

This issue is part of a series of periodic reports from the National Health Law Program's Washington office, reporting briefly on recent and forthcoming developments in federal policy of interest to NHeLP advocates and friends. We always appreciate your feedback and comments. Please send them to Sarah Lichtman Spector at lichtmanspector@healthlaw.org. For updates and information on NHeLP publications, go to <http://www.healthlaw.org>.

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HEALTH REFORM

Projected Schedule in Senate and House

On October 13, the Senate Finance Committee completed its markup of America's Healthy Future Act of 2009 (S.1796) and voted it out of committee (14-9). All committee Democrats, plus Olympia Snowe (R-Maine) supported the bill. All other committee Republicans opposed it. On October 19, the Senate Finance Committee released legislative language for its bill. Click [here](#) for full legislative text, amendments, and the committee report describing the provisions in the bill.

The projected schedule in the Senate is:

- Early November: Release of merged Senate bill (reconciling Senate Finance and HELP committee bills).
- Mid-November-Mid-December: Consideration of legislation by full Senate. Three to six weeks

of debate and amendments are anticipated.

Selected features of the Senate Finance bill include:

- **Medicaid and CHIP Maintenance of Effort:** For children in Medicaid and CHIP, states are prohibited from restricting eligibility, methodologies, or procedures until October 1, 2019. For adults in Medicaid who have income under 133 percent of the federal poverty level, states are prohibited from restricting eligibility, methodology, or procedures until December 31, 2013. For adults in Medicaid who have income over 133 percent of FPL, states may constrict the eligibility rules, methodologies, or procedures as early as January 1, 2011, if the state asserts and the Secretary of HHS certifies that the state has a budget deficit.

Note: States are required to apply the Modified Gross Income (MGI) standard to the Medicaid and CHIP programs and eliminate current income disregards starting July 1, 2013. The application of MGI to the Medicaid and CHIP programs will not violate the maintenance of effort requirements. However, Medicaid recipients for whom the application of MGI would be the sole factor making them no longer eligible for Medicaid are grandfathered in until March 31, 2014, or the next date of their recertification, whichever is later. Thereafter, in states with Medicaid coverage of adults at or over 133 percent FPL, some beneficiaries with work income and child care expenses will lose Medicaid coverage because those expenses are not disregarded under the MGI approach.

- **State Option to Offer Basic Health Plan to Non-Medicaid Beneficiaries:**

States may develop a basic health plan for individuals who are under age 65, not eligible for Medicaid, are between 133 and 200 percent FPL, and do not have creditable coverage from an employer. The plan must have at least the minimum benefits that are required in the newly established Exchange. Limits on premiums and cost-sharing are dependent on family income and tied to certain standards of cost-sharing allowed in the Exchange.

A state may contract and negotiate with private insurers to deliver the services in this basic health plan. A state contracting with private plans is required to use a competitive bid process and is encouraged to contract with more than one plan to afford individuals plan choice. States will receive 85 percent of the cost of the premium and cost-sharing credit that an eligible individual would have been able to obtain under the subsidy credits for the Exchange to help fund the program. An eligible individual who enrolls in this program may not also obtain coverage through the Exchange. Plans that participate must have at least an 85 percent

medical loss ratio (i.e., the percentage of its money the plan spends on services for beneficiaries versus administrative and other costs).

• **Care Coordination for Persons with Chronic Care Needs:** There are a number of provisions that seek to increase care coordination for certain high-need populations. Two of these are:

1. *Independence at Home Pilot:* This is a program targeted at Medicare beneficiaries with multiple chronic care needs. Services such as care coordination must be provided by an interdisciplinary team, must include “in home” visits, and be available 24 hours a day, seven days per week to carry out an individualized plan of care. An eligible provider practice team must fulfill certain requirements, such as reporting to HHS on specific quality measures. Eligible beneficiaries must be in fee-for-service Medicare, have two or more chronic conditions, and need assistance with at least two functions such as feeding, bathing, walking or other daily living activities. Participation in the pilot is wholly voluntary for beneficiaries.

2. *A Medicaid State Option for Care Coordination for Persons with Chronic Care Needs:* This program focuses on comprehensive case management and care coordination to be delivered by an interdisciplinary team for Medicaid recipients with multiple chronic illnesses persons at risk for more than one chronic illness or persons with mental illness. States are permitted to use innovative payment models to incentivize this care.

On October 29, the House released the merged Tri-Committee bill (from Energy and Commerce, Ways and Means, and Education and Labor). Click [here](#) for a link to the full legislation. The bill will go to the Rules Committee to make determinations about which and how many amendments will be considered on the House floor. Then the bill will move to consideration by the full House. The projected schedule in the House is:

- Early November: Rules Committee reports out combined bill from the Tri-Committee and decides which amendments may be considered by the full House.
- Mid-November: Votes by full House on legislation.
- December or January: Conference committee works to combine House-passed and Senate-passed legislation, depending on when the Senate completes its work.

EXECUTIVE AGENCY ACTIONS

Proposed Rules on Medicare Advantage and Medicare Part D

Proposed rules were issued on October 22 by the Center for Medicare and Medicaid Services (CMS). CMS states that these proposed rules are intended to strengthen beneficiary protections, clarify various program participation requirements for the Part C and Part D plans, and address other areas. Particular areas of interest may include sections addressing appeals processes for beneficiaries, rules about the low-income subsidy, and procedures for CMS to impose sanctions and penalties for plans in certain circumstances.

Possible Action: Comments are due by December 8, 2009. For the full text of the proposed rule, click [here](#).

Interim Final Rules Prohibiting Genetic Discrimination

These interim final rules were issued on October 7 and implement the Genetic Information Nondiscrimination Act of 2008. The regulations prohibit discrimination based on genetic information in individual health insurance coverage and group health plans and will begin to apply to the individual and group health plan markets on December 7, 2009.

Possible Action: Comments are due on or before January 5, 2010. For the full text of the rule, click [here](#).

Children's Health Insurance Program (CHIP) Guidance Issued by CMS: Dental Coverage

A State Health Official letter was issued regarding required dental coverage for kids in CHIP and the state option for dental-only supplemental coverage. The CHIPRA statute requires that all CHIP benefit packages include coverage for children "of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions." This provision went into effect on October 1.

Medicaid expansion programs can meet this provision through providing EPSDT services. Separate CHIP programs may provide this coverage either by defining the dental package of

services or by choosing one of three identified benchmarks. The letter also specifies limits in cost-sharing and co-payments for certain dental services, and overall cost-sharing limitations for the family.

The child-only supplemental dental coverage is a new state option available to children in families who have employer-based health insurance, but who are uninsured or underinsured with respect to dental coverage. This option may be provided to families whose health insurance has some, but limited dental coverage. (Issued 10/7/09.)

Click [here](#) for a copy of the letter and accompanying Q & A.

CMS/HHS – Awards \$40 Million in Outreach and Enrollment Grants

On September 30, HHS announced \$40 million in grants to 41 states, plus the District of Columbia, to support outreach and enrollment of children who are uninsured but eligible for either Medicaid or CHIP. The outreach grants were awarded particularly to those entities whose efforts will target racial and ethnic minority groups who are uninsured at higher-than-average rates. For example, 20 percent of the projects to be funded will target Hispanic children, 11 percent will focus on homeless children, and seven percent will be aimed at Native American/Alaska Native children. For more information, including the list of grantees by state and the amount of each grant, click [here](#).

STATUS OF PRESIDENTIAL APPOINTEES

U.S. Department of Justice:

On October 6, by a vote of 72-22, the Senate confirmed Thomas E. Perez to be Assistant Attorney General for the Civil Rights Division at the U.S. Department of Justice. He served as Deputy Assistant Attorney General for Civil Rights in 1998, and as the Director of the Office for Civil Rights at the U.S. Department of Health and Human Services during the Clinton Administration. Most recently, Perez was Secretary of the Maryland Department of Labor, Licensing, and Regulation.

RESOURCES

[*Health Reform: The Comprehensive Congressional Health Reform Bills of 2009*](#): A Look at Health Insurance, Delivery System, and Financing Provisions, by the Commonwealth Fund issued on October 23, 2009, provides summary and analysis of similarities and differences among the House bill and two Senate bills, the impact of the provisions, and analysis of cost.

[*Aiming Higher: Results from a State Scorecard on Health System Performance, 2009*](#), by the Commonwealth Fund issued on October 8, 2009, found wide variation of health care coverage and other indexes across states. It also found that all states are facing significant challenges because of increases in the cost of care and poor care coordination. The study measured 38 indicators of access, quality, costs, and health outcomes. An interactive map allows easy access to state level information.

Studies Focusing on Racial and Ethnic Health Disparities:

1. [*The Economic Burden of Health Inequalities in the United States*](#), published by the Joint Center for Political and Economic Studies in September 2009, found that racial disparities in health care access and quality added more than \$50 billion a year in direct U.S. health care costs over a four-year period.
2. [*Estimating the Cost of Racial and Ethnic Health Disparities*](#), by the Urban Institute released in September 2009, analyzes the costs of certain preventable diseases including diabetes, hypertension and stroke. Over the next decade, the total cost is estimated to be approximately \$337 billion.