This Week in Health Reform…
• Public Option Rejected in Senate Finance
• Prospects for Public Option
• Medicaid Challenges
• STUDY: Racial Disparities in Coronary Angiography Utilization
Senate Finance Committee defeated two amendments on Tuesday to create a public health insurance plan.

1. The first amendment offered by West Virginia Senator Jay Rockefeller to create a “public option” fell 15-8. Five Democrats (Sens. Max Baucus, Kent Conrad, Blanche Lincoln, Bill Nelson, and Tom Carper) joined all 10 republicans in opposition to the amendment. Under Rockefeller’s amendment, rates paid to doctors, hospitals, and other health care providers would be based on Medicare payment rates. This would provide savings to beneficiaries, but would be detrimental to providers in areas where Medicare reimbursement rates are below the national average.

2. A subsequent and similar amendment proposed by New York Senator Charles Schumer created a “public option” that would allow for health care providers to negotiate their reimbursement rates. This amendment still failed 13-10, however, by changing the provisions for payment rates, this amendment received support from Sens. Bill Nelson and Tom Carper, two of the senators who had previously rejected Sen. Rockefeller’s amendment.

Chairman Baucus who has indicated that he supports the principles of a “public option” voted against both amendments explaining that he wants a bill that can become law, not one doomed to fail by a Republican filibuster.
Possibilities for Public Option

SENATE:

- Debate on the public plan will resurface when it is time to merge the Senate Finance bill with the Senate HELP bill, which has a public plan included.

- Furthermore, the public option could end up in the Senate Finance bill if Maine Republican Senator Olympia Snowe pushes her amendment for a back-up public option referred to as the “trigger plan.” This amendment calls for the public option to kick in at the state level only in the situation where private insurers fail to offer affordable health insurance to at least 95% of residents within a state.

HOUSE:

- A public health insurance plan still has a chance in the House where House Speaker Nancy Pelosi has pressed for a “public option” to be included in any bill that reaches the House floor.

- However, the House is still debating on the design of the public plan. The House is in the process of merging bills from three committees with health care jurisdiction (Energy & Commerce; Ways & Means; Education & Labor). The original House bill called for payment rates to be set above, yet still tied to, Medicare rates. An amendment that passed in the Energy Committee calls for negotiated reimbursement rates.
Challenges in Medicaid Program During Tough Economic Times

The annual 50-state survey conducted by the Kaiser Family Foundation’s Commission on Medicaid and the Uninsured finds that Medicaid enrollment and spending rose sharply in 2009 as a result of the recession and the unemployment surge.

• State Medicaid enrollment grew on average 5.4% in 2009, the highest in 6 years.
• State Medicaid spending grew on average 7.9% in 2009, the highest in 5 years.
• 33 states cut or froze provider rates in 2009. Cuts in reimbursement rates wreak havoc on physician’s bottom line, reduce provider participation in Medicaid, and jeopardize Medicaid enrollee’s ability to access care.

To read the report on the annual survey of state Medicaid directors conducted by the Kaiser Family Foundation’s Commission on Medicaid and the Uninsured click here.
“Reducing Racial Disparities in Coronary Angiography”
Authors: Joel C. Cantor; Derek DeLia; Amy Tiedemann; Ava Stanley; Karl Kronebusch
Published in Health Affairs September/October 2009

This study published in Health Affairs September/October 2009, looks at New Jersey reform efforts to address racial disparities in access to cardiac diagnostic and treatment services. The study looked specifically at the utilization rates of coronary angiography, a procedure to image the heart’s blood vessels and chambers, among blacks and whites between 1995-2003.

New Jersey Reform:
New Jersey enacted a series of regulatory changes from 1996-2003 that provided stronger incentives to reduce gaps in angiography utilization. Some changes include:

- Doubling the number of angiography access points by establishing newly licensed facilities
- Mandating that newly licensed facilities create outreach plans
- Linked licensure to success records of improving access and made licensure contingent on not exceeding a rate of one in four negative angiography findings
Reducing Racial Disparities in Cardiac Services

Study Findings:

- Black-white gap disappeared by 2002-2003
- Angiography utilization increased for both blacks and whites, but the rate of increase for blacks was greater
- Urban incumbent hospitals (incumbent facilities are those that were providing coronary angiography before reform) increased services to black patients more than hospitals newly licensed after reform.

Study Conclusion:

Competition led to a reduction in racial disparities in angiography utilization. It wasn't so much that the newly licensed facilities reduced disparities; rather it was their introduction into the market that resulted in behavior changes of large urban hospital that were licensed before reform. Large urban hospitals, as a result of competition, provided more angiographies to black patients.

Joel C. Cantor, Derek DeLia, Amy Tiedemann, Ava Stanley, and Karl Kronebusch, Reducing Racial Disparities in Coronary Angiography, Health Affairs, Vol 28, Issue 5, 1521-1531
What You Can Do

What are your thoughts on the results of the “Reducing Racial Disparities in Coronary Angiography” study?

Share your experiences, comments, questions, and/or concerns with NMA Health Policy Department. Contact us at healthpolicy@nmanet.org

For the latest health policy news and information visit our page NMA Health Policy Updates
Work Cited


