

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 Deborah Reid at reid@healthlaw.org. For updates and information on NHeLP publications, go to <http://www.healthlaw.org>.

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NEW LAW

Medicaid Moratorium

President Bush signed the war "Supplemental Appropriations Act of 2008," (H.R. 2642) into law on June 30. The Act contained a moratorium to prevent the implementation of six Centers for Medicare & Medicaid Services (CMS) Medicaid regulations, which would have resulted in reduced federal spending on Medicaid services and providers. Congress failed to include in the

new law a moratorium delaying a seventh regulation relating to hospital outpatient services.

Medicare Improvements for Patients and Providers Act

On July 15, both the House and the Senate voted to override the President's veto of the "Medicare Improvements for Patients and Providers Act," (H.R. 6331), by a margin of 383-41 and 70-26, respectively. As a result, the bill became law that day.

Among other provisions, the Act directs the Secretary of HHS to develop quality performance measures to examine health disparities that reflect characteristics of patient populations (e.g., race, ethnicity, language, health status, and income levels); requires the Secretary to evaluate and report to Congress on methods for the collection of data on health disparities (although not on primary language); eliminates a pending 10 percent reduction in Medicare payments to physicians; abolishes the Medicare Part D (Voluntary Prescription Drug Benefit Program) late enrollment penalties that would ordinarily apply to individuals eligible for the Low-Income Subsidy; and gradually eliminates co-payment rates for Medicare psychiatric services by 2014.

BILLS OF INTEREST

ADA Amendments Act of 2008

On June 25, the House passed the "ADA Amendments Act of 2008," (H.R. 3195) by a vote of 401-17. The purpose of the bill is to restore some of the original provisions of the Americans with Disabilities Act of 1990 (ADA) that have been stripped away by the U.S. Supreme Court. For example, the Court has denied protection of the ADA to individuals who have partial physical disabilities, as well as those with physical disabilities that could be treated with medication (e.g., cerebral palsy, epilepsy, and cancer) or assistive devices (e.g., prosthetic limbs, oxygen therapy equipment, hearing aids and glasses). H.R. 3195 amends the ADA to clarify that a disability is any physical or mental impairment that "materially limits" one or more major life activities of that individual, as opposed to the more restrictive Supreme Court definition of an impairment that "substantially limits" life activities. As a result, the bill would now prohibit discrimination against these previously excluded individuals with disabilities.

The Senate's companion bill, the "Americans with Disabilities Act Restoration Act of 2007," (S.

1881) is currently pending before the Senate Committee on Health Education Labor and Pensions.

Healthy Americans Act

Representative Debbie Wasserman Schultz (D-FL) has reintroduced the "Healthy Americans Act," (H.R. 6444), originally introduced by Rep. Brian Baird (D-WA) as H.R. 3163 in July 2007. This is a companion bill to S. 334, which was introduced in the Senate by Senator Ron Wyden (D-OR) in January 2007 with bipartisan co-sponsorship. Among other provisions, H.R. 6444 calls for individuals to obtain private health insurance coverage, with the minimum plan being equivalent to the standard benefit option for federal employees. However, the bill would eliminate both Medicaid and the State Children's Health Insurance Program (SCHIP).

Individuals who did not enroll in a private health insurance program would be automatically enrolled in the lowest cost plan. Although the bill subsidizes premiums for individuals with incomes up to four times of the Federal Poverty Level (FPL), the legislation does not adequately address how low income communities will be able to cover other out-of-pocket, inadequately covered, and uncovered medical expenses and services. Nor does the bill make any provision for replacing the invaluable EPSDT benefits for children found in Medicaid. H.R. 6444 is now pending before the House committees on Ways and Means, Energy and Commerce, Education and Labor, and Oversight and Government Reform.

Possible Action: Those wishing to do so could inform their elected representatives that any health reform platform that does not retain Medicaid and SCHIP, or otherwise fully and adequately address the increased need and decreased ability to meet that need of the low-income community, is not worthy of their support.

FMAP Increase Bills

Several bills are pending that would temporarily increase the Federal Medical Assistance Percentage (FMAP) under the Medicaid program: Senator Rockefeller (D-WV) has introduced three bills S. 2620, S. 2586 (the "State Fiscal Relief Act of 2008"), and S. 2819 (the "Economic Recovery in Health Care Act of 2008") on this topic.

S. 2620, among other provisions, would use the higher of a state's FMAP occurring in FYs 2008 and 2009 for the first, second, and third calendar quarters of the FY 2009. H.R. 5268, introduced by Rep. Frank Pallone, Jr. (D -NJ), is the House equivalent of S. 2620. The next bill, S. 2586, allows a state to be eligible for a FMAP increase if its eligibility criteria under its

Medicaid plan are no more restrictive than those in effect on December 31 2007. Lastly, S. 2819 would provide fiscal relief to the states through a temporary increase in the FMAP, as well as appropriations for these payments. All three Senate bills remain pending before the Committee on Finance.

Possible Action: Those wishing to do so could contact their elected officials to emphasize how important it is to provide fiscal relief to states for Medicaid services during the current recession.

Primary Care Dental Academic Workforce Development Act of 2008

On July 17, Representative Hilda Solis (D-CA), along with Reps. Patrick Kennedy (D-RI), Walter Jones (R-NC), Elijah Cummings (D-MD), and Mike Simpson (R-ID), introduced the "Primary Care Dental Academic Workforce Development Act of 2008," (H.R. 6551). The bill is designed to address the national problem of faculty shortages at schools of dentistry. The bill authorizes a loan repayment program for faculty members of general dentistry or pediatric dentistry programs, as a means of recruiting and retaining needed dental faculty, and also requires the Secretary of Health and Human Services to support programs that recruit diverse faculty. Currently, H.R. 6551 is before the House Committee on Energy and Commerce.

REPRODUCTIVE HEALTH

HHS Proposed Rule Impacts Reproductive Health

The Department of Health and Human Services (HHS) recently proposed a new regulation that adds an additional requirement to federal nondiscrimination law by including a federal "conscience clause" provision found in the Weldon Amendment, the Public Health Service Act, and the Church Amendment. Among other provisions, the proposal requires that all recipients of federal health program aid certify that they will not refuse to hire health personnel who object to performing or assisting in the performance of medical services or research activity based on their "religious beliefs or moral convictions." The proposed regulation also allows individual providers and institutions to rely on their personal beliefs to determine what constitutes abortion, which therefore will, for some, include birth control, emergency contraception, and sterilization. Additionally, the proposal indicates that HHS will "work with" state and local governments and other recipients of federal funding to ensure compliance with the conscience clause provision. In the perceived absence of compliance, HHS will consider all legal options, including termination of federal assistance and the return of previous federal funding.

The proposal does not address how health employers would be able to provide these services according to accepted standards of care to patients who request them, if health provider candidates or current staff object to performing or assisting with them. This point becomes particularly critical in situations in which the patient effectively has no other options to obtain treatment, for example, in federally funded Title X clinics, health settings that treat Medicaid beneficiaries, and hospital emergency rooms seeing survivors of sexual assault.

Revised Recommendations on Use of Antiretroviral Drugs in Pregnant HIV-Infected Women
The U.S. Public Health Service (USPHS) Task Force Perinatal Guidelines Working Group issued a revised version of its *Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States* on July 8. This guideline recognizes the right of pregnant women with HIV to determine whether they will take antiretroviral (ARV) drugs for their treatment, to prevent mother-to-child transmission, or to accommodate other medical recommendations to reduce perinatal HIV transmission. The November 2007 version of the guidelines had deleted existing language providing a woman's right to refuse ARV drug therapy without penalty. The guidelines can be found at: <http://hivlawandpolicy.org/resources/view/73>.

HEALTH IS A HUMAN RIGHT

"From Market Competition to Solidarity? Assessing the Prospects of U.S. Health Care Reform Plans Through a Human Rights Perspective" – National Economic and Social Rights Initiative (NESRI) and National Health Law Program (NHeLP).

The crisis of health care in the United States is characterized by poor health outcomes, high costs, and unequal access, growing health inequities and inadequate delivery mechanisms. The human right to health care framework provides an analytical and advocacy perspective that focuses on the collective responsibility for health care as a public good, instead of a market-based and individualistic approach. Based on an assessment of the health care reform proposals promoted during the U.S. 2008 primaries, the NESRI/NHeLP article contends that the emerging framework being embraced by Democrats and many health care advocacy organizations mistakenly focuses on incremental, market-based reforms and ignores issues of

equity, participation and accountability. For further details go to:
<http://www.hhrjournal.org/index.php/hhr/article/view/23/114>

Public Health Anniversary

*July 16 marked the 210th anniversary of the first U.S. government sponsored health insurance. On July 16, 1798, President John Adams signed the "Act for the Relief of Sick and Disabled Seamen." The Act was the basis for the Marine Hospital Service (MHS), which later became the Public Health Service. Ship captains collected a monthly deduction from sailors and deposited the funds in U.S. port locations, which allowed federal medical officials in those cities to pay for the sailors' care at private hospitals or create Marine Hospitals from remaining funds. The MHS was placed under the control of the Revenue Marine Division of the Department of the Treasury and Congress regularly appropriated funding to maintain the MHS. In 1870, Congress reorganized the MHS from a network of locally controlled facilities to a centrally-controlled national agency with a designated administrative staff and headquarters in Washington, DC. In 1912, when the Marine Hospital Service became the Public Health Service, the names of the marine hospitals were changed to Public Health Service facilities. For more details, refer to: http://www.nlm.nih.gov/exhibition/phs_history/intro.html;
http://www.nlm.nih.gov/exhibition/phs_history/1.html;
http://www.nlm.nih.gov/exhibition/phs_history/2.html;
http://www.nlm.nih.gov/exhibition/phs_history/9.html.*

RESOURCE

The Center on Budget and Policy Priorities and George Washington University recently released a new study entitled, "Expanding Medicaid A Less Costly Way to Cover More Low-Income Uninsured than Expanding Private Insurance." The report determined that public programs, like Medicaid and SCHIP, generate lower average medical expenditures per person than under private insurance, and it supports expansion of public programs as a way to cover more low-income or moderate income uninsured people. The study can be found at:
<http://www.cbpp.org/6-26-08health.pdf>.

ANNOUNCEMENT

After 13 years of dedicated service to NHeLP as our Director of Communications, Brendan McTaggart is leaving to pursue a law degree. To say that we, and we suspect many of you, will miss Brendan is to state the obvious. His efforts have led NHeLP into the electronic age and made our web site a respected and reliable resource for thousands of advocates. We wish him only the best in this next phase of his life. In an effort to replace Brendan's many talents, NHeLP is now advertising for a new Director of Communications. Interested persons can find a full job description at: <http://www.healthlaw.org/library/attachment.127448?print>.