summary of Senate HELP Committee Health Care Reform Proposal, June 2009 (Information based on 12-page summary document)

### Key Goals

- Assure reliable, high quality and affordable insurance for all Americans;
- Create a higher quality, more efficient delivery system;
- Enhance prevention and wellness;
- Create long-term support and services for seriously disabled Americans;
- Remove fraud and abuse in public and private health care systems;
- Require personal responsibility, e.g., an individual mandate.

### 1. Assure Reliable, High Quality and Affordable Health Insurance for All Americans

- Allows individuals to keep their current coverage if they are satisfied.
- Requires guaranteed issue and renewal (health insurance must “take all comers”).
- Bars issuing or renewing policies based on health status, medical history or preexisting conditions.
- Requires premiums to vary only by family composition, geography and age.
- Requires insurance companies to use more of their funding for medical services.
- Provides sliding scale premium assistance for individuals and families with incomes up to four times the federal poverty level.

#### Establishes America’s Health Benefits Exchange

- Establishes an *American Health Benefit Exchange* to provide consumers with clear health insurance choices.
- Allows states to establish exchanges in collaboration with the federal government.
- Creates a national website similar to *Expedia*, etc. to purchase coverage.
- Provides a public plan option.

#### Requires Individual Responsibility

- Requires everyone who can afford coverage to sign up.

### 2. Creates a Higher Quality, Efficient Delivery System

#### Prevents medical errors

- Establishes a Patient Safety and Clinical Delivery Institute within AHRQ to “strengthen best practice research and dissemination” to prevent medical errors, e.g., by using 10-step checklists.

#### Improves efficiencies in the delivery system

- Computerizes routine administrative transactions and streamlines enrollment and documentation;
- Promotes evidence-based medicine;
- Promotes “patient-centered health information by improving health literacy.”

#### Reduces preventable hospital readmissions

- Mandates hospital discharge plans that include a “discharge advocate” to coordinate all efforts to reduce emergency visits and rehospitalizations. Establishes a confidential system for hospitals to report their readmission rates and receive technical assistance.

#### Chronic disease management

- Uses electronic medical records and medical homes to improve chronic disease management.

- Medical homes are defined to include primary care providers, access to specialists and community teams and be patient-centered.

#### Strengthens the health workforce

- Expands federal health care workforce development programs.
- Creates a *Workforce Commission*, which will make recommendations on “how to ensure a sufficient supply of primary care physicians, nurses and other practitioners.
- Creates new grant programs to train health professionals in geriatric care.
- Strengthens “primary care and nurse workforce development programs by adding new programs, e.g., adding new programs to increase the number of nurse faculty.
- Includes patient safety and best practices into the curriculum for health practitioners.

#### Addresses health disparities

- Develops quality measures that include differences in race, ethnicity, gender and vulnerable populations.
- Expands scholarship and loan repayment programs to minorities.

### **3. Enhance Prevention and Wellness**

- Reimburses essential preventive services.
- Eliminates barriers to preventive services, e.g., copayments and deductibles.
- Strengthens the nation’s public health system.
- Changes curricula in medical schools and residency programs to include training in prevention and public health.
- Provides information to consumers to encourage healthy lifestyle changes.
- Encourages workplace wellness program.
- Creates federal-level *Prevention and Public Health Council* to incorporate wellness into national policy and to develop a national strategy.

### **4. Finance Long-Term Services and Supports**

#### Creates new financing alternative for long-term services and supports

- Allows people with disabilities and chronic illness to participate in a voluntary, nationwide insurance program that has a cash benefit to pay for and choose the services and supports they need to function independently.
- Finances this program through voluntary payroll deductions (enrollment opt-out based on Medicare Part B).
- Allows individuals to qualify for benefits if they have contributed monthly premiums through a voluntary payroll deduction for at least five years. Benefits will be tiered, e.g., \$50-\$100/day to people unable to perform two or more activities of daily living or the equivalent cognitive impairment.
- Allows individuals to access this benefit through a “Life Independence” debit card to purchase services and supports.
- Limits premiums to \$65/month and those below poverty to no more than \$5/month.
- Program is funded through premiums and will be a primary payer to Medicaid.
- Program will prevent families from “spending down their life savings” to receive Medicaid benefits and will be a “payer of first resort” to Medicaid.
- Benefits established by this program will cover approximately ½ of the current average cost of long-term care to maintain a role for private insurance companies. A public option will “provide a minimum floor of protection,” allowing private insurance to provide wraparound policies. Supplementary coverage also will be available through the American Health Benefit Exchange.

## 5. Eliminates Fraud and Abuse

- Establishes a *Health Care Program Integrity Coordinating Council* to coordinate all fraud and abuse programs, including the creation of two positions at HHS to be in charge of these issues.
- Deters and punishes fraudulent health care plans.

## 6. Establishes shared responsibility

- Individuals must purchase affordable health insurance.
- Employers must “support” health coverage needs of their employees.
- Health plans must use more of their dollars to provide “meaningful and effective care.”
- All medical providers must “move our health care system toward better value” and “embrace practices and tools which promote better quality and improve performance.”
- Government at all levels must be part of the reformed system.

## Energy and Commerce Committee Health Care Reform, May 13, 2009 (Provided by Committee staff)

### Structural Overview

- Ability to keep what you have and minimize disruption.
- Provide a National Health Exchange for individuals and the smallest employers
- Requires shared responsibility among individuals, employers, and the Federal and State Government.
- Provides affordability credits to low and middle income individuals.
- Implements delivery system reforms to promote efficiency and reduce costs.
- Invests in the health care workforce and public health.
- Slows the growth of health care costs and maintains fiscal sustainability.

### National Health Exchange, Affordability Credits, Medicaid Improvements

#### Role of the Exchange

- New independent entity would make health insurance choices available to those without an employer offer, and smallest businesses (the first year: biz under 10 employees; second year: under 20 employees; etc). It would be open to large businesses over time.
- The Exchange would set and enforce standards for health plans; facilitate enrollment; receive/monitor complaints; and administer affordability credits.

#### Affordability

- Creates Sliding scale affordability for use in exchange for eligible individuals with incomes between Medicaid eligibility and \$88,200 for family of 4 (400% of poverty); everyone would be protected by an annual cap on out-of-pocket spending

#### Choice

- Ensures choice of private and public health insurance plans; provides new options for employers; and maintains and improves Medicaid for low-income individuals and families.

#### New Public Health Insurance Plan

- Health exchange includes a new public health insurance plan that would be subject to the same market reforms and consumer protections as private plans.
- Plan would have geographic adjusters for prices.
- Plan would ensure transparency, accountability, cost-containment and competition in the market.

- The public health insurance plan would likely be run by HHS, and would be independent of the Health Exchange.
- It would not have government subsidies-it'll compete on its own.

#### Provider Participation and Payment

- The public plan would build on Medicare providers and rates, similar to the practices of private plans today.

#### Benefits, Insurance Market and Reforms, and Consumer Protections

- A public private independent advisory committee would recommend benefit packages based generally on the Federal Employee Health Benefit Plan.
- Several levels of benefits would be available in the Health Exchange. They would differ predominately by cost sharing but additional benefits would be available in higher cost plans.
- After several years employer sponsored health plans would either have to meet the minimum benefit standard of plans operating within the Health Exchange or allow their employees to purchase coverage in the Health Exchange.

#### Market Reforms and Consumer Protections

- Health insurers, both inside and outside the Exchange, would be required to adhere to new insurance market reforms and consumer protections.

#### Shared Responsibility- Individual, Employer & Government Requirements

- Individual Responsibility: Individuals would be responsible for having health insurance.
- Employer Responsibility: employers would have the choice to “play” by offering health insurance to employees, or contribute:
  - Play: Employers would offer and contribute towards the health coverage of their full-time employees and their dependents.
  - Pay: Employers who do not “play” would “pay” contributing a percentage of payroll.

#### Investments in Health Care Workforce

- Expand the primary care, nursing and public health work forces through increased support for key programs.
- Create a broad, inter-disciplinary commission to examine ongoing health workforce issues.
- Support workforce diversity efforts including data collection and expansion of workforce programs.
- Remove barriers so hospitals can more easily train residents in community settings.
- Increase funds for scholarships and loan forgiveness to promote primary and nursing care.

#### Improving Health & Wellness

##### Prevention & Wellness Programs:

- Reduce disparities by supporting evidence-based, community wide efforts & health empowerment zones to improve health and wellness.
- Incorporate and improve prevention services provided in Medicare, Medicaid.
- Strengthen State Departments of Public Health.
- Substantially increased support for Comm Health Centers.
- Data collection improvements; Health IT providing & collecting data to reduce disparities.