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Customized Briefing for Kimberly Barry-Curley

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Leading the News

Democratic moderates appear to balk at Reid's health reform bill.

One day after Senate Majority Leader Harry Reid (D-NV) announced his healthcare overhaul plan, some Senate Democrats appeared uneasy about key provisions regarding the public option. Analysts say the potential defections call into question whether Democrats will be able to defeat an expected GOP filibuster. The [Washington Post](#) (10/28, Murray, Montgomery) reports that "lawmakers said that if moderates' concerns do not prevent the Senate bill from advancing next month, the opt-out provision could be ditched on the floor. Some moderate Democrats are more comfortable with the 'trigger' approach that Sen. Olympia J. Snowe (R-ME) has advocated." Sen. Snowe has already indicated that she will not back Reid's bill.

The [New York Times](#) (10/28, A20, Herszenhorn, Pear), meanwhile, reports that while the "continuing apprehension" of some lawmakers "indicated substantial uncertainty," Democrats "expressed growing confidence that a version of the healthcare bill would be adopted," either "with or without a public option."

[AFP](#) (10/28) notes that "Reid needs 60 votes to carry a procedural measure to move to the healthcare debate, and then 60 more to end debate and hold a final up-or-down ballot." The [AP](#) (10/28, Espo) reports that "Reid is expected eventually to secure all 60 Democratic votes on the critical first test to bring the bill to the Senate floor." However, Democratic "Sens. Ben Nelson of Nebraska, Mary Landrieu of Louisiana, Evan Bayh of Indiana, and Blanche Lincoln of Arkansas all declined to say on Tuesday how they would vote."

Complicating matters for Reid, [McClatchy](#) (10/28, Lightman, Talev) reports, "Sen. Joseph Lieberman (ID-CT)...said he'd back a filibuster to prevent a public option from coming to a final vote." And, "while the Democrats, including Lieberman, are expected to vote with their party leadership at least to allow debate to begin, there are serious questions about whether they'll provide the votes needed to end debate over specific parts of the bill or, in the end, to approve the legislation." That, notes [The Hill](#) (10/28, Bolton), "means that as things now stand, Democrats will not have enough votes to pass healthcare reform with a so-called public option unless" Reid "can pick up unexpected GOP votes." [USA Today](#) (10/28, Fritze) similarly notes that "without Lieberman, Reid must find support from Republicans, none of whom say they back the idea."

The [Los Angeles Times](#) (10/28, Hook, Levey) reports, "A senior Democrat said that there were about 10 Democratic senators whose support had yet to be nailed down." Reid "has been meeting one on one with balky Democrats, and made a plea for party unity at the Democrats' weekly closed-door strategy lunch Tuesday. But so fraught are the politics of the debate, some Democrats emerged from that meeting saying they were not sure they would vote even to bring the bill to the floor, let alone vote for its passage." The [Washington Times](#) (10/28, Haberkorn) runs a similar story.

In House, "more liberal" public option under 218 votes. [The Hill](#) (10/28, Allen, Soraghan) reports, "House Democratic leaders on Tuesday sought to capture some of the momentum created by the inclusion of a public health insurance option" in the Senate "by locking down as many members as possible on which public option they could support in the House healthcare bill." According to

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"Democratic leaders...a House bill could be unveiled as early as Wednesday, and go to the floor for a vote next week." But, "the leftward momentum in the Senate doesn't appear to have won the day for the most liberal alternative. After weeks of lobbying by liberals and House Speaker Nancy Pelosi herself, the more liberal, Medicare-based option had a clear majority of House Democrats, but not the 218 needed to pass it." [CQ Today](#) (10/28, Epstein, subscription required) also covers the story.

From NAHU

We know many of you have been extremely active with legislative issues and we want to thank you for your hard work and assure you it is making a difference. We are seeing some inroads on the legislative front and continue to work diligently with Congress to keep things on the right track.

The next few months will be the most intensive of times for our association's government affairs efforts. We have every reason to believe that health system reform legislation will move forward, and we need to preserve the role of agents and brokers and ensure continuance of the private market. It is for these reasons that we have decided to reinstate our Grass Roots Initiative Program. GRIP is a voluntary donation program created some years ago for our legislative expenses at the national level.

We are now soliciting both individual and chapter contributions to GRIP, and would greatly appreciate any additional help as there is still much to be done on the legislative and regulatory front. **Please click [here](#) to make a donation to GRIP today.**

Legislation and Policy

AHIP ad targets seniors.

[Roll Call](#) (10/28, Roth, subscription required) reports that America's Health Insurance Plans (AHIP) "has stepped up its opposition to the overhaul efforts as it has become clear that the final product will not be to its liking." In television spots in 10 states, the group warns "senior citizens that their benefits could be slashed."

Chamber of Commerce to run ad attacking health reform. The [AP](#) (10/28) reports that the "US Chamber of Commerce says it will begin airing new TV ads in seven states and on national cable television attacking the emerging [healthcare reform] legislation, including a government-run insurance option." The group argues that "such a public plan would force tax increases, raise peoples' healthcare costs and threaten employer-provided coverage that most Americans already have. The ad is slated to start Wednesday."

Tauzin, Ignagni's role in reform debate explored. The [New York Times](#) (10/28, A20, Stolberg) profiles PhRMA CEO Billy Tauzin and AHIP CEO Karen Ignagni, "perhaps the two most powerful health industry lobbyists in Washington." The Times reports that "after cutting an \$80 billion, 10-year deal for his industry -- blessed by the White House -- to help pay for a healthcare overhaul," Tauzin "is now working quietly to keep his pact from unraveling on Capitol Hill." Ignagni, "a Democrat who represents insurers, stood up at the White House in March and told President Obama he had her 'commitment to play, to contribute and to help pass healthcare reform this year,'" but now "is fighting to persuade official Washington she meant what she said, as Mr. Obama, a man she says she voted for, accuses her industry of waging a 'smoke and mirrors' campaign to undermine reform." According to the Times, "The story of these two lobbyists...illustrates the complexities Mr. Obama faces in the healthcare endgame." President Obama "had some early success in bringing industry on board," but "keeping it there will be easier said than done."

White House, insurance industry should acknowledge trade-offs, Pearlstein argues. In his column in the [Washington Post](#) (10/28), Steven Pearlstein writes that the "political mud fight between the White House and the insurance industry over health reform...is in nobody's interest." The insurance industry, "rather than resort to scare tactics that threaten to derail the whole reform process...could have continued to work behind the scenes to address its concerns by offering to trim benefit packages, strengthen the individual mandate and allow slightly greater variations in premiums -- details that most people, and most members of Congress, barely notice." Likewise, the White House should "stop pretending that health reform will be a winning proposition for everyone," Pearlstein argues. "Getting a fairer deal for those who are old and sick has inevitable consequences for those who aren't." Pearlstein says the Administration should be upfront about and defend such trade-offs.

California MRMIP said to illustrate drawback of private insurers involved in public-option plans.

In his column for the [Los Angeles Times](#) (10/28), David Lazarus recounts the plight of Altadena, Calif.-resident Mike Freas who "was twice rejected for health coverage by Anthem BlueCross because of a preexisting condition, forcing him into a costly state-run program," California's Major Risk Medical Insurance Program. Lazarus points out that California taxpayers "pay about 40 percent" towards MRMIP for which premiums run up to "37-percent higher than market rates." Moreover, the MRMIP plans are offered by only "a handful of

insurers," led by Anthem -- the insurer that twice rejected Freas. And according to an "MRMIP insider," Anthem "receives about \$600,000" annually in state funds for its role in the program. Lazarus concludes that this "private insurer's role in running a public plan" should serve as "a warning to all those who think a public option is the be-all, end-all of healthcare reform."

WSJournal touts study claiming reform would boost premiums.

The [Wall Street Journal](#) (10/28, A22), in an editorial, highlights a study commissioned by the insurance company WellPoint, Inc. WellPoint used its actuarial data to determine how the healthcare reform plans under consideration currently would affect its customers' premiums. The company concluded that premiums would be increased in all 14 states where it operates. The Journal describes Democrats' criticism of the study, quoting Linda Douglass, director of communications for the White House Office of Health Reform, as saying, "This is yet another insurance-industry report that twists the facts to produce a skewed result. ... This is akin to the tobacco companies commissioning another study claiming nicotine isn't addictive and cigarettes don't cause cancer."

Constitutionality of mandates disputed.

The [Washington Times](#) (10/28, Lambro) reports, "On top of all the other obstacles facing President Obama in his quest to pass health reform is this one: Does the US Constitution allow the government to require uninsured Americans to buy medical insurance or impose a tax penalty if they refuse? Congress has never before required citizens to purchase any good or service, but that is what both House and Senate health bills would mandate." Last week, House minority leader John Boehner (R-OH) said, "I'm not a lawyer, and I'm certainly not a constitutional lawyer, but I think it's wrong to mandate that the American people have to do anything." Michael Cannon, director of health-policy studies at the Cato Institute, says, "It's been on all the legal blogs. ... The Constitution does not grant Congress the power to force Americans to purchase health insurance."

Medicare cuts said to worry doctors, seniors.

[CNNMoney.com](#) (10/27, Kavilanz) reports some doctors are beginning to boycott Medicare "because they are tired of dealing with the yearly threat of a payment cut." Now, with a proposed 21 percent reduction in Medicare reimbursements to doctors, "most physicians at Kansas City Internal Medicine, with 65% of its nearly 70,000 active patients age 65 or older, have stopped accepting walk-in Medicare enrollees," according to an internist at KCIM, Dr. David Wilt. Wilt said further cuts to Medicare reimbursements will mean "functioning at a loss" for his group. Dr. John Hagan, a Kansas City-area ophthalmologist who is eligible for Medicare, says he fears enrolling because he may not be able to find a participating doctor. The Centers for Medicare and Medicaid Services (CMS) counter that "96.5% of all practicing physicians, nearly 600,000 doctors, currently participate in Medicare," and that it is unlikely seniors will have difficulty finding a doctor.

USA Today: Health reformers should consider including CLASS Act.

[USA Today](#) (10/28) editorializes that "for all the pervasiveness of long-term care problems, possible solutions haven't had a prominent place in this year's healthcare debate." USA Today argues for putting the Community Living Assistance Services and Supports (CLASS) Act into health reform legislation. "This plan would establish government-run, long-term insurance through payroll deductions. It would not be subsidized by employers, and people could opt out. After paying in for five years...people who became unable to take care of themselves would qualify for modest stipends." Including the act "could focus Americans' attention on long-term care issues. It might even kick-start interest in the fledgling private long-term care insurance market that provides more complete 'wraparound' benefits."

CLASS Act expected to add to deficit. In an "Opposing View" op-ed in [USA Today](#) (10/28), Frank Keating, president and CEO of the American Council of Life Insurers, argues that the CLASS Act, "while well-intended...amounts to little more than an unfunded entitlement program that would add to our nation's deficit. It would do little to address Americans' long-term care needs." Keating argues that the program's deductions are unlikely to have "a sufficient base of participants," and without that "it would take significant increases in premiums or billions of federal dollars to keep this program running."

Latino groups unveil healthcare priorities.

[CQ HealthBeat](#) (10/27, Jane Norman, subscription required) reported that leaders of Latino groups Tuesday "outlined their priorities for the healthcare overhaul, including a new office of minority health and an end to a five-year ban on legal immigrants' eligibility for federal programs such as Medicaid." The members of Latinos United for Healthcare "said in a conference call with reporters that their broad-based coalition wants to remain active in the overhaul debate alongside other groups, and they also want to dispel misinformation in their communities and explain the impact of overhaul proposals." Rosa Rosales, president of the League of United Latin American Citizens, "said the coalition favors a government-run health insurance option to compete with private insurance, assistance for small businesses, an end to bans on pre-existing conditions, stronger consumer protections in private plans, prevention programs that understand cultural and

linguistic differences, and recruitment of more minorities as healthcare professionals."

Public Health and Private Healthcare Systems

CMS reversing decision on reimbursement for off-label Avastin use.

The [Wall Street Journal](#) (10/27, Goldstein, subscription required) "Health Blog" reported that the Centers for Medicare & Medicaid Services (CMS) appears late yesterday to have changed its mind about reimbursement for small amounts of Avastin [bevacizumab], which physicians use to treat patients with age-related macular degeneration (AMD). Avastin, which is similar to Lucentis [ranibizumab], is used off-label to manage AMD, but unlike Lucentis, which costs approximately \$2,000 per injection, Avastin costs only about \$30 per injection, making it considerably cheaper. Late yesterday, however, CMS announced without explanation that as of Jan. 1, it will reverse its Oct. 1 decision to reimburse Avastin at approximately \$7 per dose, and will return to its previous higher reimbursement for the drug.

[MedPage Today](#) (10/27, Phend) explained that even after CMS lowered its reimbursement for Avastin on Oct. 1, "reimbursement for Lucentis...remained unchanged at a whopping \$2,039," thereby creating "a disincentive for using a drug that has been estimated to save Medicare \$1.5 billion each year in treating macular degeneration alone."

Consumer Directed Healthcare News

New national database to detail out-of-network healthcare costs for consumers.

The [AP](#) (10/28, Kates) reports that New York Attorney General Andrew M. Cuomo yesterday announced that consumers "will be able to find impartial information about out-of-network healthcare costs on a new website." The data will be "collected by a new not-for-profit company, FAIR Health, in partnership with a research consortium." Cuomo said that consumers "will be able to look up the exact procedure" and "know what the cost is...there will be no surprises." The website also will give consumers "information on how much they are likely to be reimbursed by their insurance company for using doctors outside of their network, based on the costs of healthcare services in their area."

The [New York Times](#) (10/28, B4, Abelson) explains that the database is part "of a settlement reached over the last year with more than a dozen insurance companies" over the use of UnitedHealth subsidiary Ingenix' database for the payment of out-of-network claims. Insurers were accused of using the database to understate "the doctors' fees for more than a decade and" shortchange "consumers by hundreds of millions of dollars. Consumers' reimbursements 'will actually go up now because the reimbursements were artificially deflated,'" said Cuomo.

But, the [National Underwriter Insurance News](#) (10/28) reports that Zirkelbach "said he does not believe this initiative will lower healthcare rates because it is merely changing who compiles data from Ingenix to a not-for-profit company." He noted that "no one has been looking at what physicians are charging insurers, and with the information now available to consumers," they "may be shocked when they find out."

Healthcare pricing websites helping patients make medical decisions. The [Wall Street Journal](#) (10/28, Mathews, subscription required) reports on the increasing number of websites that provide healthcare pricing for consumers, enabling them to make better decisions on medical plans, hospitals and physicians. Such sites include the HealthcareBlueBook.com, which suggests reasonable prices for procedures; Medicare's HospitalCompare and LeapfrogGroup's site, which provide quality of care information; Changehealthcare.com, which estimates how much providers are paid by insurers; and the AMA's website, which enables users to see what Medicare pays physicians for specific types of care. A companion piece in the [Wall Street Journal](#) (10/28, Mathews, subscription required) provides a complete list of 23 websites providing healthcare pricing estimates.

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