Health Proposals Differ By Principles, Strategy

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WASHINGTON — Lawmakers are brimming with ideas about what to do for the nation's 47 million uninsured, but it is not clear whether any single proposal has enough support to overcome political obstacles.

Just months into the start of this session of Congress, several bipartisan bills have been introduced and sweeping reforms have been proposed, including some that would expand health coverage to most—if not all—Americans. Lawmakers are also proposing incremental approaches that would build on ongoing state efforts.

Although those proposals would require increased federal spending, they would also bring about administrative savings within the health care system. Reductions in the amount of paperwork and in uncompensated care could yield savings of between $4.5 billion and $60.7 billion, according to a new report from the Commonwealth Fund.

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The report, with cost estimates produced by the Lewin Group, contains analyses of recent proposals, including the tax reforms that President Bush described in his state of the union address in January.

In that speech, the president proposed a health insurance tax break to everyone who purchases coverage, rather than only for those who get it through their employers. Under the proposal, anyone covered by a private plan would get the standard deduction of $7,500 for individuals and $15,000 for families.

The implementation of this tax change would help 9 million uninsured Americans get coverage at a cost of $70.4 billion in federal subsidies in the first year, according to the report.

The goal of this or any reform should be to make health insurance more affordable and efficient, explained Katherine Baicker, Ph.D., a member of the president's Council of Economic Advisers, at a recent briefing sponsored by the Alliance for Health Reform.

"The parts of the country where we spend the most on health care are not the parts where people end up with the highest quality health care, they're not the parts where people are sickest. …There is evidence …that we could get more for our money," said Dr. Baicker.

Proposals in Congress tend to have more ambitious aims. Legislation introduced last year by Rep. Pete Stark (D-Calif.) would open both Medicare and the Federal Employees Health Benefits Program to all Americans. It would cover almost all of those who are currently insured and uninsured and increase federal health care spending by $154.5 billion in the first year.

Another proposal from Sen. Ron Wyden (D-Ore.) would extend coverage to 95% of the uninsured through large, regional risk pools whereby individuals and families could purchase private plans. Because it requires employers to buy into the plan, this approach would cost the federal government only $24.3 billion in the first year.

More modest proposals have also been circulating on Capitol Hill and are receiving bipartisan support. Among these are calls to ensure that all children are covered, which is likely to arise during discussions on the reauthorization of the State Children's Health Insurance Program. Other lawmakers would like to see more federal government support for state experiments with sweeping reforms.

However, there are more fundamental differences in the philosophies that undergird many of these proposals.

Some are rooted in the belief that the health care system cannot be fixed until everyone is brought into it.

"As long as coverage is incomplete, efforts to achieve cost control with respect to the insured population will generate social and health consequences that none of us would find tolerable," said Henry Aaron, Ph.D., an economist and senior fellow at the Brookings Institution in Washington, D.C.

He explained that in a situation in which some patients are insured and others are not, physicians and other providers are forced to prioritize by attending to patients who can pay so that they can subsidize those who can't. But as increasingly fewer people can afford coverage, it will become more difficult for physicians to accept patients without insurance. "Cross-subsidies that the uninsured now enjoy would be squeezed, and it would give the state of being uninsured a whole new and terrifying meaning."

Others argue that covering everyone without first dealing with the rising cost of health care would aggravate existing problems. "Getting the fundamental cost drivers under control is a necessary precondition for covering the uninsured. If we don't do that, no system we design today will be affordable tomorrow," said Dr. Baicker.

Dr. Aaron pointed out that such differences in perspective are reflected in the diversity of proposals that are on the table, which is why it may be necessary to try reforms at state rather than the national level.

"We are not—let's be honest here—on the verge of a national consensus about which of those models will work, and we are not close to the prospect of being able to get 60 votes in the Senate and a presidential signature," he said. "Health care financing is too vast to be remade in a single bill. It will come gradually and over time." ■

POLICY & PRACTICE

Mich. Derm Faces Jail Time

A Michigan dermatologist has been found guilty of defrauding Medicare and a Blue Cross Blue Shield plan. Dr. Robert W. Stokes of Grand Rapids, Mich., faces up to 10 years in prison for his conviction on 31 counts of health care fraud. The U.S. Attorney for the Western District of Michigan alleged that Dr. Stokes was upcoding surgical procedures and then billing for follow-up visits for post-operative infections that did not exist. Dr. Stokes came to the attention of federal authorities through patient complaints and audits conducted by Medicare and Blue Cross Blue Shield of Michigan. The Health and Human Services Department's Office of Inspector General and the Federal Bureau of Investigation conducted the inquiry into Dr. Stokes' billing practices and estimated that he fraudulently charged at least $500,000. Dr. Stokes has agreed to cease the practice of medicine, but has not been sentenced yet. His attorney, Mark Kriger of LaRene and Kriger in Detroit, said in an interview that his client had no fraudulent intent and will appeal the conviction.

Medicis Settles With Feds

Medicis Pharmaceutical Corp. of Scottsdale, Ariz. has agreed to pay the U.S. government $9.8 million to settle allegations that it illegally promoted Loprox (ciclopirox) as a diaper rash treatment. Loprox is not approved by the Food and Drug Administration for skin disorders in children under age 10 years. The settlement is the result of a whistle-blower complaint by four former Medicis sales representatives, who, as a result, will get a portion of the settlement. They alleged that from 2001 to 2004, Medicis representatives targeted pediatricians in an attempt to get them to prescribe Loprox for diaper rash. The case was jointly investigated by the FDA and the Kansas Attorney General's office. Medicis says "the alleged off-label promotion" was by its former pediatric sales division, which it divested in 2004. "Medicis confronted this situation head on and fully cooperated with the government, consistent with the company's strong commitment to compliance and integrity," said company general counsel Jason Hanson in a statement.

Top Ten Questions on Injectables

Safety is a top concern about the use of injectable treatments among women aged 25 years and older, according to a survey by Harris Interactive commissioned by the National Women's Health Resource Center (NWHRC) and Allergan Inc. About 1,300 women were queried by Harris in early April. After safety, respondents' next nine questions were about cost, whether results would look natural, duration of treatment and length of the procedure, insurance coverage, whether there would be pain, scarring, bruising or other side effects, and finally, if facial expressions would still be possible after treatment. The survey is part of a joint Allergan-NWHRC campaign to educate women on injectable treatments; fuller results will be released later this summer. The not-for-profit, independent NWHRC develops and distributes objective women's health information based on the latest advances in medical research and practice, according to its Web site.

IVIG Pay, Access Issues Confirmed

Two new reports from HHS confirm that Medicare payments for intravenous immune globulin (IVIG) are severely lagging behind price increases from manufacturers, making it difficult for hospitals and physicians to offer the therapy. In an April report, the HHS Inspector General found that in the third quarter of 2006, 56% of hospitals and 59% of physicians bought IVIG at prices below the Medicare reimbursement amount, which means they were able to marginally profit on the therapy. But that means that 44% of hospitals and 41% of physicians paid more for IVIG than Medicare reimbursed, said Marcia Boyle, president of the Immune Deficiency Foundation, in an interview. Further, the Inspector General found that a majority of physicians and hospitals were underpaid by Medicare relative to IVIG price for the first half-quarters of the year. Medicare acknowledged that the market was fragile, due to tight supplies and price increases and that physicians in hospitals would face the same crisis this year that they did last.

Debridement Restrictions Lifted

The American Academy of Family Physicians said it has succeeded in its drive to remove restrictive language from a Medicare carrier's draft local coverage determination on wound care. The restriction would have affected physicians in Texas, Delaware, Maryland, and Virginia. Last December, AAFP questioned TrailBlazer Health Enterprises' proposed debridement limits of three times for one wound. AAFP said that although repetitive debridement of one wound is uncommon, sometimes, serial debridement is the only option. TrailBlazer removed the restrictions from its final policy, released in April.

Juries Side With MDs

Juries in malpractice cases sympathize more with physicians and less with their patients, according to an extensive review of studies involving malpractice cases from 1989 to 2006. Philip Peters, of the University of Missouri–Columbia School of Law, found that plaintiffs rarely win weak cases, although they have more success in cases viewed as a "toss-up" and better outcomes in cases with strong evidence of medical negligence. Mr. Peters, whose study appeared in the May edition of the Michigan Law Review, said that several factors systemically favor medical defendants in the courtroom, including the defendant's superior resources, physicians' social standing, social norms against "profiting" by injury, and the jury's willingness to give physicians the benefit of the doubt when evidence conflicts.

—Alicia Ault