

NHeLP's Capital Communique

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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.

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HEALTH REFORM

- Medicaid Eligibility
- Affordability of Insurance in the Exchange
- Abortion Coverage in the Exchange

On December 24, the Senate voted to approve its health reform legislation (60-39). The bill is available on www.thomas.gov, but there is not yet an active link to it. On November 7, the House of Representatives passed its version of health reform (220-215). Click [here](#) for a full text of the House bill;

[here](#)

for summaries, implementation timeline, and budget analyses produced by House staff; and

[here](#)

for a listing of votes by Members of Congress.

A few of the important issues that remain to be resolved between the House and Senate bills concern:

Medicaid Eligibility:

- The Senate bill extends Medicaid eligibility to almost all non-elderly individuals with income up to 133 percent of the Federal Poverty Level (FPL), with the exception of certain

immigrants. The Senate bill eliminates income disregards and assets tests for many Medicaid-eligible persons, but exempts the elderly, those with disabilities and some others from this policy change. See [Capital Communique, October 2009](#) under Medicaid/CHIP Maintenance of Effort for more details on the effect of this policy.

- The House bill extends Medicaid eligibility up to 150 percent FPL, with the same exceptions found in the Senate bill. However, the House bill does not change current rules with respect to income disregards, but it does eliminate the asset test for most groups.

Possible Actions: Anyone interested in doing so could ask his or her Member of Congress to urge acceptance of the House policy of Medicaid eligibility up to 150 percent FPL. Expanding Medicaid eligibility actually reduces the overall cost of the bill.

Interested people could also urge adoption of Senate Amendment 2991, which would allow a state to make legal immigrants eligible for Medicaid by eliminating the current five-year bar that applies to many legal immigrants.

Affordability of Purchasing Insurance in the Exchange:

Both the House and Senate bills offer federal subsidies for low-income persons purchasing private or small group coverage in any newly created Health Insurance Exchange (the Senate bill conceives of state-based Exchanges, while the House bill envisions one national Exchange).

The subsidies help with monthly premiums and other cost-sharing (deductibles, co-payments, etc) on a sliding scale basis up to 400 percent FPL.

- The Senate bill: Requires payment of a monthly premium up to 4 percent of an individual's monthly income (\$981/year) for a person with income of 134 percent FPL through 9.8 percent of monthly income (\$7,178/year) for persons at 400 percent FPL. The rates of cost-sharing assistance range between covering 90 percent of the actuarial value of a plan for a person at 133 percent FPL and 70 percent of the actuarial value of a plan for a person at 400 percent FPL, with the individual being responsible for the remaining balance through co-pays and deductibles.

- The House bill: Requires payment of a monthly premium up to 3 percent of an individual's monthly income (\$824/year) for a person with income of 150 percent FPL through 12 percent of monthly income (\$8,789/year) for persons at 400 percent FPL. The rates of cost-sharing assistance range between covering 97 percent of the actuarial value of a plan for a person at 150 percent FPL and 70 percent of the actuarial value of a plan for a person at 400 percent FPL, with the individual being responsible for the remaining balance through co-pays and deductibles.

For more detail on the operation of the premium and cost sharing subsidies, see the [Center of](#)

[Budget and Policy Priorities report comparing the affordability protections in the health reform legislation.](#)

Possible Action: Those inclined to do so could encourage Members of Congress to support affordability of coverage by including subsidies at least as good as the House package for lowest income persons and at least as good as the Senate package for middle-income persons.

Abortion Coverage in Insurance Plans Offered Through the Exchange:

- House bill: A provision introduced by Rep. Bart Stupak (D-Mich.) prohibits the sale of an insurance policy in the Exchange that contains coverage of abortion (either in the public option or in a private plan) if the plan serves anyone who receives a federal subsidy. Individuals would have to purchase a separate supplemental plan, paid for with their own money, to cover abortion services. Abortion advocates argue that this policy changes the status quo, for the first time prohibiting coverage of abortion even when a woman purchases general health insurance with her own funds, as well as leading to the erosion of current abortion coverage in private insurance due to the administrative complexity involved. Proponents of the amendment state that women who want such coverage will be able to purchase coverage for abortion separately, although they have not addressed the administrative complexity issue.
- Senate bill: To address concerns stated by Sen. Ben Nelson (D-Neb.), plans can choose whether or not to cover abortion, although a state Exchange may prohibit insurance plans from doing so. It requires all persons in the Exchange to make two separate premium payments -- one for the main part of the insurance and one for the abortion coverage. Like the House proposal, it prohibits federal subsidies to be used to fund abortion coverage.

Possible Action: Those wishing to do so can convey to Members of Congress the impact that these provisions will have on the ability of women, and especially low-income women (who lack financial resources to purchase a separate health plan solely to cover unanticipated pregnancies), to make their own choices with respect to their health needs. The White House might also be reminded of the President's promise that health reform will not take away the health care coverage Americans currently have, which includes current coverage of abortion.

EXECUTIVE AGENCY ACTIONS

CMS Withdraws Medicaid Rehabilitative Services Proposed Rule

On November 17, CMS withdrew the proposed rule, "Medicaid Program; Coverage for Rehabilitative Services," originally published in the Federal Register on August 13, 2007. The rule proposed to change the definition of Medicaid "rehabilitative services," significantly limiting Medicaid reimbursement for rehabilitative services that are currently covered. This rule had been subject to two Congressional moratoria and therefore never took effect.

For the full text of the withdrawal, click [here](#) .

Final Rule that Delays State Flexibility in Benefit Packages and Cost-Sharing

This final rule delays until July 1, 2010, the effective date of two earlier rules, entitled "Medicaid Program; Premiums and Cost Sharing" and "Medicaid Program; State Flexibility for Medicaid Benefit Packages," which implemented sections of the Deficit Reduction Act of 2005 by giving states flexibility to change benefit packages and cost-sharing provisions in their Medicaid programs. Due largely to the enactment of CHIP reauthorization and the Recovery Act earlier this year, which had provisions that intersected with these rules, CMS decided to delay the effective dates to consider those issues further.

For the full text of the rule, click [here](#) .

Medicare Adds HIV Screening to Covered Services

On December 8, 2009, HHS announced that it would include HIV screening services as covered preventive services under Medicare. This decision includes coverage for any Medicare beneficiary, regardless of age, who requests the screening be done, including pregnant women.

For more information about this change in policy and a link to the full coverage decision, click [here](#) .

JUDICIAL CONFIRMATIONS

On November 19, the Senate confirmed (59-39) U.S. District Judge David Hamilton of Indiana to the U.S. Court of Appeals for the 7th Circuit. President Clinton appointed Hamilton to the District Court in Indianapolis in 1994, and he was elevated to chief judge last year. News reports note that he was active in the Indiana branch of the American Civil Liberties Union and is on the board of the Center for Constitutional Democracy in Plural Societies, which studies the effect of Constitutional ideas across the world.

On December 1, the Senate confirmed (97-0) Jacqueline Nguyen as a U.S. District Court Judge for the Central District of California. Nguyen has worked for the Criminal Division of the United States Attorney's Office and served on the California Superior Court. In addition, she was a founding member and former president of the Asian Pacific American Bar Association. She is the first Vietnamese American to serve as a federal district court judge.

RESOURCES

A Survey of Primary Care Physicians in 11 Countries, 2009: Perspectives on Care, Costs, and Experiences, by the Commonwealth Fund, studied more than 10,000 primary care physicians in

11 countries, and concludes that the United States lags far behind in terms of access to care and the use of financial incentives to improve the quality of care. Read a summary and view charts of the report [here](#).

A few key findings:

- More than half (58 percent) of U.S. physicians, by far the most of any country surveyed, said their patients often have difficulty paying for medications and care. Half of U.S. doctors spend substantial time dealing with the restrictions insurance companies place on patients' care.
- Only 29 percent of U.S. doctors said their practice had arrangements for getting patients after-hours care -- so they could avoid visiting a hospital emergency room. Nearly all Dutch, New Zealand, and U.K. doctors said their practices had such arrangements.
- While all the countries surveyed use financial incentives to improve the quality of care, primary care physicians in the U.S. are among the least likely to be offered such rewards; only one-third reported receiving financial incentives. Rates were also low in Sweden (10 percent) and Norway (35 percent), compared with large majorities of doctors in the U.K. (89 percent), the Netherlands (81 percent), New Zealand (80 percent), Italy (70 percent), and Australia (65 percent).

National State-by-State Medicaid Statistical Information System (MSIS) Tables

The CMS website has been updated with the new 508 compliant National State-by-State Medicaid Statistical Information System (MSIS) Medicaid eligibility and claims tables from 31 states for federal fiscal years 2005-2008. Individual or groups of tables may be selected using multiple category options. Examples of the types of data found on the site include race/ethnicity, gender, age, managed-care enrollees, and Medicaid eligibility categories. To link to the data click [here](#).

FACTOID -- DOUBLE DIGIT PROFIT INCREASES FOR INSURERS

The following is from Majority Leader Hoyer's Daily Dose Health Alert (11/5/09) -- Amid declining enrollment, insurance companies have reported double-digit profit increases. At the same time, health care premiums continue to skyrocket and the number of uninsured Americans steadily rises.

The latest insurance company profit figures include:

United Health: \$1.04 billion (up 13 percent) [10/20/2009]
Cigna: \$329 million (up 92 percent) [11/5/2009]
Aetna: \$326.2 million (up 18 percent) [10/29/2009]

Humana: \$301.5 million (up 65 percent) [11/2/2009]

Universal American: \$59.7 million (up 22 percent) [10/29/2009]

Health Spring: \$42 million (up 44 percent) [10/29/2009]

Centene: \$21.3 million (up 13 percent) [10/27/2009]

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