Can the Public Remedy Health Care?

After studying why health reform efforts have failed, a U.S. senator decides to look outside Washington.

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

WASHINGTON — Sen. Ron Wyden (D-Ore.) says that the answer to America's health care problem does not lie with Congress—at least, not initially.

"I spent 2 years studying what went wrong in the Clinton debacle," he said at a meeting sponsored by America's Health Insurance Plans. Sen. Wyden was referring to President Bill Clinton's unsuccessful effort to get Congress to pass health care reform in the 1990s. He also looked at a similar effort in the 1940s by President Harry S Truman.

His conclusion: "There is a remarkable parallel in 60 years of failure. …For 6 decades, the effort has involved trying to write a piece of federal legislation in Washington, D.C. [But] the special interests would attack the legislation and each other, and everything would fail."

Instead, "I decided to go 180 degrees the other way," he said. "We'll start it outside [Washington]."

In March, Sen. Wyden, along with Sen. Orrin Hatch (R-Utah) and Comptroller General David Walker, announced the formation of the Citizens' Working Group on Health Care. The group is composed of 14 people from across the country, including physicians, health advocates, hospital administrators, academicians, nurses, and a union representative. Health and Human Services Secretary Mike Leavitt will serve as the 15th member.

The group is one result of a new law known as the Health Care That Works for All Americans Act, which was cosponsored by the two senators. One thing the working group will do, according to Sen. Wyden, is "tell people where the $1.8 trillion spent on health care actually goes. …I think people will be pretty surprised." The information will be made available online as well as in booklets and in libraries.

The working group also will hold public hearings to get input on what should be done to reform the system. "No one has walked the public through the choices and tradeoffs that come with a health care system that works for everybody," he said. "We're now going to have a real debate about how we create a system that works for everybody."

After publishing the spending information and listening to public comment, the working group will develop a set of tentative recommendations on a system that works for everybody.

"When they have the tentative set of recommendations, they go back to the public again for another crack," Sen. Wyden said. Then the recommendations go to Congress, and all committees with jurisdiction over health care will have to hold hearings within 60 days of getting the recommendations.

Although there is no mandate for Congress to take any further action on the recommendations once it has held hearings, "you will have a citizens' road map of where the country feels we ought to be headed in health care, and if at that point the Congressional committees decide they want to ignore what the citizens have to say, then it will be really clear who they're siding with—powerful Washington interests rather than the citizens," he said.

Sen. Wyden gave a specific example of the type of issue he hopes the working group will address. "We know that a big chunk of the health care dollar gets spent in the last few months of someone's life. And we know in many of those instances, the best doctors and hospitals can't do anything to increase the quality of the person's life, and they can't do anything that's medically effective," he said.

"So the question for the country that the political leaders have been ducking—and that they aren't going to be able to duck any longer—is, in those kinds of instances, do we want to start spending more money on hospice and in-home services and less on expensive treatments and interventions?"

Even the semantics surrounding these issues are difficult to deal with, Sen. Wyden noted. For example, "it took me 3 months to negotiate the title of this bill. When we started, the Democrats wanted the words 'universal coverage,' but the Republicans said, 'We're not going there; that's socialism.' The Republicans wanted to call it universal access, but the Democrats said, 'We're not going there; no one will ever get anything.' " ■

For more information on the working group, go to www.gao.gov/special.pubs/citizenshealthpr0228.pdf.

CMS Eyeing Part D Performance Measures

BY JENNIFER SILVERMAN
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WASHINGTON — Medicare intends to use performance measures to monitor cost, quality, and access issues related to the new prescription drug benefit, a research analyst said during a meeting of the Medicare Payment Advisory Commission.

However, Medicare has not yet "determined what those measures will be and how they will be used," said MedPAC analyst Cristina Boccuti. MedPAC makes recommendations to Congress on Medicare payment issues.

The Centers for Medicare and Medicaid Services will be collecting a large amount of data on the new drug benefit—or Medicare Part D—including drug utilization and plan benefit information, to construct these performance measures, Ms. Boccuti said. In addition to the agency's need for the data, "congressional agencies will need Part D data to report to the Congress on the impact of the drug benefit on cost, quality, and access."

MedPAC commissioners recommended that the Health and Human Services department establish a process for the timely delivery of this data to interested parties.

To identify how policy makers could use these measures to monitor the Part D program, MedPAC convened a panel of 11 experts representing health plans, pharmacy benefits managers (PBMs), employers, pharmacies, consumers, quality assurance organizations, and researchers. The panel analyzed measures such as cost control, access and quality assurance, benefit administration and management, and enrollee satisfaction.

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Based on the panel's findings, CMS plans to collect data on the following:

- Dispensing fees, generic dispensing rates, aggregate rebates, drug claims, and drug spending by plans and beneficiaries.
- Pharmacy networks, formularies (which include prior authorization and exceptions), appeals rates, and drug utilization.
- Claims processing, including plans' out-of-pocket calculations.
- Beneficiary satisfaction, grievances, call center operations, and disenrollment rates.

MedPAC commissioner Nancy-Ann DeParle, a health care consultant in Washington and former head of CMS' predecessor agency (the Health Care Financing Administration), asked whether CMS would be looking at this data at a physician level, in terms of who did the prescribing. "In our pay-for-performance discussions around physicians, [MedPAC indicated that] it would be useful to have this."

Ms. Boccuti noted that there is a prescriber code associated with each drug.

The agency will be collecting data on actual drugs and the spending associated with those drugs, "so there will be the ability to track how much was paid at the point of sale," Ms. Boccuti commented. ■

PPAC Members Scrutinize Part B Drug Proposal

BY JOYCE FRIEDEN
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WASHINGTON — Members of a Medicare physician advisory group have reservations about the Centers for Medicare and Medicaid Services' proposed new program for paying for physician-administered outpatient drugs under Medicare Part B.

Medicare currently pays physicians the average sales price (ASP) of the drug—a number that is supposed to represent the total paid for the drug by all buyers divided by the number of units sold—plus an additional 6%. But under the proposed rule, beginning next year physicians would have a choice: they could either stick with the current system or obtain the drugs directly from a vendor that will be selected by Medicare via a competitive bidding process.

The system would require that physicians choose one system or the other for all the drugs commonly furnished to their specialty, according to Don Thompson, director of outpatient services at CMS's Center for Medicare Management.

But Ronald Castellanos, M.D., a Cape Coral, Fla., urologist and chairman of the Practicing Physicians Advisory Council, said at a council meeting that an all-or-nothing system wouldn't work very well in his practice. "There are certain drugs that I use that I can't buy for ASP plus 6%."

Mr. Thompson said that while Dr. Castellanos couldn't pick and choose what system he would use for which drug, he could try to influence which urology drugs will be included in the program. "The categories could be structured differently; your comment [on the proposed rule] could be, 'I think the category should include these drugs and not these other drugs,'" Mr. Thompson said at the meeting.

Dr. Castellanos proposed that the council, which advises Medicare on matters of interest to physicians, urge CMS to revise the rule to allow physicians to pick and choose which system they would use "on a drug-by-drug basis." That recommendation passed easily.

Dr. Castellanos wondered whether the drug vendors who are going to contract with Medicare would be required to provide drugs for beneficiaries who couldn't afford the copays.

"The contractor would be required to supply that drug to you," Mr. Thompson replied. "If you're asking if a contractor would waive coinsurance for that particular beneficiary, there's no separate requirement for vendors that would be any different from physicians," who can waive the copay on a case-by-case basis, he said.

Dr. Castellanos pressed further. "These patients have ongoing treatments that can last for years. You're telling me that even though a patient is unable to pay coinsurance, that the contractor will bill the patient, but still has to supply the drug?" he asked.

Mr. Thompson seemed to answer in the affirmative. "We did not propose any mechanism for a contractor to deny supplying drugs to a beneficiary," he said. ■