

This issue is one in 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>

SUBJECTS COVERED

SCHIP Directive, the GAO and CRS

Minority Health

CERD Briefing

Reauthorization of the Indian Health Care Improvement Act

Study on Practice Resources and Quality of Care

Proposed HRSA Rule on Medically Underserved Populations

Bills of Interest

Protecting the Medicaid Safety Net Act

Genetic Nondiscrimination Act

Resource

SCHIP DIRECTIVE, THE GAO AND CRS

On April 17, the U.S. Government Accountability Office (GAO) submitted a report to Senators John Rockefeller (D-WVA) and Olympia Snowe (R-ME) that determined the rulemaking status of the Centers for Medicare & Medicaid Services (CMS)' August 17 "Dear State Health Official Letter." The August 17 letter purportedly "clarified" how the agency reviews state requests to expand State Children's Health Insurance Program (SCHIP) eligibility to children in families with incomes above 250 percent of the federal poverty level (FPL).

The August 17 letter announced that CMS would no longer allow states to cover children with gross incomes above 250 percent of FPL, unless a state could demonstrate that it was already covering at least 95 percent of all children eligible for Medicaid and SCHIP with incomes below 200 percent of FPL. No state has yet been able to achieve this level of coverage. Ostensibly to

prevent individuals from substituting SCHIP coverage for private health insurance (so-called "crowd-out"), CMS mandated a one-year period of non-insurance before a child could be covered by SCHIP, and a showing that private employer sponsored insurance in the state has not declined by more than 2 percent over a five year period. Some states viewed the CMS letter as an illegal attack on their SCHIP programs instead of a "clarification" of existing policy, especially since states were not afforded the opportunity to submit comments on the pronouncement.

GAO ultimately determined that the August 17 CMS directive to state health officials is a rule subject to the Congressional Review Act, since it is "designed to implement, interpret, or prescribe law or policy with regard to SCHIP." As a result, GAO maintained that the Act requires the directive to first be submitted to both houses of Congress and the GAO Comptroller General before it can be considered legally effective.

The Congressional Research Service (CRS) had reached a similar conclusion in January 2008, in a memorandum to Senator Rockefeller. The CRS opinion indicated that the Congressional Review Act and its legislative history, as well as subsequent court decisions, broadly define an agency rule and concluded that the August 17 CMS directive is an agency action that cannot be effectuated until it is subjected to the review of Congress and the Comptroller General.

MINORITY HEALTH

Convention on the Elimination of All Forms of Racial Discrimination (CERD) Briefing

On April 24, several representatives from non-governmental organizations, including NHeLP, discussed the findings from their “shadow report” to the United Nations, entitled *Unequal Health Outcomes in the United States*, before Congressional members and staff. The shadow report was in response to the State Department’s commentary to the United Nations on our nation’s progress towards the elimination of all forms of racial discrimination, including in health and health care. The U.N. CERD Committee agreed with some aspects of the government’s report, but noted numerous failures on the part of our government, including that the United States has not recognized and remedied instances where facially neutral policies have discriminatory effects that contribute to inequality in health and health care.

The briefing presented findings from the *Unequal Health Outcomes* shadow report that illustrated examples in the United States of non-compliance with CERD in the right to health, health care access, and treatment, and demonstrated the historic and ongoing animosity of our judicial system towards efforts to eliminate racial disparities caused by anything other than conduct overtly intended to discriminate.

Reauthorization of the Indian Health Care Improvement Act

The House Committees on Ways and Means and Energy and Commerce are currently considering the “Indian Health Care Improvement Act,” (H.R. 1328). Among other provisions, the legislation would extend authorization for Indian health care through FY 2017; expand coverage for qualified Native Americans under SCHIP, Medicare, and Medicaid; direct the Secretary of HHS, through the Indian Health Service, Indian tribes and tribal organizations to consolidate identified existing programs into a new program of comprehensive behavioral health, prevention, treatment, and aftercare for Indian tribes; and require confidentiality of medical quality assurance records of the Indian Health Program or any health program of an urban Indian organization as part of a medical quality assurance program.

The Senate approved its version of the Indian Health Care Improvement Act (S. 1200) on

February 26, but the Senate bill includes Senator David Vitter's (R-LA) amendment (S. 3896) excluding funding for abortion services or use of Indian Health Services facilities for this care in most circumstances. S. 1200 is currently pending before the House Committees on Natural Resources, Energy and Commerce, and Ways and Means.

Native American communities and advocates remain concerned that reauthorization of the Indian Health Care Improvement Act, which is critical to the well-being of many Native Americans, may become a casualty of the Vitter Amendment to the Senate bill. Not only does that amendment tether Indian health to an unrelated, highly political issue, but also it undermines tribal sovereignty by prohibiting the use of tribal monies to provide certain services in what are often the only health facilities in their nations.

Possible Action: Those wishing to do so could contact their elected officials and urge them to support reauthorization of the Indian Health Care Improvement Act without amendments that impinge upon tribal sovereignty and women's rights.

Study on Practices, Resources and Quality of Care

The April 22 issue of *Health Affairs* published a study entitled, "Do Primary Care Physicians Treating Minority Patients Report Problems Delivering High-Quality Care?" Using national survey data, the researchers determined that physicians in high-minority practices (more than 70 percent) received a greater percentage of their practice revenue from lower Medicaid managed care capitated payments. The report also indicated that physicians in high-minority practices were more likely to report problems getting specialty care for their patients, because more of their patients were uninsured or had insurance that impeded access to care. Physicians in high-minority practice areas also reported that they often experienced difficulty communicating with their patients, due to language access barriers. For the complete study, go to:

<http://content.healthaffairs.org/cgi/content/full/hlthaff.27.3.w222/DC1>

PROPOSED HRSA RULE ON MEDICALLY UNDERSERVED POPULATIONS

On February 29, the Health Resources and Services Administration (HRSA) at the U.S. Department of Health and Human Services, proposed a new rule to consolidate the criteria used for designating medically underserved populations (MUPs) and health professional shortage areas (HPSAs). The proposed rule introduces new categories of “Tier 1, Tier 2, and Safety Net” facilities, which community health centers and others fear will be used to alter future funding allocations. In the face of public criticism that it was offering too short a public comment period for such a potentially significant change in policy, HRSA recently agreed to extend the public comment period on the proposed rule until May 29. NHeLP will be among those preparing comments on the proposal.

BILLS OF INTEREST

Protecting the Medicaid Safety Net Act of 2008

The House on April 23 voted to approve the “Medicaid Safety Net Act of 2008,” (H.R. 5613) by a vote of 349 - 62. The legislation places a moratorium on seven CMS regulations that impact federal Medicaid policy and payment formulas; reimbursements for services in public and teaching hospitals; the scope of Medicaid coverage for school-based administrative and transportation costs; and services related to rehabilitation, case management, and hospital care. The bill imposes a moratorium until April 1, 2009 on these regulations, in order to provide time for further legislative and administrative consideration of the impact of these cutbacks to the Medicaid program.

While the Senate is currently considering similar legislation, it is reported that a Republican

“Dear Colleague” letter is circulating in opposition to a moratorium.

Possible Action: Those wishing to do so could contact their elected officials in the Senate to urge their support of a Senate version of H.R. 5613.

Genetic Nondiscrimination Act

On May 1, the House passed the “Genetic Information Nondiscrimination Act,” (H.R. 493) by a vote of 414 – 1. The Senate passed the bill by a vote of 95 – 0 on April 24. Among other provisions, H.R. 493 prohibits group health plans from changing premiums for a group on the basis of genetic information. The legislation also prevents group health plans from requiring individuals or their family members from undergoing a genetic test, although a health provider may make a request. In addition, the bill does not prohibit a group health plan from obtaining the results of a genetic test for the purposes of payment determinations. It is anticipated that President Bush will sign the bill.

RESOURCE

A recent long-term analysis of life expectancies in the United States determined that 19 percent of the female population and 4 percent of the male population began experiencing declines or stagnations in mortality rates, starting in the 1980s. The report, entitled, “The Reversal of Fortunes: Trends in County Mortality and Cross-Country Mortality Disparities in the United States,” was published in the April 2008 issue of *PLoS Medicine*. Researchers from Harvard’s

School of Public Health and the University of Washington determined that the health status of many individuals in the nation has been worsening for about twenty years. The majority of the counties that had the most significant decreases in life expectancy were in the Deep South, along the Mississippi River, and in Appalachia, extending into the southern portion of the Midwest and into Texas. For further details, go to:

<http://tinyurl.com/5wrv5c>

.