Catholic Health Association of Minnesota
P.O. Box 65217
St. Paul, MN 55165-0217

Updates from our membership...

...What's happening in your organization. Please send your news to Toby Pearson, CHA-MN executive director. Telephone: (651) 503-2163; e-mail: tpearson@chamn.org. Ask your public relations or communications director to put us on the news release list: CHA-MN, P.O. Box 65217, St. Paul, MN 55165. ■

News & Notes

- The **Kaiser Family Foundation** (www.kff.org) provides an array of health care reform analysis at no cost to the public including a detailed Implementation Timeline as to when specific provisions of the legislation are scheduled to take effect.
- Each year the month of May is proclaimed **Older American Month** throughout the nation. This year's them is Age Strong! Live Long! – recognizing the diversity and vitality of today's older Americans who span three generations. They have lived through wars and hard times, as well as periods of unprecedented prosperity. America's senior population is expected to number 71.5 million by 2030.
- According to the **Genworth Financial survey** released last week, Minnesota long-term care costs are very close to national averages. The report includes data from 60,000 providers nationwide and can be viewed in its entirety at www.genworth.com.

* CHAMN is in the process of updating our current website design to include more regular feeds of both national and local Catholic health news. Look for an announcement in the next few months. Visit **www.chamn.org**.

* Thanks to the CHAMN Members for your continued commitment of membership to our important mission.

TIDINGS!

Newsletter of the Catholic Health Association of Minnesota May 2010

Believing in the worth and dignity of the human person made in the image and likeness of God, the Catholic Health Association-Minnesota assists its members to fulfill the healing mission of the Church.

National Health Care Reform: A Significant Step Forward

Toby Pearson, CHA-MN Executive Director

With the passage of Federal Health Care Reform, the work does not stop, but continues. The reform law will save and improve lives across our country. It represents great progress in the long effort to make health care available and affordable to everyone in the United States.

The reform is far from perfect, however, the reform law significantly expands coverage, especially to low-income and vulnerable populations, and is a tremendous step toward protecting human dignity and promoting the common good. The law will prevent insurance companies from denying policies to those with pre-existing conditions; protect families from bankruptcy due to medical expenses; help small businesses provide insurance for their workers; improve Medicare drug benefit coverage by closing the "doughnut hole" and significantly cut the federal deficit. Most importantly, 32 million people who were previously uninsured will be able to obtain meaningful coverage at an affordable price.

We have long championed health care reform that protects life, makes coverage affordable for the greatest possible number of people and puts our system on a path to reducing costs while providing better and safer care. The national health care reform bill that became law is a step in that direction. We are also pleased that the bill includes $250 million to fund counseling, education, job training and housing for vulnerable women who are pregnant or parenting.

Reaching this point has not been easy, and the days ahead involve hard work to implement the law effectively. We will have to be vigilant that the implementation of the reform law does not allow federal funding of abortion and that it keeps in place important conscience protections for caregivers and institutions alike.

In this issue of *Tidings*, we will share several reflections on the new Health Care Reform, from three different voices that represent Minnesota membership. We will touch on the Long Term Care perspective, the Acute Care perspective, and the Sponsorship perspective. ■

SR. CAROL KEEHAN, CHA PRESIDENT AND CHIEF EXECUTIVE OFFICER,ON THE NATIONAL DISCUSSION IN HEALTHCARE REFORM.

Mark Your Calendar

June 8, 2010
CHA-MN Board of Directors
Carondelet Center, St. Paul
FFI: 651-503-2163

June 13-15, 2010
2010 Catholic Health Assembly
Denver, CO
FFI: www.chausa.org

SAVE THE DATE!

November 11, 2010

CHA-MN Annual Meeting
Registration and details to follow.

FFI: 651-503-2163

Long-Term Care Perspective

Health Care Reform Brings Enhanced Opportunity for Catholic Post-Acute and Long-Term Care

Dale M. Thompson, President/CEO, Benedictine Health System

Catholic long-term care, as part of America's health care delivery system is engaged in an ongoing effort to transform itself on many fronts. Nursing facilities are rapidly adding short-stay or post-acute care units where the focus is to transition patients from an acute care stay to home. New specialized care settings focusing on dementia and end-of-life care are also emerging throughout the industry. Housing with services options continue to improve and are being more creative to meet the needs of consumers with higher expectations for living settings design and the care and services provided to them.

The Benedictine Health System's (BHS) strategic initiative calls upon us to move in this direction as well. We are also focusing on a new vision for providing care at home, developed using an established care coordination model that is designed to deliver care and support across a broad spectrum of services aligned with integrated, at risk payment systems.

As we enter a significantly new era of health care delivery, the common identity we share as part of the Catholic Healthy Ministry would have us positively embrace this change.

Although most media attention regarding national health care reform has focused on expanding coverage for the uninsured, a very important national and moral imperative, there is a great deal of language in the recently passed legislation that will enable new forms of service delivery and greater collaboration and integration of services across the entire health care continuum.

The Patient Protection and Affordable Care Act (PPACA) of 2010 provides insight into what opportunity exists to create an enhanced use of post-acute settings. The alignment of these settings with acute care providers seems to be timely.

BHS has developed partnerships with several hospital systems to design post-acute settings to help serve patients who require discharge to transitional or rehabilitative care facilities. For example, we have two new facilities currently under construction that will creatively meet the new, high expectations of the upcoming baby boomer consumer.

Some of the most interesting provisions of **The Act** regarding the development of post-acute settings include:

THOMPSON

- **National Pilot Program on Payment Bundling (Section 3023)**...Requires the Secretary of the Treasury by January 2013 to implement a national, voluntary pilot program to coordinate care for Medicare beneficiaries. Services to be included (among others) are acute care and post-acute services including skilled nursing, inpatient rehabilitation and home health care.
- **Value-Based Purchasing (Section 3006)**...Requires a Medicare value-based purchasing implementation plan for Skilled Nursing Facilities be developed and presented to Congress.
- **Hospital Readmissions Reduction Program (Section 3022)**...Beginning in FY2012, payments to hospitals will be reduced for preventable Medicare readmissions. A strengthened post-acute continuum of care aligned with hospital discharge needs could reduce the risk of negative payment consequences.
- **Medicare Share Savings Program (Section 3022)**...Looks to Accountable Care Organizations (ACOs) to take responsibility to reduce costs and improve quality. ACOs can include a broad definition of providers including post-acute, long-term care professionals and providers.
- **Community-based Care Transitions Program (Section 3026)**...Provides funding to hospitals and community-based entities that furnish evidence-based transitional care services to Medicare beneficiaries at high risk of readmission.
- **Independence at Home Demonstration Program (Section 3024)**...Creates a new program for chronically ill Medicare beneficiaries that would test payment incentives and service delivery systems that utilize home-based primary care teams aimed at reducing expenditures and improving health outcomes.
- **Medicaid Bundled Payment Project (Section 2704)**... Establishes a demonstration project in eight states to begin on January 1, 2012. Services included in the bundling would be acute care hospital and post-acute services.

Across the broader long-term care continuum there are numerous other provisions of the reform legislation that will impact care and service delivery.

As we enter a significantly new era of health care delivery, the common identity we share as part of the Catholic

Long-Term *cont. on page 5*

Focus on Health Care Reform

Summary of Coverage Provisions in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act passed by the Senate on December 24, 2009 and by the House of Representatives on March 21, 2010. The following summary explains key health coverage provisions in the new law and incorporates modifications to the law included in the Health Care and Education Reconciliation Act of 2010, signed by President Obama on March 30, 2010.

The legislation will do the following:

- Most individuals will be required to have health insurance beginning in 2014.
- Individuals who do not have access to affordable employer coverage will be able to purchase coverage through a health Insurance Exchange with premium and cost-sharing credits available to some people to make coverage more affordable. Small businesses will be able to purchase coverage through a separate Exchange.
- Employers will be required to pay penalties for employees who receive tax credits for health insurance through the Exchange, with exceptions for small employers.
- New regulations will be imposed on all health plans that will prevent health insurers from denying coverage to people for any reason, including health status, and from charging higher premiums based on health status and gender.
- Medicaid will be expanded to 133% of the federal poverty level ($14,404 for an individual and $29,327 for a family of four in 2009) for all individuals under age 65.

The Congressional Budget Office estimates that the legislation will reduce the number of uninsured by 32 million in 2019 at a net cost of $938 billion over ten years, while reducing the deficit by $124 billion during this time period.

INDIVIDUAL MANDATE

All individuals will be required to have health insurance, with some exceptions, beginning in 2014. Those who do not have coverage will be required to pay a yearly financial penalty of the greater of $695 per person (up to a maximum of $2,085 per family), or 2.5% of household income, which will be phased-in from 2014-2016. Exceptions will be given for financial hardship and religious objections; and to American Indians; people who have been uninsured for less than three months; those for whom the lowest cost health plan exceeds 8% of income; and if the individual has income below the tax filing threshold ($9,350 for an individual and $18,700 for a married couple in 2009).

EXPANSION OF PUBLIC PROGRAMS

Medicaid will be expanded to all individuals under age 65 with incomes up to 133% of the federal poverty level ($14,404 for an individual and $29,327 for a family of four in 2009) based on modified adjusted gross income. This expansion will create a uniform minimum Medicaid eligibility threshold across states and will eliminate a limitation of the program that prohibits most adults without dependent children from enrolling in the program today (though as under current law, undocumented immigrants will not be eligible for Medicaid). Eligibility for Medicaid and the Children's Health Insurance Program (CHIP) for children will continue at their current eligibility levels until 2019. People with incomes above 133% of the poverty level who do not have access to employer-sponsored insurance will obtain coverage through the newly created state health insurance Exchanges.

- The federal government will provide 100% federal funding for the costs of those who become newly eligible for Medicaid for years 2014 through 2016, 95% federal funding for 2017, 94% federal funding for 2018, 93% federal funding for 2019, and 90% federal funding for 2020 and subsequent years. States that have already expanded adult eligibility to 100% of the poverty level will receive a phased-in increase in the FMAP for non-pregnant childless adults.
- Medicaid payments to primary care doctors for primary care services will be increased to 100% of Medicare payment rates in 2013 and 2014 with 100% federal financing.

AMERICAN HEALTH BENEFIT EXCHANGES

States will create American Health Benefit Exchanges where individuals can purchase insurance and separate exchanges for small employers to purchase insurance. These new marketplaces will provide consumers with information to enable them to choose among plans. Premium and cost-sharing subsidies will be available to make coverage more affordable.

- Access to Exchanges will be limited to U.S. citizens and legal immigrants. Small businesses with up to 100 employees can purchase coverage through the Exchange.
- Although there will not be a public plan option in the Exchanges, the Office of Personnel Management, which administers the Federal Employees Health Benefit Program, will contract with private insurers to offer at least two multi-state plans in each Exchange, including at least one offered by a non-profit entity.

Reform *cont. on page 4*

Reform *cont. from page 3*

In addition, funds will be made available to establish non-profit, member-run health insurance CO-OPs in each state.

- Plans in the Exchanges will be required to offer benefits that meet a minimum set of standards. Insurers will offer four levels of coverage that vary based on premiums, out-of-pocket costs, and benefits beyond the minimum required plus a catastrophic coverage plan.
- Premium subsidies will be provided to families with incomes between 133-400% of the poverty level ($29,327 to $88,200 for a family of four in 2009) to help them purchase insurance through the Exchanges. These subsidies will be offered on a sliding scale basis and will limit the cost of the premium to between 2% of income for those up to 133% of the poverty level and 9.5 % of income for those between 300-400% of the poverty level.
- Cost-sharing subsidies will also be available to people with incomes between 133-400% of the poverty level to limit out-of-pocket spending.

CHANGES TO PRIVATE INSURANCE

New insurance market regulations will prevent health insurers from denying coverage to people for any reason, including their health status, and from charging people more based on their health status and gender. These new rules will also require that all new health plans provide comprehensive coverage that includes at least a minimum set of services, caps annual out-of-pocket spending, does not impose cost-sharing for preventive services, and does not impose annual or lifetime limits on coverage.

- Health plan premiums will be allowed to vary based on age (by a 3 to 1 ratio), geographic area, tobacco use (by a 1.5 to 1 ratio), and the number of family members.
- Health insurers will be prohibited from imposing lifetime limits on coverage and will be prohibited from rescinding coverage, except in cases of fraud.
- Increases in health plan premiums will be subject to review.
- Young adults will be allowed to remain on their parent's health insurance up to age 26.
- States will be allowed to form health care choice compacts that enable insurers to sell policies in any state that participates in the compact.
- Waiting periods for coverage will be limited to 90 days.
- Existing individual and employer-sponsored insurance plans will be allowed to remain essentially the same, except that they will be required to extend dependent coverage to age 26, eliminate annual and lifetime limits on coverage, prohibit rescissions of coverage, and eliminate waiting periods for coverage of greater than 90 days.

EMPLOYER REQUIREMENTS

There is no employer mandate but employers with more than 50 employees will be assessed a fee of $2,000 per full-time employee (in excess of 30 employees) if they do not offer coverage and if they have at least one employee who receives a premium credit through an Exchange. Employers that do offer coverage but have at least one employee who receives a premium credit through an Exchange are required to pay the lesser of $3,000 for each employee who receives a premium credit or $2,000 for each full-time employee.

- Employers that offer coverage will be required to provide a voucher to employees with incomes below 400% of the poverty level if their share of the premium cost is between 8-9.8% of income to enable them to enroll in a plan in an Exchange. Employers that offer a free choice voucher will not be subject to the above penalty.
- Large employers that offer coverage will be required to automatically enroll employees into the employer's lowest cost premium plan if the employee does not sign up for employer coverage or does not opt out of coverage.

COVERAGE AND COST ESTIMATES

The Congressional Budget Office (CBO) estimates that the legislation will reduce the number of uninsured by 32 million in 2019 at a net cost of $938 billion over ten years. According to CBO, by 2019, the legislation will result in 24 million people obtaining coverage in the newly created state health insurance Exchanges, including some who previously purchased coverage on their own in the individual market. In addition, 16 million more people would enroll in Medicaid and the Children's Health Insurance Program. The cost of the legislation will be financed through a combination of savings from Medicaid and Medicare and new taxes and fees, including an excise tax on high-cost insurance. The Congressional Budget Office estimates the health care components of the legislation will reduce the deficit by $124 billion over ten years (the total reduction in the deficit including the health care and education components is estimated to be $143 billion over ten years).

For more information about the Summary of Coverage Provisions in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 see the side-by-side comparison of the health reform proposals at http://www.kff.org/healthreform/sidebyside.cfm. ■

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Acute Perspective

Bret Reuter, President, CHA-MN

We may not remember where we were when we heard the health care bill had passed, but many such as myself, likely had a deep and profound sense of gratitude.

Where were you when the Health Care Bill passed?

The Catholic Health Association has long advocated for the provision of health care coverage for the nearly 50 million uninsured in this country. Many of us have lobbied our legislators, raised awareness through Cover the Uninsured events, and created our own programs to address this significant need. Our nation has truly taken a giant step toward covering millions of Americans who prior to this legislation suffered unnecessary exacerbations of their illness, financial catastrophe, and even death.

According to a report by the Institute of Medicine, approximately 18,000 Americans die prematurely each year because they lack health insurance. People who don't have health insurance typically do not seek medical care until their illnesses have progressed to the point when they can no longer be ignored. Then the illness is far more difficult (and expensive) to treat.

Catholic social teaching has a long history of being a voice for the voiceless, standing up for the poor and those at the margins of society. Eighty percent of the 49 million uninsured citizens of this country are working Americans, people who work hard each day for employers who either don't provide health coverage or don't do so at a level which their employees can afford. Now their voices have been heard as well, and 32 million of these uninsured Americans will be able to obtain meaningful coverage at an affordable price. Other important provisions in the healthcare bill will benefit millions more in other significant ways.

REUTER

Catholic social teaching has a long history of being a voice for the voiceless, standing up for the poor and those at the margins of society.

Here in Minnesota we have prided ourselves for a number of years by having the lowest uninsured rate in the nation. Even so, there are several hundred thousand people in MN who lack coverage. Recent budget challenges in MN have meant significant reductions in the level of funding for important programs such as GAMC which have significantly diminished our ability to meet basic healthcare needs for thousands of Minnesotans.

There are still voices which need to be heard. We have taken an important step at a federal level and now we must work to ensure that MN continues to lead the nation in its care and advocacy for the poor and uninsured, protecting human dignity and promoting the common good. Positive change is on the horizon, but it won't happen overnight. As always, Catholic-sponsored health care providers will continue to serve everyone who requires our care and compassion—regardless of their ability to pay. ■

Long-Term *cont. from page 2*

Health Ministry would have us positively embrace this change as a way to enhance our efforts to "care for the poor and vulnerable persons, promote the common good and steward resources." Catholic long-term care providers probably have never had a better opportunity to enhance the quality of their services and align them collaboratively with hospitals, physicians and others, to create the future. ■

Health Reform Survey – April 2010

The first Kaiser Foundation Health Tracking Poll fielded since the passage of health reform last month finds that 8 in 10 Americans know that President Obama signed the legislation into law. But 55 percent say they are confused about the law and more than half (56%) say they don't yet have enough information to understand how it will affect them personally.

The poll finds that the public supports many of the provisions of health reform that are set to be implemented in the short term. When asked about 11 specific provisions scheduled to take effect this year, in each case a majority of Americans viewed them favorably, often with bipartisan support.

Still, the public remains divided on the law overall, with 46 percent viewing it favorably, 40 percent unfavorably and 14 percent undecided. Similarly, 31 percent of Americans say they expect personally to be better off because of the law, while 32 percent say they will be worse off and 30 percent say they don't expect to be affected. ■

Now That Health Care Reform Has Passed

KEEHAN

Sr. Carol Keehan, DC
CHA President and Chief Executive Officer

No one said it would be easy. However, the last two weeks leading up to the historic passage of the health reform bill were among the most challenging in CHA's history.

We shared with so many a desire that finally people in this country would have access to health care. We had a vision for health reform that outlined our non-negotiables and our priorities. Chief among these was respect for the life and dignity of all from conception to natural death.

We worked closely with other hospital associations, particularly the American Hospital Association and the Federation of American Hospitals, on the myriad of technical and financial issues in the various bills. Hospitals can take pride in the cohesiveness with which we worked representing them.

CHA had incredible input and support from its members at all levels. Your guidance and responsiveness cannot be exaggerated; and, as staff, we are profoundly grateful to you.

We worked closely with the United States Conference of Catholic Bishops, especially in getting the president's clear statement in his address to the joint session of Congress that there would be no federal funding of abortion.

As the House bill was developing, we supported the Stupak amendment as a good method of preventing federal funding of abortion.

As the Senate bill was developing, the attempt to use the Stupak language in the Senate failed. We then spent many hours working with Sen. Robert Casey and Sen. Ben Nelson and their staffs to get language in the bill that would prevent federal funding of abortion. We also worked with Senate Majority Leader Harry Reid to assure the language was clear, effective and did not have loopholes that would allow federal funding of abortions. As you know, Senators Casey and Nelson are very pro-life and have been courageous and consistent in their stands in defense of life.

The CHA staff repeatedly analyzed the bills, especially in regard to any federal funding of abortion. We used the legal research of others as well. We had multiple dialogues with USCCB staff. Our conclusion, and that of many others, was that the Senate bill as written prevented federal funding of abortion. It may not have been our preferred method, but our conclusion is that it is an effective method to prevent federal funding of abortion, and that is the essential criteria.

Unfortunately, the staff of the USCCB did not reach the same conclusion, and their advice to the bishops reflected their views of the legislation as written. Despite repeated discussions, we were not able to bridge this difference of opinion. It is important to appreciate that the difference of opinion was on how effective the legislation was in preventing federal funding of abortion. We are in complete agreement on the grave evil of abortion. ■

USCCB Perspective

Abortion Funding in the New Health Care Reform Act

Congress and the public agree that the federal government should not fund elective abortions. For over three decades this policy has been reflected in the Hyde amendment to the Labor/HHS appropriations bill and many similar laws. In key respects the newly enacted "Patient Protection and Affordable Care Act" (henceforth "the Act") does not follow this longstanding policy:

- Federal funds in the Act can be used for elective abortions. For example, the Act authorizes and appropriates $7 billion over five years (increased to $9.5 billion by the Health Care and Education Reconciliation Act of 2010) for services at Community Health Centers. These funds are not covered by the Hyde amendment (as they are not appropriated through the Labor/HHS appropriations bill governed by that amendment), or by the Act's own abortion limitation in Sec. 1303 (as that provision relates only to tax credits or cost-sharing reductions for qualified health plans, and does not govern all funds in the bill). So the funds can be used directly for elective abortions.
- The Act uses federal funds to subsidize health plans that cover abortions. Sec. 1303 limits only the direct use of a federal tax credit specifically to fund abortion coverage; it tries to segregate funds within health plans, to keep federal funds distinct from funds directly used for abortions. But the credits are still used to

Abortion *cont. on page 7*

Sponsorship Perspective

Sr. Mary Elliot, OSF, SMH Sponsorship Board

For many, passage of health care reform legislation provided a deep sigh of relief that the masses will at long last have coverage for their health needs. While it is not a panacea, it is the beginning of the creation of a healthier America. The work to achieve this first milestone has taken time, energy, and collaborative efforts by many. The next steps will take dogged determination as the details begin to get worked out. As road blocks appear, are thrown up and we who sponsor and provide health care for persons on all levels of the continuum will need to keep tuned in and assist in making the legislation and details work.

Reflections on the healthcare reform legislation

As a sponsor of a Catholic hospital we look forward to continuing to provide the best care that is available for the needs of all of our patients. There will always be challenges but the mission is solidly before us. Staff will continue to give their best with compassion, respect and clinical excellence while attending to the whole person. This is no different than what has always been. With reforms in place, we will hopefully be able to make a difference in the lives of those who have, until now, avoided or been rejected from obtaining the benefits of good health and excellence in health care.

ELLIOT

At a Catholic hospital, our role continues to be one of advocacy, as we identify the community's needs, the individual's concerns and ways to address both in the interim and long-term. Active involvement in the legislative process at both the state and federal levels will impact health care reform where the "rubber hits the road." ■

Abortion *cont. from page 6*

pay overall premiums for health plans covering elective abortions. This violates the policy of current federal laws on abortion funding, including the Hyde amendment, which forbid use of federal funds for any part of a health benefits package that covers elective abortions. By subsidizing plans that cover abortion, the federal government will expand abortion coverage and make abortions more accessible.

- The Act uses federal power to force Americans to pay for other people's abortions even if they are morally opposed.
- The Act mandates that insurance companies deciding to cover elective abortions in a health plan "shall… collect from each enrollee in the plan (without regard to the enrollee's age, sex, or family status) a separate payment" for such abortions.

While the Act says that one plan in each exchange will not cover elective abortions, every other plan may cover them -- and everyone purchasing those plans, because they best meet his or her family's needs, will be required by federal law to fund abortions. No accommodation is permitted for people morally opposed to abortion. This creates a more overt threat to conscience than insurers engage in now, because in many plans receiving federal subsidies everyone will have to make separate payments solely and specifically for other people's abortions. Saying that this payment is not a "tax dollar" is no help if it is required by government.

The solution is to follow current law. The Stupak/Pitts provision in the House-passed health bill (also offered but rejected in the Senate as the Nelson/Hatch/Casey amendment) would have solved these problems by following longstanding current laws such as the Hyde amendment: No funds authorized or appropriated in the entire bill may be used for elective abortions or health plans that cover them. People would not be forced to pay for other people's abortions, and those who want abortion coverage could buy it separately without using federal funds. Legislation to maintain this longstanding federal precedent is still needed, to ensure that health care reform will truly expand life-affirming health care and not abortion.

For more in-depth analysis of the Act on these issues, and of President Obama's executive order issued after its enactment,see www.usccb.org/healthcare/03-25-10Memo-re-Executive-Order-Final.pdf. ■