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Customized Briefing for Brett Houston

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Leading the News

Nebraska Medicaid deal may be "unconstitutional," South Carolina AG says.

[Politico](#) (12/29, Barr) reports that "South Carolina Attorney General Henry McMaster said Monday that the deal Sen. Ben Nelson (D-NE) struck with Senate leadership in exchange for his vote on healthcare reform 'represents corruption.'" McMaster has joined nine other "Republican state attorneys general [in] questioning the constitutionality of the Medicaid deal, which would exempt Nebraska from paying its share of the program's expansion in the state." He said the deal "represents corruption. ... It will cost 49 states money to have to pay Nebraska's share. We think that is unconstitutional."

In its "Blog Briefing Room," [The Hill](#) (12/29, Romm, subscription required) also notes McMaster's comments, adding that there is "an implicit economic argument motivating states' legal action against Democrats' healthcare reforms." Many governors have "argued that a Medicaid expansion during a national budget crisis could further hamstringing their finances, but only one state -- Nebraska -- was able to avoid the mandate."

Top New York politicians spar over healthcare reform. The [AP](#) (12/29, Gormley) reports that federal healthcare reform legislation "is heating up New York politics, pitting the state's two top Democrats against each other and giving Republicans an opportunity to snipe at a side deal that swayed a key vote in the US Senate." US Sen. Charles Schumer (D-NY) and Gov. David Paterson (D) "are at odds over how good -- or bad -- the Senate version of the bill is for New York." According to Gov. Paterson, the state will "lose over \$1 billion dollars if they don't fix" a "proposed lower rate of federal reimbursement for New York's Medicaid." Sen. Schumer accused Paterson of "counting as cuts items included in the House version of the bill, but not the Senate's."

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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.**

Healthcare lobbyists seen as driving reform debate in statehouses.

In a front-page story, the [New York Times](#) (12/29, A1, Kirkpatrick) reports that "insurance companies, hospitals and other healthcare interests have been positioning themselves in statehouses around the country to influence the outcome of the proposed healthcare overhaul." In fact, "about a dozen" states, including Florida, are currently debating state constitutional amendments "that would try to block, at least symbolically, much of the proposed federal healthcare overhaul on the grounds that it tramples individual liberty." In Florida, backers of one such amendment "were almost all recipients of outsized campaign contributions from major healthcare interests." While "any federal legislation is likely to supersede state constitutional amendments...backers of the state measures" intend to "lay groundwork for fights about elements of the healthcare package that are expected to be left up to the states."

Medicare spending cuts may be double-counted in reform bills.

The [New York Times](#) (12/29, A20, Pear) reports on a "paradox" in the healthcare reform legislation "that befuddles lawmakers of both parties." Cutting Medicare spending over the next 10 years "would help offset the cost of providing coverage to people who are uninsured," according to the bills, but "federal accountants say the money would [also] shore up the Medicare trust fund, so the program could continue paying hospitals to treat older Americans in the future." The Times notes that this means there would be "both more money available to spend now and the appearance of more money to spend later on Medicare." The Congressional Budget Office called the assertions "double-counting," but "the clarification came too late to affect the outcome of debate over the legislation."

Trial lawyers launch advertising campaign against tort reform.

The [New York Times](#) (12/29, B6, Olson) reports, "Lawmakers debating healthcare reform in recent weeks haven't been reticent about blaming trial lawyers for driving up the nation's medical costs by pursuing large malpractice awards." In response, trial lawyers have launched an advertising campaign with "a blizzard of brightly colored ads on the platform and walls" of "the subway system" in Washington, DC, in an effort to argue that "tort reform won't fix the healthcare system." The ads are intended imply "that patients need legal recourse because preventable medical errors are the sixth-leading cause of death in America," citing figures from the Institute of Medicine's 1999 report called *To Err Is Human*.

"Cadillac tax" expected to hit middle class.

In his column in the [New York Times](#) (12/29, A31), Bob Herbert writes, "There is a middle-class tax time bomb ticking in the Senate's version of President Obama's effort to reform healthcare." The "confiscatory 40 percent excise tax on so-called Cadillac health plans...will hammer millions of middle-class policyholders, forcing them to scale back their access to medical care." According to Herbert, "the tax on health benefits is being sold to the public dishonestly as something that will affect only the rich, and it makes a mockery of President Obama's repeated pledge that if you like the health coverage you have now, you can keep it."

Reform provision would "nudge" Americans to get long-term care insurance.

The [AP](#) (12/29, Johnson) reports that "most people may want to plan for the future, but they need a nudge to overcome their avoidance and laziness" to buy long-term care insurance. "At least that's the assumption behind a program tucked into the healthcare overhaul legislation emerging from Congress." Automatic enrollment into the program effectively would "nudge" Americans to get the insurance, according to the AP, thereby helping to "shift the financial burden of an aging population from Medicaid, now the largest funder of long-term care, to individuals. The federal-state health insurance program for the poor is straining state budgets." According to some economists, "governments and the private sector can and should nudge people into doing what's best for them," but critics say people are being "tricked into" enrolling.

Legislators ponder shape of final health reform bill.

[CNN](#) (12/29) reports that "House Democrats are signaling that a final healthcare bill will drop the government-run public health insurance option favored by liberals but rejected by conservatives from both parties." CNN notes that Reps. James Clyburn (D-SC) and Chris Van Hollen (D-MD) have signaled that they would approve a bill without a public option. "A House-Senate conference committee will begin negotiations next month on merging healthcare bills passed by the Democratic majorities in each chamber."

But, according to Sen. Bob Menendez (NJ), chairman of the Democratic Senate Campaign Committee, "any major changes [to the Senate healthcare reform bill] would jeopardize final approval," [Bloomberg News](#) (12/28, Salant) noted.

[Roll Call](#) (12/29, Drucker, subscription required) reports that "congressional aides began laying the groundwork Monday for

Democratic leaders in the House and Senate to negotiate competing healthcare reform bills into legislation that can be signed by President Barack Obama, a senior Senate aide confirmed." According to one Senate aide, "Everything happening this week is happening behind the scenes. ... Staff is taking the week to review documents. Informal staff meetings may happen, but nothing is scheduled just yet."



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Public Health and Private Healthcare Systems

State insurance regulators approve Health Net, UnitedHealth membership-renewal agreement.

[American Medical News](#) (12/29) reports that "insurance regulators in New Jersey, New York and Connecticut approved UnitedHealthcare's purchase of renewal rights for Health Net's membership in the three states, making the deal official as of Dec. 11." The transaction, which "was opposed by the American Medical Association," gives UnitedHealth access to "Health Net's 578,000 members in the Northeast as Health Net focuses on its business in California and Arizona. The deal could be worth as much as \$630 million over the next five years." Meanwhile, Connecticut Attorney General Richard Blumenthal continues to "investigate the potential anticompetitive effect the arrangement might have in the state, but his approval was not required for the transaction to go through because the purchase of renewal rights...is not subject to the terms of the federal Hart-Scott-Rodino Act."

Analysis shows slight decrease in BlueCross affiliates' membership.

[Insurance and Financial Advisor](#) (12/29, Graham) reports, "The national federation of BlueCross and BlueShield licensees saw a small decrease in the number of people" to whom it provides health insurance coverage, according to an analysis by Mark Farrah Associates. "As of June 30, the 39 independent Blues plans provided major medical coverage to 102.3-million people." The total "marks a 0.2-percent decrease from June 2008. Still, Mark Farrah researchers said BCBS organizations "have done slightly better in terms of membership than the rest of the health plans in the country during the recession." At present, Blues and affiliates "cover one of every three Americans -- including nearly 20-million unionized workers, families and retirees and roughly 5.2-million" people on federal plans. Moreover, Blues organizations "cover more than half of all commercially insured persons in the US."

CDPHP launches integrated health IT management system.

[Healthcare IT](#) (12/29, Monegain) reports Albany, NY-based insurer CDPHP, which comprises the "Capital District Physicians' Health Plan, Inc., CDHP Universal Benefits, Inc., and the Capital District Physicians' Healthcare Network, Inc." has launched "new software to help reduce costs and boost quality." Utilizing applications from "enterprise, network management and Web-based applications" by TriZetto, CDPHP's system "administers claims, provider contracts and transactions and the exchange of information between the payer organization and its constituents."

Florida providers file suit alleging low Medicaid pay violates federal access requirements.

[American Medical News](#) (12/29, Sorrel) reports. "Florida health officials have violated federal law by not ensuring that the state's 1.4 million

children on Medicaid have adequate access to primary and preventive care," according to a class-action lawsuit filed by "physicians, dentists, and patients." The suit, filed in the US District Court for the Southern District of Florida, alleges that Florida "health officials set physician payments at such low levels" that not enough doctors "are available to provide services." The plaintiffs contend that such "insufficient rates violate the federal Medicaid Act's equal-access requirements by depriving" more than 40 percent of low-income children on Medicaid "of their right to prompt care." The lawsuit also "points to administrative barriers that have disrupted children's care," such as "failing to notify recipients of available services" and "improperly terminating their eligibility."

Open-enrollment deadline looms for Minnesotans with Medicare-drug plans.

The [Minneapolis Star Tribune](#) (12/29, Wolfe) reports, "With Thursday's midnight open-enrollment deadline fast approaching," Minnesotans with Medicare "drug insurance are running out of time to examine their policies for next year. They should at least consider their options, experts say, because all 107 private plans approved for Minnesotans by Medicare will change their costs, drug coverage or both next year." According to the Minnesota Board on Aging, "about 510,000 currently have Part D plans and 83,000 have no drug coverage." For more details, the Tribune recommends that enrollees access CMS' Medicare-Compare [website](#) or download a publication at the state's Aging Board [website](#).

Medicare drug plan changes cause service backlog. The [Hampton Roads Virginian-Pilot](#) (12/29) reports, "Insurance advisers at Senior Services of Southeastern Virginia are experiencing a backlog of calls from people 65 and older and the disabled who need to make changes to their Medicare Part D drug plans before the end of open enrollment at midnight Thursday." The system will keep taking calls through Wednesday, but any beneficiaries whose changes have not been processed by then will be referred until midnight Thursday to a Medicare toll-free number. The paper notes that persons with Tricare military insurance, federal employees and beneficiaries want to keep their same prescription coverage do not need to call.

Oregon's Medicaid plan expands with stimulus funds but could see future cutbacks.

The [AP](#) (12/28, McCall) reported that Oregon health officials, who have used \$833 million in federal stimulus funds to increase the caseload of the state's Medicaid plan by about 15%, or 460,000 beneficiaries, "are worried about what's going to happen when the stimulus money runs out in 2011." State Sen. Alan Bates (D), a physician and healthcare reform advocate, notes that the federal stimulus funds helped the state maintain the Oregon Health Plan at a time of greater demand and falling state revenues, but warns, "We're looking at a real crisis here, and I think it's about a year to a year and a half away." The state legislature resumes in February; state residents will also vote on two tax measures in a special January 24 referendum.

Uninsured

Gaps in COBRA coverage leave many without insurance.

The [Wall Street Journal](#) (12/29, A14, Dugan, subscription required) reports that despite recent COBRA expansions, many people still cannot access the program because the health plan's costs remain high in spite of subsidies. Furthermore, workers who are self-employed, work for small businesses, or employees of companies that did not offer health coverage do not qualify for COBRA. White House officials call the COBRA expansion a "short-term response" and note that the program is helping many, even with these gaps in coverage.

Also in the News

Cardiology group sues Sebelius over Medicare cuts.

[USA Today](#) (12/29, Sternberg) reports that the American College of Cardiology "on Monday filed suit against Secretary of Health and Human Services Kathleen Sebelius in an effort to stave off steep Medicare fee cuts for routine office-based procedures such as nuclear stress tests and echocardiograms." The group "charges that the government's planned cutbacks will [force] thousands of cardiologists to shutter their offices, sell diagnostic equipment and work for hospitals, which charge more for the same procedures." Jonathan Blum, director of the government's Center for Medicare Management, explained that CMS "is bound by law not to increase spending when making reimbursement decisions each year. That means the agency must" use funds from "cardiologists to pay the internists and family physicians -- to boost payment rates for long 'undervalued' primary care services."

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