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MASI HEALTH POLICY UPDATE

The big news for February was the release of President Bush's much-anticipated budget, kicking off the Fiscal Year (FY) 2006 budget negotiations process. As expected, the \$2.57 trillion budget is marked by spending cuts in several areas. Organized medicine will work throughout the budget process to avoid final cuts to health care interests.

Congress spent most of January confirming several top administrators, completing committee rosters, and changing congressional leadership positions. Rep. Joe Barton (R-TX-6) was elevated to chair the House Energy and Commerce Committee, while Rep. Nathan Deal (R-GA-10) will chair the Health Subcommittee.

Sen. Thad Cochran (R-MS) will chair the Senate Appropriations Committee, while Rep. Jerry Lewis (R-CA-41) will chair the House Appropriations Committee. However, the larger issue of the overall configuration of the Appropriations Committees and various subcommittees is holding up the final rosters. A House proposal to reduce the number of subcommittees from 13 to 10 may be pushed through, although recent reports indicate that the Senate appropriators reject the House plan to reduce the number of subcommittees. Several health care groups have asked Sen. Arlen Specter (R-PA) to remain as chairman of the Labor, Health and Human Services, Education subcommittee, in part due to his longtime support of medical research efforts and funding. His willingness depends on a number of factors, including whether a new intelligence subcommittee is established (he has expressed interest in chairing it).

President Bush Releases Fiscal Year 2006 Budget

President Bush released the Fiscal Year (FY) 2006 Budget on February 7, beginning the 2006 budget negotiation process. The \$2.57 trillion budget contains big spending cuts, most notably in domestic discretionary spending and entitlement programs, such as Medicaid. The proposal also reduces or eliminated funding for health care programs offering preventive health services and chronic disease prevention and health promotion. Interestingly, the President's budget does not reduce annual payment updates to Medicare providers; however, it also does not contain a legislative proposal to address a projected five percent payment reduction beginning in 2006.

Appropriations

Overall, the administration is asking for a 9.9 percent increase in funding for Health and Human Services (HHS) programs for Fiscal Year (FY) 2006. The president's budget seeks \$642.5 billion for HHS for the fiscal year that will begin Oct. 1, up from \$584.4 billion for the current fiscal year.

Included in this budget request is \$69 billion for discretionary spending in 2006, up 2.8 percent from \$67.1 billion for the current fiscal year, and \$573.5 billion in 2006 for mandatory programs such as Medicare and Medicaid, up 10.9% from \$517.3 for FY 2005. For 2006, the budget proposal seeks \$340.2 billion for Medicare, an increase of 17.2 percent over \$290.3 billion in 2005. The proposal also includes a 2.3 percent increase for the federal portion of Medicaid: for 2006, the budget is requests \$198 billion, up from \$193.6 billion in 2005.

The President's proposed budget for FY 2006 includes \$11 million total for the Title VII programs for Scholarships for Disadvantaged Students (\$10 million) and Workforce Information and Analysis (\$1 million). Primary care was once again zeroed out. This is a 96 percent cut below last year's level of \$300 million. Also included is \$150 million for Title VIII nursing (level funding).

2006 funding for the Agency for Health Research and Quality (AHRQ) is level at \$319 million with no changes in the allocation. There will be a transfer of \$14 million from AHRQ's health information technology portfolio to the Office of the National Coordinator for Health Information Technology.

The White House is seeking \$28.8 billion for the National Institutes of Health for FY 2006, a \$196 million increase FY 2005 levels.

The proposed budget for the total Center for Disease Control and Prevention's (CDC) funding stands at \$7.5 billion, a reduction of \$491 million. This includes cuts as follows: infectious disease decreased by \$1 million, HIV/AIDS and tuberculosis prevention decreased by \$4 million, preventive health and health services decreased by \$131 million, and buildings/facilities decreased by \$240 million. For the CDC's Vaccines for Children program, cuts of \$100 million are proposed.

The President's budget allocates \$393 million to VA research in FY 2006, which would be a 2.2 percent reduction from the approved FY 2005 level of \$402 million. The budget also allocates \$30.705 billion to VA health care in FY 2006, which would be a 2.5 percent increase over the FY 2005 approved level of \$29.953 billion. However, the FY 2006 figure assumes \$2.6 billion in collections from non-VA sources. As the \$2.6 billion is not considered likely to be realized, the true increase will be lower.

Cuts proposed for the Health Resources and Services Administration (HRSA) include a decrease of \$846 million; funding would be set at \$6.5 billion. Included in the cut is \$252 million health professional training activities, and \$101 million from HRSA's children's hospital graduate medical education program.

Drug Reimportation Debate Begins in Congress

Competing drug reimportation bills were introduced in Congress in late January. Representative Gil Gutknecht (R-MN-1) led a group of eight lawmakers to introduce companion bills in the House and Senate (S. 109/H.R 328). The legislation, entitled the

“Pharmaceutical Market Access Act of 2005,” is a revised version of a House measure that passed in 2003, and would allow pharmacies and wholesalers to legally import lower-cost drugs from Canada and 24 other countries. Freshman Senator David Vitter (R-LA) introduced the Senate version. Senator Judd Gregg (R-NH) introduced the “Safe Import Act of 2005,” which is identical to legislation he previously introduced. The bill does not penalize pharmaceutical companies that limit the number of prescription drugs available for reimportation.

Senators Byron Dorgan (D-ND) and Olympia Snowe (R-ME) plan on reintroducing their bipartisan drug import bill, and have reportedly received a commitment from Senate Majority Leader Bill Frist (R-TN) and Senate Health, Education, Labor and Pensions (HELP) Committee Chairman Mike Enzi (R-WY) to hold a hearing within 90 days of introduction. The Gregg bill and Dorgan-Snowe bill were competing entities last year; the former did not move past the Senate HELP Committee while the latter was denied a floor vote. The issue of prescription drug reimportation has received bipartisan support in Congress; however, the Administration opposes it due to safety concerns. In addition, Canadian Health Minister Ujjal Dosanjh urged limits to the practice in early January by drafting a proposal to mandate that Canadian physicians cannot co-sign prescriptions for U.S residents who they have not examined.

Health Information Technology (HIT) Remains a Priority

Representatives John McHugh (R-NY-23) and Charles Gonzalez (D-TX-20) introduced the “National Health Information Incentive Act of 2005” on February 10. This bill is aimed at implementing a national HIT infrastructure. In particular, the bill would create incentives to encourage physicians and other health professionals to adopt HIT, such as interoperable electronic health records, electronic prescribing systems, evidence-based clinical support tools, and patient registries.

Several signs indicate that HIT will be a hot issue for the 109th Congress. President Bush last year expressed the need to improve the quality of care, cut costs, and reduce medical errors throughout the health care system using HIT. In May 2004, the President set up the Office of the National Coordinator for Health Information Technology (ONCHIT) within HHS, and appointed Dr. David Brailer as Coordinator to facilitate HIT adoption. However, ONCHIT was zeroed out in the FY 2005 omnibus spending package. President Bush recently stated that a budget reshuffle within the HHS budget will restore the promised \$50 million to Dr. Brailer. In addition, he requested \$125 million in the FY 2006 budget to help fund new regional and community health information organizations.

News from the Centers for Medicare and Medicaid Services (CMS)

The Centers for Medicare and Medicaid Services (CMS) reported its initial contractor reform plans to Congress on February 7. The President’s FY 2006 budget plan calls for \$58.8 million in discretionary funding for Medicare contractor reform. CMS already allocated over \$27 million in FY 2004 and FY 2005 for implementing the transition from using fiscal intermediaries and carriers to Medicare Administrative Contractors (MAC). The first stages of the transition will begin with requests for proposals and the first actual MAC contract is expected to be awarded in December 2005 for durable medical equipment MAC. The first

Part A/B MAC is expected to be awarded in June 2006. The MAC system is expected to be comprised of 23 contractors with non-overlapping jurisdictions.

The agency also announced the start of a demonstration designed to test financial incentives for improved quality and coordination in large group practices. Through the Physician Group Practice Demonstration, ten large physician groups will participate in the first pay-for-performance initiative for physicians under the Medicare program. Physician groups were selected based on technical review panel findings, organizational structure, operational feasibility, geographic location, and implementation plan. The multispecialty groups consist of at least 200 physicians and include freestanding group practices, integrated delivery systems, faculty group practices, and independent practitioner associations. CMS will assess both quality performance and quality improvement under the demonstration. The demonstration is budget-neutral, additional payments to providers will come from savings in increased efficiency of care.

Other Health Policy News

- A bipartisan group of senators introduced the “Medicare Enhancement for Needed Drugs (MEND) Act” on February 1 that would allow HHS to negotiate drug prices with pharmaceutical companies for the upcoming Medicare prescription drug benefit. The legislation would effectively undo a key provision in the Medicare Part D program, created in the MMA. The bill would also require the HHS Secretary to negotiate “fallback plans” – Medicare-operated plans aimed at expanding choices for beneficiaries who live in areas with limited private options.
- Representatives Sam Johnson (R-TX-3) and Nydia Velázquez (D-NY-12) have reintroduced the “Small Business Health Fairness Act” (H.R. 525). The bill would allow small businesses to band together to form Association Health Plans (AHPs). The bill, as introduced in the 108th Congress, passed the House in June 2003 with 162 House cosponsors.
- The “Geriatric and Chronic Care Management Act of 2005” (S. 40) was introduced by Senator Blanche Lincoln (D-AR) on January 24. The legislation, identical to last year’s bill, aims to provide Medicare beneficiaries with access to geriatric assessments and chronic care management.
- On February 2, Elias Zerhouni, Director of the National Institutes of Health (NIH) announced guidelines that restrict all NIH employees’ outside consulting activities for health providers, hospitals, insurers, and pharmaceutical companies. NIH officials are still reviewing previously identified potential conflicts of interest and will enter the “penalty phase” if violations are found, according to Deputy Director Raynard Kingston.
- Michael Leavitt, HHS Secretary stated that he is open to considering administrative action to address pending cuts to physician payments under the sustainable growth rate (SGR) formula; however, he is not willing to retroactively remove the cost of Part B drugs from the formula. The Medicare Payment Advisory Commission

(MedPAC) previously indicated that the agency has the legal authority to make a retroactive fix to the SGR formula.

- The President's budget contains a proposal to trim \$60 billion over ten years from Medicaid. Secretary Leavitt has expressed the need to institute new coverage flexibility and tighter financial oversight of state programs. Medicaid stakeholders continue to oppose cuts or limits to Medicaid; a broad-based Medicaid Coalition sent a letter to all members of Congress urging them to avoid cuts. SGIM signed on to this letter.
- Medical causes were cited in a February 2 report to be the cause of 55 percent of the bankruptcies filed in 2001. The three most specific causes cited were: a specific illness or injury (28.3%), uncovered medical bills exceeding \$1000 (27%), and loss of at least two weeks of pay because of illness or injury (21.3%). Few of those bankrupted had elected to go without medical coverage. Fifty-six percent said that they were unable to afford the premiums and seven percent were unable to obtain coverage because of pre-existing conditions. Others cited employer issues for their loss of coverage. Seventy-six percent of those surveyed indicated that they had medical coverage at the onset of the illness or injury that led to bankruptcy; one-third of those with private coverage lost their coverage during the course of the illness.