

## CCHC in the News

Mar: *St. Paul Pioneer Press*  
*Star Tribune*  
*Associated Press*  
*Session Weekly*  
*Benefits Link*  
*Pioneer Press - Q&A*  
*Health Freedom Watch*  
*KKMS Radio*  
*KSTP - FM 107*

April: *Philadelphia Inquirer*  
*KMWB TV's Face to*  
*Face - a debate on*  
*privacy with Rep.*  
*Thomas Huntley (D-*  
*Duluth)*  
*KSFO Radio - Hottalk*  
*(San Francisco, CA)*  
*MN Health Care News*  
*Hospice Patients*  
*Alliance Newsletter*  
*Minnesota Physician*  
*Privacy Journal*  
*NaturalHealthLine*  
*Pro-Family News*

May: *The Business Journal -*  
*Minneapolis/St. Paul*  
*St Cloud Times*  
*Star Tribune*  
*KSTP Talk Radio*  
*WBAI Pacifica Radio*  
*(Hawaii)*

June: *Canadian Broadcasting*  
*Company - radio,*  
*Edmonton, Alberta*  
*The Business Journal -*  
*Minneapolis/St. Paul*

## CCHC Sends Warning on Medicare Bill

Calling the Senate's Medicare bill "drug coverage by committee," CCHC sent a press release with these concerns:

- *Limited Access.* Any drug that Medicare defines as not "reasonable and necessary" can be excluded. Drugs not on a health plan's drug formulary will be excluded from coverage. A "pharmacy and therapeutic committee" must develop the plan's formulary.

- *Access Denied?* Seniors may be forbidden to purchase any *covered* medication that is denied. Unless seniors are given Advance Beneficiary Notices warning them of possible denial, current law forbids private payment for covered services that Medicare denies.

- *Deductible Discrimination?* It is unclear how the \$275 deductible and the \$3,700 cost-sharing limit are reached. Only with Medicare-approved drugs, or with all medications purchased by the senior citizen?

- *Private Drug Coverage to Decrease.* Seniors may enroll without penalty after the initial enrollment period if their drug coverage plan terminates them, ceases to provide drug coverage, or reduces the value of their drug coverage. This encourages companies and groups that currently offer private drug cover-

age to seniors to drop such coverage.

- *No Drug Coverage in Medigap?* Enrollees in the new Medicare Part D drug plan will not be allowed to buy Medigap drug policies. This may encourage Medigap plans to drop all drug coverage.

- *Managed Care.* Entities offering drug coverage will be required to have a cost-effective drug utilization management program. They must "detect patterns of overuse and underuse of drugs".

### What Congress should do:

- Provide Medicare drug coverage only to the most needy.
- Offer tax deductions for providing medication as charity.
- Change the Medicare program to a defined contribution system: provide all seniors with a defined dollar amount so they can choose a private insurer that meets their personal needs, including drug coverage.
- Repeal the law that prohibits access to social security benefits for seniors who refuse to enroll in Medicare.
- Repeal the law that prohibits seniors from paying cash for Medicare-covered services that Medicare denies.

Contact information for Congress:  
<http://www.cchconline.org>

***Two Washington, D.C. think tanks called to thank CCHC for the information. Your financial support will continue to allow CCHC to get the details that make the difference!***

## CCHC Stops Minnesota Plan to Ration Care

Conservatives often feel justified in rationing care to Medicaid recipients. It's the taxpayer's money, they reason. While that's true, CCHC successfully pointed out the bigger picture to this year's MN legislature, stopping a plan to deny care to the medically vulnerable.

Sen. Linda Berglin, chief author of the 1992 state law that put almost all Minnesotans into managed care,

proposed explicit rationing for people in Medicaid and other public programs.

A list of 217 broad categories of health care conditions were to be excluded from treatment. And anyone with cancer whose doctor gave them five percent or less chance of being alive in *five years*, would be denied treatment.

The big picture, argued CCHC in a list of 9 arguments distributed to the media and legislators, and mentioned in the *Star Tribune*, is the slippery slope: "Once state bureaucrats are authorized

by law to make priority of treatment decisions—and effectiveness of treatment decisions—in public health care programs, there will be pressure to implement their decisions in the private sector." Other concerns included: state-imposed value judgments, authorizing pain and suffering, and supplanting individual ethics, patient choice, and medical decisions with state directives.

***Your contributions and emails made this effort possible!***

## CCHC Gets Earful on the New Privacy Rule

A frustrated public has been calling CCHC to share their experiences with the new so-called medical privacy rule. The following stories are true, but the names have been changed.

Albert, who has long kept his own set of family medical records, took them to the office of a new doctor where he had an appointment. He forgot to retrieve them when he and his wife left. When he went back for them, he was told that he could not get them unless he signed an authorization. He refused—they were his own copies. He owned them. He contacted CCHC who provided him with information on his rights. He then got his records. The clinic did not know that the Rule requires doctors to share patient medical records with the patient.

Marie took an online CCHC privacy declaration form to her appointment with a specialist. She'd given this form to several other clinics without a problem. But this clinic left her waiting in the waiting room, then asked her to step into the conference room and explained that they could not accept the form. And furthermore, the appointment was cancelled. She left untreated and contacted CCHC. The clinic didn't understand that while patients are allowed to ask for greater privacy protections, clinics are not required to comply with the request.

Sarah told CCHC about her personal experience with a Twin Cities nursing home. She called the facility to ask if she and her children could come to sing for their aunt. The nursing home staff informed her that they were not allowed to tell her if her aunt even resided at the facility.

Much of the public has been led to believe their privacy is protected. Not so. Some 600,000 entities have received federally-approved access to private medical records.

*GOOD NEWS: The Rule allows states to pass stronger state privacy laws. Government officials and health care corporations oppose such laws. Let your legislators know that real privacy protections depend on their action.*

## Doctors Say No

Doctors providing charity care - 1997.....	76.3%
Doctors providing charity care - 2001.....	71.5%
Calif. speciality Drs. who do not accept HMO patients - 1998.....	23%
Calif. speciality Drs. who do not accept HMO patients - 2001/2002.....	33%

*Information from Center for Studying Health System Change, and the California HealthCare Foundation.*

## Where Have all the Doctors Gone?

Getting a doctor when you need one, even in critical situations, is no longer guaranteed. There are several reasons.

Due to high malpractice insurance premiums, the American Medical Association (AMA) reports that Mississippi could lose 20 percent of its doctors. Las Vegas could lose 10 percent. A Nevada trauma center closed for 10 days because it couldn't afford premiums up to \$200,000. And in one Penn. county, 65 percent of the doctors are thinking of moving out of the state.

Second, payments for providing care are inadequate. According to John DuMoulin, director of practice advocacy for the American College of Physicians, the cost of running a medical practice has increased by 60 percent in the last 10 years while payments from the federal government and health insurers have stayed the same.

Third, Medicare fraud investigations put physicians in constant fear of prosecution. Claiming that inadequate payment is less troublesome than federal investigators, Dr. Jane Orient, director of the American Association of Physicians and Surgeons says, "More doctors would rather treat uninsured

patients, possibly for free, than risk being prosecuted as a 'Medicare cheat.'"

There are over 130,000 pages of Medicare regulations to follow. Despite the best of intentions, any doctor can be found guilty of some infraction when put under a government microscope. The penalty is harsh: \$10,000 per incident; even prison. The Senate Medicare bill raises it to \$12,500.

Although there has been no relief from the federal threat of prosecution, recent articles in the *Los Angeles Times* and *The Washington Post* find doctors flexing their muscles where they can. To deal with low reimbursements, they have begun to charge for every phone call and every form completed. Some specialists are even refusing to come to the Emergency Room until adequate payment is assured.

When patients are sick, they want a physician. Unless patients and consumers start purchasing their own insurance and paying cash for routine and minor care, the public will find fewer doctors in practice. Physician shortages lead to long waits. Long waits lead to poor care. Ask Canada. Americans should view with skepticism any claim that government programs and prepaid managed care offer patients the health care they want and need. **tB**

## Feedback!

*Thank you for all the help and information you provided. It was critical in helping to block the Oregon system from becoming law in Minnesota. - Minnesota Rep. Tim Wilkin (R-Eagan)*

*I was in your HIPAA presentation at the Solucient Conference and we gave a little report to our manager about the new things we learned about HIPAA. She was fascinated as was I. She was not told about the things we found out from your talk...This was an eye-opening session. - T.M., Lincoln, Nebraska*

*You have my thanks. This will have to include the thanks of my children and their children, since they will never know and not realize that someone stood up there battling for them year after year when the fuzzy tried to control their unknowing lives. - R.G., St. Paul, MN*

*Thank you for being the eyes and ears of concerned Minnesotans as our State's legislature was in session. Keep up the great work." - T. C., Minneapolis, Minnesota*

*Brava! Brava! Brava! You are on the right track. Your Medicare proposals have set the stage to AVERT THE TRAIN WRECK! - Stephen Barchet, Issquah, Washington*

## HillaryCare Advances - Starting in Maine

Almost a decade after President and Hillary Clinton's national health plan was defeated, liberals around the country have returned with more Big Government plans. Not only are Democratic presidential candidates proposing \$700 billion universal coverage initiatives, the states are also getting in on the action.

On June 18, universal health insurance *became law* in **Maine**. The government will compete with private insurers to offer coverage. Federal funds, new taxes on insurers, and premiums paid by employers and recipients will cover the cost. **Massachusetts** legislators may also be back for a second run at government health care for all. Although residents of Massachusetts narrowly defeated a single-payer initiative two years ago, consultants who were required to study universal coverage recently offered three options, including a single-payer system costing the state \$3 billion to \$6 billion a year.

Universal coverage proposals are not limited to the East coast. The **Wisconsin** Medical Society on March 19, 2003 unveiled a report encouraging a universal health care system for Wisconsin. All employers would be required to offer insurance or pay into a state insurance pool. Although hospitals oppose the "pay or play" proposal, Patrick Remington, director of the Wisconsin Public Health and Health Policy Institute at the University of Wisconsin-Madison, said that providing health care to the uninsured is more expensive than universal coverage and that the state will

be forced to adopt "some form" of universal coverage as the health care "situation worsens" (*Milwaukee Journal Sentinel*, 3/19/03). Meanwhile, the **Illinois** House has passed The Health Care Justice Act. Cost: \$2.6 billion to \$4 billion. A 25 to 40 percent income tax hike would be required. The bill passed 60-45-11. Then there's **Texas**, where a 2002 University of Houston poll found 52% of Texans favored universal coverage while 43% opposed the plan. And cabinet-secretaries of Health and Human Services in **New Mexico** are holding hearings to discuss requiring all state residents to have health insurance.

Corporations have chimed in with similar ideas. Bruce Bodaken, CEO of Blue Shield of **California**, has proposed a universal coverage plan for all Californians. It would cost the state \$4.5 billion and employers \$3.2 million if it were enacted this year, according to *The Wall Street Journal*. In addition, a coalition of big businesses, labor unions, and others are supporting universal coverage under the umbrella of a group called the National Coalition on Health Care. Their new report, "Charting the Cost of Inaction" calls for requiring all employers to provide insurance (*Washington Business Journal*, 5/26/03).

Finally, *Managed Care* magazine reported in January that William McGuire, MD, CEO, of UnitedHealth Group sent letters to each member of Congress requesting "essential health care for all Americans." No doubt Mr. McGuire expects his company to get a big piece of the government's business. He was a speaker for one of the federal *Covering America* presentations. **tB**

## Eye Openers

**Basically, health plans have wide open access to information they didn't have before.**

Michael Tedford, M.D., privacy rule segment, *KARE-TV*, June 12, 2003.

**Rather than protect an individual right to medical privacy, these regulations empower government officials to determine how much medical privacy an individual 'needs.'**

U.S. Rep. Ron Paul (R-Texas), *WorldNetDaily*, April 17, 2003.

**Running for President? Health Care better be your priority.**

Poster at Des Moines, IA airport, created by Service Employees International Union, "Universal Health Care Gets Boost," *The Washington Post*, June 26, 2003.

**Health insurance should work like home insurance. With home insurance, you call in the insurance company if your roof collapses. But you don't call the insurance company if the garbage disposal gets stuck. Homeowners or landlords pay such routine maintenance bills out of their own pockets.**

Michael K. Evans, *Industryweek.com*, June 2003.

**[T]here can be no serious, long-term cost containment without a willingness to deny beneficial care.**

M. Gregg Bloche, professor of health policy and law, Georgetown and Johns Hopkins Universities, *St. Paul Pioneer Press*, May 25, 2003.

**There is no obesity epidemic in America. Only fat bureaucrats and tubby lawyers feasting on a growing number of people who refuse to take responsibility for their actions.**

Payton Knight, "The New Tobacco," *The DeWeese Report*, August 2002.

CCHC President Twila Brase conversing with Jim Frogue, American Legislative Exchange Council at the Altas Foundation/State Policy Network Health Care Forum - Boston

## Short Takes

### CCHC President in Action

**June 5:** Panelist/Speaker at a health care forum sponsored by Atlas Economic Research Foundation and the State Policy Network - Boston, MA.

### The Uninsured: no excuse for Universal Health Care

A recent Congressional Budget Office report notes: "It is frequently stated that about 40 million Americans lack health insurance. That estimate, however, overstates the number of people who are uninsured all year." The following statistics on the uninsured are taken from the CBO report, and a Heartland Institute's analysis of a Blue Cross and Blue Shield Association report:

#### CBO Report (5/03)

Insured in America	240 million
Uninsured any time of year	56.8 - 59 mil.
- Uninsured all year	21 - 31 mil.
	(9 - 13.3 percent)

#### BCBS Report

Income over \$50,000	15 million
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Despite the fact that the fastest growing group of uninsured have incomes above \$75,000 (BCBS), the CBO reports that the high cost of health insurance and lack of access to employment-based coverage are the most common reasons given for uninsurance.

### Research Monkeys Get \$24M Retirement Home

Chimpanzees used in medical research now have a plush chimp sanctuary in the South, courtesy of Congress. On September 30, 2002, the National Institutes of Health (NIH) announced that Chimp Haven had been awarded a ten-year \$24 million contract to "provide lifetime care for Federally owned or supported chimpanzees that are no longer needed for biomedical research. [Chimp Haven] will maintain high standards for quality care and ensure state-of-the-art treatment of the chimpanzees," according to the NIH press release. The free-range sanctuary to be built in Shreveport, Louisiana on land donated by county government will initially house 75 chim-

panzees. It was mandated by The Chimpanzee Health Improvement, Maintenance, and Protection (CHIMP) Act of December 2000. State-of-the-art treatment likely means there are no HMO prior authorizations, drug formularies or appeals processes required when a chimp gets sick.

### Medicare Rationing 101

Medicare recipients with irregular heartbeats are the latest targets of health care rationing. On June 6, the Centers for Medicare and Medicaid Services said only 10,000 additional seniors will be eligible for an implantable cardiac defibrillator (ICD) to prevent a heart attack. This is less than the number reported in a March 2002 study by Guidant Corporation, maker of the ICD. Although a federal advisory group agreed with Guidant's higher numbers, CMS will allow only those who *survive* a heart attack *and* have abnormally rapid heartbeats to receive the \$30,000 device. CMS's decision makes a total of 281,000 patients eligible for the ICD.

Ineligible seniors with heart-beat abnormalities may be out of luck. Unless they receive an Advance Beneficiary Notice from their doctor telling them Medicare may deny the ICD, 1997 federal law prevents recipients from using their own money to buy any covered service denied by Medicare.

The ICD is one of many products available to cure disease, sustain life, and ease pain. More are coming. Funding for medical research at the National Institutes of Health was recently doubled. However, the implementation of rationing by Congress and federal regulators means seniors may not be allowed to benefit from medical advances.

**Action Item:** *Any Medicare reform bill should include a repeal of the proscription against private payment for care.*

### Public Enemy #1: Health Care Costs

For the first time since 1986, small business owners have rated the cost of health insurance, not taxes, as their number one problem. This is according to a four month survey by the National Federation of Independent Business. *USA To-*

*day*, which reported the bad news, notes that many employers are looking at 20 percent increases or more this year. Only 1 percent of small companies are adding workers. That's the lowest rate since 1991. Instead, employers are eliminating benefits, shifting costs to employees, and cutting overhead. For example, Abator, an employment agency, has delayed computer system upgrades. It was hit with a 36 percent increase this year, on top of last year's 17 percent increase (*USA Today*, 4/21/03)

**Action Item:** *Employees who don't think they received a 20 to 36 percent increase in actual benefit from their health insurance can slip a note in the employee suggestion box. If MSAs, HSAs, or cash were offered instead of the current coverage, employees could shop for a better deal with their hard-earned dollars.*

### Health Savings Accounts: Better than a MSA

H.R. 2351, the bipartisan "Health Savings Account Availability Act of 2003" is working its way through Congress. According to a June 6, 2003 letter by co-authors, Reps. Bill Thomas (R) and William Lipinski (D), the HSA would:

- Be permanent and portable.
- Be available to all individuals with a qualified high-deductible plan.
- Have a minimal deductible of \$1,000 per individual plan and \$2,000 per family plan.
- Allow contributions to equal 100 percent of the deductible.
- Allow both employer and employee contributions.
- Be available through Preferred Provider Plans.
- Be offered by cafeteria plans.
- Not place a cap on participation.
- allow tax-free rollover of up to \$500 in unspent flexible spending accounts per year.

As this newsletter goes to press, the HSA may be taken out of the bill. The MSA Coalition reports that H.R. 2351 may instead remove all caps and restrictions from Medical Savings Accounts, making them permanent. However, it also appears that MSAs will not be available to recipients of Medicare, Medicaid, and other public welfare programs.