Capitol Hill Gears Up for Health Reform in 2009

Expectation of a serious reform bill being developed between November and January is fueling excitement.

BY ALICIA AULT
Associate Editor, Practice Trends

Democrats and Republicans are so confident about the chances of some type of health reform in the next administration that staff meetings and hearings geared toward crafting legislation have been going on in earnest in both the House and the Senate, with the goal of being ready to go in January, according to advocates and policy watchers.

Many health policy analysts have compared and contrasted this election cycle with that of 1992, which sent Bill Clinton to the White House and launched the Clintons' health care reform efforts.

Both elections—1992 and 2008—feature a high level of public concern about access to health care and its costs, said Len Nichols, an analyst at the New America Foundation, a nonpartisan public policy institute.

For instance, a Harris Interactive survey conducted for the Commonwealth Fund in May found that 82% of Americans think the health care system should be fundamentally changed or completely rebuilt.

But the differences between the two elections are striking in a positive way, said Mr. Nichols, in an interview.

First, the two major candidates themselves have acknowledged that cost is an overriding concern, he said. Also, a common theme is the use of private markets, which he called "evidence, I would say, of moderation" and, perhaps, the proposals' better legislative traction.

Both candidates—Sen. Barack Obama (D-Ill.) and Sen. John McCain (R-Ariz.)—have also learned that "no president is going to send [to Congress] a 1,400-page health bill written in a hotel room by 300 wonks," Mr. Nichols said.

Instead, "Congress is going to own this [effort] far earlier and deeper than before," he said, adding, "It's still going to require a lot of presidential leadership. But the Congress has to be an equal, more than it has before."

Several proposals are likely starting points for congressional negotiations with the new administration, he said. First is the Healthy Americans Act, introduced in January 2007 by Sen. Ron Wyden (D-Ore.) and Sen. Bob Bennett (R-Utah). It has 16 cosponsors from both parties, including Sen. Chuck Grassley (R-Iowa), the Finance Committee's ranking minority member.

The bill is being championed in the House by Rep. Debbie Wasserman Schultz (D-Fla.) and Rep. Jo Ann Emerson (R-Mo.). Rep. Wasserman Schultz is important "because she's a rising star and has impeccable liberal credentials," said Mr. Nichols.

In a paper published in the May/June 2008 issue of the policy journal Health Affairs, Sen. Wyden and Sen. Bennett said they saw "signs of an ideological truce" on the Hill, with agreement that there is a need for the Democratic-backed universal coverage and the Republican-supported desire for market forces to promote competition and innovation.

"The Healthy Americans Act strikes a balance between these ideals," they wrote (Health Affairs 2008;27:689-92).

The bill would require individuals to purchase insurance for themselves and their dependent children, and would require insurers to offer a prescribed package of benefits.

It would subsidize coverage for Americans with incomes up to 400% of the federal poverty level. Employers would convert benefit dollars into salary; such compensation would be tax free, with the goal that the money would be used to purchase coverage.

Sen. Wyden is likely to be front and center in crafting a bill, as he is a member of two of the committees of jurisdiction: finance and budget, said Mr. Nichols, adding that those committees, along with the Health, Education, Labor and Pensions (HELP) Committee "will play very important roles."

Ron Pollack, executive director of the advocacy group Families USA, said that although Sen. Wyden may play a part, "I have little doubt that Sen. Baucus is going to be as instrumental in the process as anyone."

Sen. Max Baucus (D-Mont.), chairman of the Finance Committee, held a health care summit in mid-June.

Staff from the Finance Committee and the HELP Committee, led by Sen. Edward M. Kennedy (D-Mass.), have been coordinating meetings with those two panels and the Budget Committee, Mr. Pollack said in an interview.

Committee chairs have the greatest influence on the legislative process, he said. Both Mr. Pollack and Mr. Nichols also expect Sen. Kennedy to play a very significant part in creating the legislation, as much as his cancer will allow.

Even so, "to pass anything of significance will require bipartisanship," said Mr. Pollack, noting that Sen. Baucus and Sen. Grassley have worked closely on many bills.

The House is not as far along in preparing for health reform, but staffers on the four relevant committees with jurisdiction over health care have been meeting, said Mr. Pollack.

"I think there's significant movement underway in anticipation of health care reform being a top domestic priority," he commented.

But, "I don't think any of the proposals that have come out so far are going to be *the* proposals," added Mr. Pollack.

Instead, the expectation is that a health reform bill will be developed during the transition period between November and January, "and that's what we should look at most seriously," he said. ■

$20 Million Savings?

'Never' Events *from page 1*

care at risk. The AMA said that Medicare officials are lumping together true "never" events such as wrong-site surgery with "often unavoidable" conditions such as surgical site infections.

"Focusing on determining whether or not medical conditions exist when the patient enters the hospital will increase Medicare spending on tests and screenings with questionable benefit to patients," Dr. J. James Rohack, AMA president-elect, said in a statement. "A more effective patient safety approach would be to encourage compliance with evidence-based guidelines by health care professionals."

Officials at CMS estimate that the nonpayment for preventable errors policy will save Medicare about $20 million a year. However, the policy is not about saving money, Kerry Weems, CMS acting administrator, said during a press conference.

"I would be perfectly happy if we never came to a point where we didn't have to pay because somebody got a hospital-acquired condition," Mr. Weems said. "This is about changing hospitals and making them safer places."

The CMS originally had proposed adding nine new conditions to the preventable conditions nonpayment list. Agency officials pared down the list after public comments raised questioned about including the other conditions. Some conditions that were not included in the final rule are delirium, ventilator-associated pneumonia, *Staphylococcus aureus* septicemia, *Clostridium difficile*–associated disease, legionnaires' disease, and iatrogenic pneumothorax.

However, those conditions may appear in future proposals once the agency has refined them, said Mr. Weems.

The CMS also is in talks with the National Quality Forum, the Agency for Healthcare Research and Quality, the Leapfrog Group for Patient Safety, and others about expanding the list of never events and considering how to expand the nonpayment policy to non-hospital settings such as nursing homes and home health agencies.

In addition to the expansion of the conditions on the preventable hospital-acquired conditions list, CMS is also beginning to develop three National Coverage Determinations to deny Medicare coverage for three never events—surgery on the wrong body part, surgery on the wrong patient, and wrong surgery performed on a patient.

'Not only will the measures promote quality improvements by hospitals and … staff, they will also allow patients to compare different hospitals.'

"These national coverage decisions will mandate what seems obvious—never events should never occur," Mr. Weems said. "They should not be reimbursed by the Medicare trust fund."

A proposed decision memorandum on these surgical errors is scheduled to be issued by next February and is expected to be made final by the end of next April.

Including these events in Medicare's coverage policy also would apply to Medicare Advantage plans. Medicare Advantage plans are required to follow all Medicare fee-for-service coverage policies, even when those policies differ from their commercial practices, according to the CMS.

The CMS also sent a letter to state Medicaid directors to encourage states to adopt similar policies on payment for preventable hospital-acquired conditions. The letter also provides information on how states can adopt the policies outlined in the final Medicare inpatient prospective payment system regulation. Nearly 20 states are considering methods to eliminate payment for certain never events, or already have them in place, according to the CMS.

Finally, as part of the Acute Care Inpatient Prospective Payment System final rule, the CMS is adding 13 new measures to the Reporting Hospital Quality Data for Annual Payment Update program. Under the program, hospitals are required to report quality data publicly on the Medicare Hospital Compare Web site in order to receive their full payment update. The payment implications for the new quality measures will take effect in fiscal year 2010.

"Not only will the measures promote quality improvements by hospitals and their staff, they will also allow patients to compare different hospitals, to [help them] decide where they will receive the best care," Mr. Weems said. ■

The Existing Eight on Medicare's 'Never' List

Medicare currently lists eight preventable health care–acquired conditions under its nonpayment policy and will not reimburse hospitals for secondary diagnoses associated with the following eight conditions if acquired after hospital admission:

- Foreign object retained after surgery.
- Air embolism.
- Blood incompatibility.
- Pressure ulcer at stages III and IV.
- Falls and trauma.
- Catheter-associated urinary tract infection.
- Vascular catheter–associated infection.
- Mediastinitis after coronary artery bypass graft.