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New LaCHIP plan insures more children
The Advocate | 07.23.08
By MARSHA SHULER

They work at car dealerships, engineering firms, oilfield supply businesses, government offices and retail stores such as Wal-Mart.

They are among the parents who have enrolled their children in a new state-subsidized health insurance program.

In its first month of existence, the new “Affordable Plan” in the Louisiana Children’s Health Insurance Program, called LaCHIP, has allowed 622 children in moderate income families to get health insurance coverage.

The parents pay a $50 monthly premium — no matter the number of children per household. There are deductibles and co-payments too.

“It’s a pretty good deal,” said Crystal Bob, who recently enrolled her two young children. They have been diagnosed with attention deficit hyperactivity disorders.

“It helps a lot with the doctor visits,” she said.

A co-pay for medicine the children require still exists and costs can get expensive, but it is better than her prior situation, Bob said.

The children had been insured, but when their father died, the family lost coverage, Bob said. “I had not been able to afford health insurance. I was paying out-of-pocket,” said the 31-year-old New Iberia resident.

Bob said she had too much income previously for her children — ages 4 and 6 — to qualify for other government health programs.

Enter the Affordable Plan.

At no cost to parents, traditional LaCHIP covers children in families with incomes up to double the federal poverty level, which is a sliding scale dependent on the number of family members. That’s a $42,400 value for a family of four.

The new plan covers children in families with incomes from double to 2‰ times the federal poverty level and parents must help cover costs. That’s $53,000 for a family of four.

In Bob’s family-of-three situation, it was the difference between incomes of $35,000 to $44,000 annually.

Families cannot drop private insurance coverage for their children and move to the new program under the state guidelines. The idea is to get more children on health insurance.

Today, 771,526 children have health insurance coverage through state Department of Health and Hospitals government-sponsored programs, DHH Secretary Alan Levine said.

Of that, 648,850 children get insurance through traditional Medicaid, the state insurance program for the poor. The remainder are enrolled in LaCHIP — a program launched by the federal government to help low-income working families get health care for their children.

The new subsidized program requiring parental contribution to costs is an off-shoot of LaCHIP.

Information about LaCHIP and its Affordable Plan may be obtained by going to www.lachip.org or by calling (877) 252-2447.

DHH's budget projects the combined programs to add 28,500 more children in the fiscal year that began July 1, Levine said. Of those, 6,500 are projected to be LaCHIP and Affordable Plan members, he said.

"One thing I have been impressed with has been the assertiveness of our programs in getting our children enrolled," Levine said. "I'm proud of what our folks and community partners have done."

But, Levine said, just because a child is enrolled in the programs doesn't guarantee access to care today because of a lack of a sufficient number of pediatric, general practice and specialty physicians that agreed to the reimbursement rates provided by Medicaid.

Levine said his agency is in the process of designing a program to fix that problem with the development of private provider networks of care — similar to insurance plan offerings. Families would be able to choose from at least three plans.

The 622 children enrolled in the new Affordable Plan are involved in an experiment of sorts that for the first time does not require children to see physicians who are enrolled Medicaid providers.

The children, who are from 412 families, are covered through the state's Group Benefits insurance program. Group Benefits is Louisiana's insurance program for state employees, retirees and others.

Sandra Adams, director of the Louisiana Maternal and Child Health Coalition, said she is "pleasantly surprised that the numbers are that high for the first month of enrolment" in the new Affordable Plan.

But Adams said the program brings with it disparate treatment.
"It gives children access to private providers who have never been willing to accept Medicaid," Adams said. "You are adding a category of some higher income families who, although they are participating in costs, get access to providers who have never been available."

Adams said Levine continues to say he is concerned about access. But, she said, "I don't think he's doing anything to help solve the problem when he creates a new program" that changes the rules on how much physicians are paid.

In addition, Adams said children do not have dental benefits at this point through the Affordable Plan.

http://www.2theadvocate.com/news/25787629.html

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N.O.-area hospitals bleeding red ink, federal report says
The Times-Picayune | 07.19.08
By Bruce Alpert
Washington bureau

WASHINGTON -- The five major New Orleans area hospitals lost a combined $386.8 million between 2005 and 2007, and still face major financial hurdles despite lower losses projected in 2008, according to a congressional report released Friday.

Some hospital executives said they hope the Government Accountability Office report will persuade Congress to approve a stalled $350 million package intended to help hospitals in Louisiana and Mississippi deal with continuing post-Katrina cash-flow problems. The five New Orleans area hospitals would combine to receive $135 million under the package.

The GAO said that operating losses for the five hospitals totaled $212.5 million in 2005 -- the year Katrina hit -- dropped to $28.7 million in 2006 when some of the hospitals were struggling to reopen; shot back up to $145.6 million in 2007 and are projected to be about $103 million in 2008.

It also said that the reduced losses projected for this year aren't a sign of improving financial health because four of the five hospitals reported a decline in assets, meaning they are using the assets to pay for operating costs.

"We've been living off our savings accounts, assets that we've saved over the years," said Lawrence Van Hoose, senior vice president of Ochsner Health Systems. "We can't continue to do that."

GAO broke down the losses for the five hospitals:

-- Tulane University Hospital and Clinic lost $42.6 million in 2007 and is projected to lose another $37.6 million in 2008;

-- Touro Infirmary lost $36.4 million in 2007 with a projected loss of $15 million in 2008;

-- West Jefferson Hospital lost $5.8 million in 2007, and is likely to lose $3.5 million in 2008;

-- East Jefferson Hospital lost $29.6 million in 2007 and projects a loss of $23.9 million this year;

-- Ochsner Health Systems lost $31.6 million in 2007 and is projected to lose $23 million in 2008.

The GAO said three of the five hospitals lost money in the year before Hurricane Katrina, but far less than they did after the hurricane.

The post-Katrina financial problems are caused, in part, by the higher salaries being paid key personnel because of the shortage of nurses and physicians, the GAO said.

The GAO report had been requested by the leaders of the House Energy and Commerce Committee after hospital administrators testified last year that they couldn't sustain their operating losses much longer.

The Senate included the hospital bailout package in an emergency war supplemental spending bill last month. But the funds were stripped out following negotiations between House leaders and the White House.

Sen. Mary Landrieu, D-La., and other Louisiana lawmakers have vowed to try to get the financing approved as part of another emergency spending bill Senate and House leaders hope to take up in September.

Dr. Robert Lynch, CEO of Tulane University Hospital and Clinic, said Tulane is trying to cut costs as best as possible, but the report shows that federal help is required if area hospitals are to meet the growing medical needs as more people return from the devastation of Katrina.

None of the hospitals will discuss what specific cutbacks might result if the federal financing is not forthcoming.

http://www.nola.com/timespic/stories/index.ssf?/base/news-2/121644493751980.xml&coll=1.

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Tough Times Prompt Patients to Skip Care
The Wall Street Journal | 07.23.08
By BENJAMIN BREWER, M.D.

With gas prices hovering around $4 a gallon, my patients are cutting back on medical care.

A 59-year-old woman decided not to have a mammogram this year. At her age, she should be screened for colon cancer, too, but she is holding off until she becomes eligible for Medicare at 65.

Despite having some medical insurance as a self-employed cleaning woman, she is pinching pennies by scrimping on preventive care. If she develops cancer of the colon or breast she won't have saved anything. This year she is taking her chances.

Rising deductibles, stiff drug co-payments and increasing prices for just about everything are forcing some hard choices about health. Care that doesn't strike patients as critical is getting delayed. As the economy squeezes my patients, they are showing up sicker.

A patient quit smoking so he could afford gas for the 40 mile commute to work in a packaging plant. He has been living paycheck to paycheck for years and his rent just went up. I was glad that something finally motivated him to stop smoking.

The bad news was that he came to the office with severe pneumonia two days after refusing to let an E.R. doctor admit him to the hospital. My patient was afraid of the expense and all the time he would go without pay from work.

To make matters worse, he didn't fill the antibiotic prescription he was given either. The $50 co-payment was unaffordable, he said. This is a case when an insurer would have been better off picking up the antibiotic tab to avoid a larger expense. But there's no easy way for a doctor to override a plan's co-pay or to let an insurer know its rules are about to make something very expensive happen.

When the patient came to see me, his condition had deteriorated. I persuaded him to let me admit him to the local hospital. He was in such bad shape that he was soon transferred to the ICU of a large medical center. His care will end up costing tens of thousands of dollars.

It was no surprise to me to read recently that claims severity and costs for health insurers took an unexpected jump this year. Many patients are not able to bear even a moderate expense to save their insurance companies the cost of major claims.

A 53-year-old patient couldn't avoid a trip to see me when his finger was fractured in a log splitter. After X-rays and having his fingertip sutured together, the man required several trips to the office for dressing changes and monitoring for infection.

He's been unable to work as a laborer in the month since he got hurt. With no money coming in, he's racked up $200 in office co-payments for visits that his insurance won't be covering. We're carrying his balance until he can get back to work.

He isn't the only one in arrears. As a result of lean times, accounts receivable from uninsured patients in my practice is trending up. About 5% of our patients are uninsured.

Patients are still having babies at the same rate. But elective procedures, preventive exams and compliance with prescriptions are all down.

Some of my patients are taking themselves off medications. Just last week I encountered patients who stopped their cholesterol medication and urinary incontinence medications. I'm getting fewer refill requests for E.D. drugs, like Viagra, too.

I noticed an uptick in patients canceling appointments and just not showing up over the last few weeks. More people are asking for advice over the phone and trying to avoid an office visit.

Many of our patients travel 20 or 30 miles to see us, and I think gas prices are affecting no-show and cancellation rates, particularly with low income patients.

My total number of office visits is off 5% from last year. Another indication of the slowdown is that I'm getting my nursing home rounds done. I'm pretty well caught up on my daily deluge of paperwork, too. When things are busy, I almost never get those things accomplished.

It occurred to me in an idle moment that I would be a lot busier if the $600 government stimulus checks had been spent on a basket of basic primary care services. That would have paid for 130 million people to have had most of their health needs met for a year. Instead, folks around here seem to be spending more on $4 gas.

http://online.wsj.com/article_print/SB121675678304374527.html

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Foreign-born TB cases need better control, US says
The Times-Picayune | 07.23.08
By LINDSEY TANNER
The Associated Press

CHICAGO (AP) — Tuberculosis cases continue to fall in the United States, but some immigrants have disturbingly high rates of the disease, according to a study released Tuesday that called for more aggressive action.

TB rates were highest among residents from lower Africa and parts of Southeast Asia. Most drug-resistant TB cases also were from foreign-born residents, the study noted.

The researchers called for wider testing, including efforts to seek out latent cases of TB from long-term immigrant residents in certain populations.

Rates of at least 250 TB cases per 100,000 were found among people from African countries such as Ethiopia, Kenya and Somalia and from Southeast Asian nations including Vietnam, Cambodia and the Philippines.

By comparison, the overall rate of TB in the U.S. is fewer than 5 per 100,000, according to researchers at the Centers of Disease Control and Prevention, whose study is based on data from 2001-06. Their findings are being published in Wednesday's Journal of the American Medical Association.

Dr. Henry Blumberg of Emory University's medical school, said the research shows "that it's in the interest of the United States to try to enhance global TB efforts."

Of those infected, drug-resistant TB was found in 20 percent of recent immigrants from Vietnam and 10 percent of foreign-born residents overall, compared with a little more than 4 percent of U.S.-born residents.

Public health officials worry that drug-resistant TB could become a worldwide scourge because of global travel and immigration. The issue made headlines last year when an Atlanta attorney with drug-resistant TB flew to several countries. Tests later showed he did not infect anyone on those flights.

U.S. law requires TB screening for people who want to immigrate to the United States, said the CDC's Dr. Kevin Cain, the study's lead author.

Another step that would help curb the rise of tuberculosis, he said, would be to find and treat latent TB infections. He said the study helps identify which foreign-born groups would be most appropriate for such an effort.

While most TB cases come from recent arrivals, a significant number involve people who have lived in the United States for at least 20 years, the study authors said. Most of these likely resulted from latent infections acquired years earlier abroad, they wrote.
Latent, non-contagious infections mean germs are present but the body is able to fight off symptoms. Latent infections can morph into active disease, causing contagious illness, at any time, particularly as people age and their immune systems weaken.

Latent infections are detected with skin tests and treated with nine months of antibiotics. Foreign-born U.S. residents aren't routinely tested for latent TB. And with more than 37 million foreign-born people living in the United States, giving all of them skin tests "would be daunting to say the least," Cain said.

http://www.nola.com/newsflash/index.ssf?/base/national-9/121677204723170.xml&storylist=health

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Health Plan From Obama Spurs Debate
The New York Times | 07.23.08
By KEVIN SACK

Rick Friedman for The New York Times

David M. Cutler, an adviser to the Obama campaign.

It is one of the most audacious promises in a campaign that has been thick with them.

In speech after speech, Senator Barack Obama has vowed that he will lower the country's health care costs enough to "bring down premiums by $2,500 for the typical family." Moreover, Mr. Obama, the presumptive Democratic nominee, has promised that his health plan will be in place "by the end of my first term as president of the United States."

Whether Mr. Obama can deliver is a matter of considerable dispute among health analysts and economists. While there is consensus that the American health care system is bloated with waste, eliminating enough to save $2,500 per family would require simultaneous and synergistic solutions to a host of problems that have proved intractable for decades.

Even if the next president and Congress can muster the political will, analysts question whether significant savings would materialize in as little as four years, or even in 10. But as Mr. Obama confronts an electorate that is deeply unsettled by escalating health costs, he is offering a precise "chicken in every pot" guarantee based on numbers that are largely unknowable. Furthermore, it is not completely clear what he is promising.

His words about lowering "premiums" by $2,500 for the average family of four have been fairly consistent. But the health policy advisers who formulated the figure say it actually represents the average family's share of savings not only in premiums paid by individuals, but also in premiums paid by employers and in tax-supported health programs like Medicare and Medicaid.

"What we're trying to do," said one of the advisers, David M. Cutler, in explaining the gap between Mr. Obama's words and his intent, "is find a way to talk to people in a way they understand."

The original arithmetic was somewhat basic. In May 2007, three Harvard professors who are unpaid advisers to the Obama campaign — Mr. Cutler, David Blumenthal and Jeffrey Liebman — produced a memorandum offering their "best guess" that a menu of changes would produce savings of at least $200 billion a year (it has since been revised to $214 billion). That would amount to about 8 percent of the $2.5 trillion in health care spending projected for 2009, when the next president takes office.

The memorandum attributed specific savings to several broad initiatives, with the numbers plucked from recent studies. Investments in computerized medical records would save $77 billion a year, the advisers wrote. Reducing administrative costs in the insurance industry would yield up to $46 billion. Improving prevention programs and chronic disease management would be worth $81 billion.

The total savings were then divided by the country's population, multiplied for a family of four, and rounded down slightly to a number that was easy to grasp: $2,500. The average cost of family coverage

bought through an employer was $12,106 in 2007, with workers paying $3,281 of that amount, according to the Kaiser Family Foundation, a health research group.

Mr. Obama aspires to cover the country's 47 million uninsured by requiring insurers to accept all comers, regardless of their health status, and by providing generous tax credits to low-income workers. The tax credits could be used to buy into a new federal health plan or private plans marketed through a government exchange.

The subsidies are expensive, estimated at well over $100 billion. Other components of the Obama plan also bear up-front costs, like a pledge to spend $50 billion over five years to speed the computerization of health records, $6 billion a year on tax credits to small businesses that provide coverage to workers, and an unspecified amount to buffer businesses from high-cost insurance claims.

The source Mr. Obama has identified to pay for them — the repeal of President Bush's tax cuts for those making more than $250,000 — would cover only about half. That means additional health care savings would be needed, not only to keep premiums under control but also to help pay for the subsidies.

A consensus has emerged among health economists that at least a third of the country's spending on health care is unnecessary. Both Mr. Obama, of Illinois, and his Republican rival, Senator John McCain of Arizona, agree that significant sums could be saved through reductions in unneeded procedures and improvements in electronic record-keeping, prevention and chronic disease management.

But the dollar values Mr. Obama has attached to individual components of his plan are beginning to attract scrutiny. In particular, the Congressional Budget Office issued a report in May questioning the amount to be saved from the computerization of health systems.
Mr. Obama took his estimate of $77 billion a year from a 2005 study by the RAND Corporation (which cautioned that reductions of that magnitude would not emerge for 15 years). The Congressional analysts found, however, that for various methodological reasons the RAND study was "not an appropriate guide" to potential savings.

This month, Mr. Obama's health advisers tried to recast the debate so that the questioning of any one number would not undermine the plan's broader credibility. They enlisted eight health policy experts to sign a letter that, without endorsing the math behind any single initiative, proclaimed it was "not only possible, but likely" that Mr. Obama could save $200 billion annually. They did not say by when.

Mr. Cutler, who helped collect the signatures, said he and his colleagues had decided "that our attempt to lay out one plausible scenario for the savings had created more problems than it had solved." He added: "Putting the debate where this message puts it — do you believe we can save 8 percent of health spending through a major series of public and private reforms — asks the question in a way that is much more productive than the issue of 'Do you believe a single estimate among many, many studies?' "

Mr. Obama's economic policy director, Jason Furman, said the campaign's estimates were conservative and asserted that much of the savings would come quickly. "We think we could get to $2,500 in savings by the end of the first term, or be very close to it," Mr. Furman said.

The campaign won additional backing this week from Kenneth E. Thorpe of Emory University, an authority on health care costs who helped formulate Bill Clinton's failed plan in 1993. In an assessment that he initiated in coordination with the campaign, Mr. Thorpe wrote that if all of Mr. Obama's proposals were enacted they would reduce health spending by between $203 billion and $273 billion by 2012. He calculated that half of the savings would accrue to the federal government.

The Obama advisers said that while not all of the savings would translate into lower premiums, consumers would gain in other ways. The savings to employers would be passed along as higher wages, they predicted, and the savings to government would eventually mean either lower taxes or added benefits.

But whether employers and governments respond that way cannot be guaranteed, particularly in a difficult economy. And a number of health policy experts have questioned whether the $2,500 projection is either fiscally or politically realistic. Reducing health care costs, they emphasized, means taking money

from someone's pocket and rationing care that Americans have come to expect, a recipe for stiff resistance.

"There is no easy money because, as the saying goes, one person's fraud and abuse is another person's income," said Joseph R. Antos of the American Enterprise Institute. "I wouldn't think that four years or eight years or probably 10 years will be enough to see numbers of that sort."
The Commonwealth Fund, a health research group in New York, published a study in December projecting that a robust overhaul consisting of 15 broad initiatives would generate savings of only 6 percent after 10 years. "Doing it by the end of a first term is ambitious and would require tough policies," said Karen Davis, the group's president.

Jonathan B. Oberlander, who teaches health policy at the University of North Carolina at Chapel Hill, called it wishful thinking. "Do they have the potential to generate significant savings in the long run?" Dr. Oberlander asked. "Yes. Do I believe they will produce substantial savings in the short run that can be used to finance Obama's plan? No."

http://www.nytimes.com/2008/07/23/us/23health.html?adxnnl=1&adxnnlx=1216818820-+GkMnjeV1H8gJFFJWqhq5g

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Veto Seems More Likely in Battle Over Tobacco Bill
The New York Times | 07.23.08
By STEPHANIE SAUL

Denis Balibouse/Reuters

In a letter, Michael O. Leavitt, the secretary of health and human services, said a smoking bill could overextend the F.D.A.

In its sharpest criticism yet of the tobacco legislation pending in Congress, the Bush administration has said it “strongly” opposes the effort to give the Food and Drug Administration regulatory authority over tobacco.

The criticism came Monday in a letter by Michael O. Leavitt, the secretary of health and human services, which some saw as a signal that a veto would be likely if the legislation cleared the House and Senate.

The letter was sent to Joe L. Barton of Texas, the highest-ranking Republican member of the House Energy and Commerce Committee, which approved the bill in April. Mr. Barton voted against the bill.

The White House and the F.D.A. commissioner, Dr. Andrew C. von Eschenbach, have previously raised concerns about the legislation. The letter provided the strongest indication yet that the administration would try to block the bill.

The proposal has broad support in the House but, in the Senate, it is believed to be three votes short of a majority sufficient to override a veto. The House could vote on the measure as early as this month.

In the letter, Mr. Leavitt said his department supported efforts to encourage adults who smoke to quit and to keep children from starting, and he said the department would spend $680 million toward those ends in 2008.

But he said the administration had “serious concerns” that the bill could overload the F.D.A. by piling on “significant added responsibility” that is inconsistent with the agency’s mission of ensuring the safety of food, drugs and medical devices.

The new regulations included in the bill may cost more to impose than the bill raises in revenues through user fees and taxes, the letter said.

“This could result in diverting personnel and resources from current programs within the F.D.A., with the potential to seriously undermine the public health,” the letter said.

Furthermore “adding tobacco to F.D.A.’s regulatory responsibilities could also leave the public with the misperception that tobacco products are safe, or at least safer, with the F.D.A. regulating them,” the letter said, predicting a “perverse and unintended consequence of lowering the perceived risk of tobacco.”

The legislation has the support of the nation’s largest cigarette company, Philip Morris USA, but most other cigarette makers oppose it.

The letter also raises new questions about the bill’s treatment of menthol cigarettes.

The bill would ban candy, fruit and spice-flavored cigarettes, including clove cigarettes, but menthol cigarettes would be exempt from the ban. Menthol cigarettes make up 28 percent of the United States cigarette market.

Indonesia, which exports a clove-flavored cigarette called kretek, has objected to the favorable treatment of menthol over other flavorings, Mr. Leavitt said. "The government of Indonesia has repeatedly objected to the bill on the ground that this disparate treatment is unjustified and incompatible with W.T.O. trade rules," Mr. Leavitt wrote, in reference to the World Trade Organization.

In voicing concern about the menthol exemption, the administration finds itself on the side of black antismoking advocates who have criticized the bill.

Menthol cigarettes are chosen by about 75 percent of black smokers. Researchers have long worried that menthol may play a role in the disproportionate diagnosis of smoking-related cancers among blacks, possibly by masking tobacco's harsh taste, and some research suggests that menthol smokers find it more difficult to quit.

Supporters of the bill have said that, although menthol is exempt from the ban on flavorings in the bill, the F.D.A. would have the power to limit or ban menthol if it is proved harmful. Some members of the Congressional Black Caucus have said they would press for a floor amendment of the bill to impose additional restrictions on menthol cigarettes or require a study of them.

http://www.nytimes.com/2008/07/23/business/23tobacco.html?_r=1&oref=slogin

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UnitedHealth Beats Wall St. Expectations
The New York Times | 07.23.08
By THE ASSOCIATED PRESS

The UnitedHealth Group beat Wall Street expectations on Tuesday, and its shares rose despite a sharp drop in second-quarter profit.

Shares of the health insurer and managed-care provider, based in Minneapolis, rose $2.38, or 10 percent, to $26.21, and shares of other publicly traded health insurers like Aetna and WellPoint also jumped several percentage points.

“The worst case didn’t happen to managed care, and that was enough for people to jump back in,” said an analyst, Les Funtleyder, of Miller Tabak & Company. “The assumption is the worst is over.”

UnitedHealth’s net income fell to $337 million, or 27 cents a share, from $1.23 billion, or 89 cents a share, a year ago. Hefty lawsuit settlements and thinner margins in its health care services business contributed to the profit drop.

Tough economic conditions, including competition as fewer employers offer insurance, were among factors cited by company officials in a conference call with analysts.

In the company’s UnitedHealthcare segment, second-quarter membership decreased less than 1 percent, partly because of a drop of 95,000 people in risk-based programs where the company provides the insurance.

Earnings from operations in UnitedHealth’s main business line, health care services, fell to $1.14 billion, from $1.75 billion.

http://www.nytimes.com/2008/07/23/business/23insure.html?ref=health

Drug Firm's Profit Surpasses Estimates
The New York Times | 07.23.08
By REUTERS

Biogen Idec reported a higher-than-expected second-quarter profit on Tuesday as sales of its closely watched multiple sclerosis drug Tysabri surged past Wall Street estimates.

The company, which this month fended off the activist investor Carl C. Icahn in his attempt to place three hand-picked candidates on the board, posted a net profit of $206.6 million, or 70 cents a share, compared with $186.1 million, or 54 cents a share, in the period a year earlier.

Excluding items, Biogen earned 91 cents a share, beating analysts' average expectations by 6 cents.

Revenue for the quarter jumped 28 percent, to $993.4 million, topping Wall Street estimates of $962.6 million.

Shares of Biogen were up 6.6 percent, or $4.43, to $71.28.

http://www.nytimes.com/2008/07/23/business/23biogen.html?ref=health

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Widespread Adoption of E-Prescribing Could Save U.S. $156M Over Five Years, Reduce Drug-Related Error Injuries, HHS Secretary Leavitt Says
Kaiser Network | 07.23.08

HHS Secretary Mike Leavitt on Monday discussed the details of an electronic prescribing incentive program scheduled to begin on Jan. 1, 2009, that will increase Medicare payments to physicians who adopt the technology, the AP/Chicago Tribune reports. The e-prescribing initiative was included in a new Medicare law that delays a 10.6% reduction to Medicare physician payments. Congress last week overrode a presidential veto of the legislation. Leavitt said widespread adoption of e-prescribing could save taxpayers as much as $156 million over five years, as well as reduce the 1.5 million injuries caused by drug-related errors annually (Freking, AP/Chicago Tribune, 7/21).

Under the law, physicians who adopt e-prescribing technology in 2009 and 2010 will receive a 2% bonus in their Medicare payments; those who use the technology in 2011 and 2012 will receive a 1% bonus; and those who use it in 2013 will receive a 0.5% bonus (Kornblum, USA Today, 7/22). Medicare payments for physicians who do not use the technology will be reduced by 1% in 2012, 1.5% in 2013 and 2% in 2014. Some health care providers will be exempt from the requirements (AP/Chicago Tribune, 7/21).

Acting CMS Administrator Kerry Weems said the initial expense for each physician to adopt the technology is about $3,000, with additional monthly costs of between $80 and $400 to operate and maintain the electronic systems.

Conference
Weems also discussed preliminary plans for a conference that will be held this fall to address what physicians need to do to participate in the e-prescribing program. The conference will address issues such as the technological options available to physicians to qualify for the Medicare payment bonuses, as well as how those payments would fit together with bonuses from the Physician Quality Reporting Initiative. Weems said physicians who adopt e-prescribing technology and participate in the quality reporting program would receive Medicare payments that are 4% higher in 2009 -- a 2% bonus for e-prescribing and a 2% bonus for reporting quality measures.

Weems indicated that further details about how the programs could overlap would be addressed at the conference. He said the conference will be a "bully pulpit" to spur nationwide adoption of the technology.

Comments
In a statement issued on Monday in response to the Medicare e-prescribing requirement, Scott Serota, CEO of the BlueCross and BlueShield Association, said that "this new e-prescribing requirement will likely have repercussions that extend far beyond Medicare." Serota said, "As a purchaser of health care services for more than 44 million Americans, Medicare's e-prescribing requirement is likely to encourage use of e-prescribing and other health information technology among others, including: Fortune 500 employers, small businesses, labor unions and other public programs" (Reichard, CQ HealthBeat, 7/21).

James King, president of the American Academy of Family Physicians, said, "It is fairly costly for a small practice to begin the change-over to e-prescribing, so the incentives in this particular bill will help" (AP/Chicago Tribune, 7/21). However, he said that some barriers still must be lowered to encourage widespread adoption of the technology, adding that not all pharmacies have adopted e-prescribing, some drugs cannot be prescribed electronically and some medications cannot be prescribed across state lines (CQ HealthBeat, 7/22).

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CMS Proposal Would Limit Industry Practice That Raises Costs for Some Medicare Drug Plan Beneficiaries
Kaiser Network | 07.22.08

A CMS proposal under consideration would limit a practice used by pharmacy benefit managers known as "lock-in pricing" that can increase costs for beneficiaries enrolled in the Medicare drug benefit and bring them into the so-called "doughnut hole" coverage gap more quickly, the Wall Street Journal reports. The doughnut hole begins when total annual drug spending by beneficiaries and their health insurers reaches $2,510. When in the doughnut hole, a beneficiary is responsible for 100% of prescription drug costs until total spending reaches $5,726 for the year.

Under lock-in pricing, PBMs charge a higher rate to insurers with whom they have contracted to administer their drug benefit than what they pay pharmacies to dispense the drugs to beneficiaries, according to the Journal. The PBMs then keep the difference.

Beneficiaries can reach the doughnut hole faster under lock-in pricing because the insurer is charged more than a drug's actual cost, increasing total annual spending more quickly. According to the Journal, the proposal would mitigate that effect by requiring insurers to break down PBM payments into two rates: the cost of the drug and an "administrative" cost. The administrative cost would be the difference between a PBM's drug price and the insurer's payment. The proposal would not ban lock-in pricing.

CMS estimates that about 19% of drug benefit plans are using lock-in pricing. The agency says the practice affects about 14% of the 25.8 million beneficiaries enrolled in the drug benefit program. According to the Journal, the price difference from using lock-in pricing is much higher for generic drugs than brand-name drugs.

The Journal reports that CMS officials have been attempting to counter the effect of lock-in pricing almost since the inception of the Medicare drug benefit. Abby Block, director of the Center for Drug and Health Plan Choice at CMS, said that the agency thought lock-in pricing was prohibited when the drug benefit was created. "We thought we had a clear policy," Block said, adding, "We learned that there are different ways of interpreting a policy statement." CMS plans to make a final rule later this summer that would go into effect in 2010.

PBMs, Insurers Defend Practice
According to the Journal, some PBMs defend lock-in pricing, saying that it is common in the private insurance market and that they use the extra money to encourage beneficiaries to use less expensive drugs. Some insurers say they will be forced to increase premiums if they are not permitted to add the extra charge to plans' total annual drug spending, the Journal reports. Steve Littlejohn, a spokesperson for the PBM Express Scripts, said the company's overall per-prescription profit margin from using lock-in pricing is a "single digit" percentage. He also said that the company's pricing on generics "is generally far better than (uninsured) cash-paying customers obtain on their own" (Rubenstein, Wall Street Journal, 7/22).

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Medicare to Pay Bonuses for 'E-Prescribing'
Washington Post | 07.21.08
By Steven Reinberg

MONDAY, July 21 (HealthDay News) -- Starting next year, doctors can earn additional money from Medicare if they use electronic prescribing systems, U.S. health officials said Monday.

The bonus program, which will continue for four years, is designed to streamline the prescription process and cut down on errors. In 2009 and 2010, Medicare will give doctors an additional 2 percent bonus on top of their fee for "e-prescribing." In 2011 and 2012, the bonus will drop to 1 percent, and in 2013, the bonus will drop again to 0.5 percent, officials said.

"There are terrific human and financial costs to illegible prescriptions," Mike Leavitt, secretary of the U.S. Department of Health and Human Services, said during a Monday afternoon teleconference.

According to the Institute of Medicine, 1.5 million Americans are injured every year by drug errors, Leavitt said. Another study found that each year pharmacists make more than 150 million phone calls to doctors to clarify what was written on the prescription, he added.

"That's a lot of people needlessly hurt and a lot of time spent trying to sort out bad handwriting," Leavitt said.

"E-prescribing will help deliver safer or more efficient care to patients," Leavitt said. He noted that the law that set up the Medicare prescription drug program in 2006 mandated that participating pharmacies be able to accept e-prescriptions.

After five years, bonuses for e-prescribing will be phased out; doctors who haven't adopted e-prescribing will be reimbursed at lower rates, Leavitt said. There will, however, be exceptions for doctors who have legitimate reasons for not complying.

"We expect this will have a profound effect on the adoption and use of e-prescribing," Leavitt said.

Medicare started paying bonuses to doctors last year for using the Physician Quality Reporting Initiative, which collects data on the quality of care delivered by doctors. Medicare recently paid the first bonuses to more than 56,000 doctors, totaling more than $36 million. Payments ranged from $600 for individual doctors to $4,700 for group practices.

The new bonuses for e-prescribing will be on top of those paid as part of the Physician Quality Reporting Initiative and other Medicare reimbursements. Medicare expects to save up to $156 million over the life of the e-prescribing program in fewer adverse drug events.

Despite the advantages of e-prescribing, barriers to implementing such systems remain. One of the largest barriers is the cost.

"It is fairly costly for a small practice to begin to change over to e-prescribing," Dr. James King, a family physician in Tennessee and president of the American Academy of Family Physicians, said during the teleconference. "These incentives will help."

It's estimated that it will cost about $3,000 per doctor to initiate an e-prescribing system. It also takes between $80 and $400 a month to maintain and operate a system, Kerry Weems, acting administrator of the U.S. Centers for Medicare & Medicaid Services, said during the teleconference.

Other barriers include state laws that prohibit e-prescribing across state lines, King said. And, there are areas in the country where computer systems are slow and inefficient, he said.

More information

For more on electronic medical records, visit the American Medical Association.

http://www.washingtonpost.com/wp-dyn/content/article/2008/07/21/AR2008072102035.html

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AHA expresses support for SCHIP legislation
AHA News | 07.22.08

The AHA today expressed strong support for legislation (S. J. RES. 44), introduced by Sens. Jay Rockefeller (D-WV) and Max Baucus (D-MT), that would nullify an August 2007 directive issued by the Centers for Medicare & Medicaid Services regarding the State Children's Health Insurance Program.

The directive, which was not subject to the rulemaking process, requires states to enroll 95% of children in families with incomes up to 200% of the federal poverty level before expanding coverage to children in higher-income families.

The Senate Finance Committee is expected to mark up the legislation tomorrow. "These new requirements – which are almost impossible to achieve – will directly affect the 23 states that already cover or have authorized expansions for children living in families with incomes above 250% of the FPL," the AHA said in a letter to members of the Finance Committee.

"Further, it will limit states' opportunities to expand their programs at a time of economic downturn, when more and more children will come to rely on public health care coverage."

http://www.ahanews.com/ahanews_app/jsp/display.jsp?dcrpath=AHANEWS/AHANewsNowArticle/data/ann_080722_SCHIP&domain=AHANEWS

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Transparency Law Empowers Consumers
Louisiana Medical News | 07.23.08
TED GRIGGS

Gary Curtis, Louisiana Health Care Review Inc.
A new state law moves Louisiana a step closer to healthcare transparency and gives consumers information that can help them choose providers and insurers.

The Louisiana Consumers' Right to Know Act was a key piece of Gov. Bobby Jindal's healthcare legislative package. The law, according to Department of Health and Hospitals Secretary Alan Levine will give residents an independent source of "clear and relevant information" about providers' costs, quality and performance.

"By making the outcomes of healthcare providers transparent to consumers, this bill will help improve quality, strengthen competition and ultimately reduce healthcare costs in our state," Levine said in a prepared statement.

The legislation is the latest effort to help consumers make informed healthcare decisions, said Gary Curtis, chief executive officer of Louisiana Health Care Review Inc., a quality improvement group.

The new law calls for DHH to post the information online. The DHH site will eventually join the CMS site, www.hospitalcompare.hhs.gov, which provides Medicare procedure data; and the Louisiana Hospital Association's site, LouisianaHospitalInform.org, which includes information from nearly all of the group's members.

It's too early to say just how big a leap the right-to-know legislation represents, Curtis said. But the law speaks to how Gov. Bobby Jindal, Levine, the Legislature and lots of interest groups came together to say that healthcare information is going to be transparent in Louisiana.

"And that's a statement that's never been effectively put forth," Curtis said.

Consumers do have a right to know costs, Curtis said, and that right to know can lead to a richer conversation with providers, which in turn will lead to improved outcomes.

Supporters of consumer-directed healthcare say that transparency is an important part of controlling costs. Without that information, consumers cannot make informed decisions. The proposed Web site will reportedly allow patients to search for information about complications, mortality rates, frequency of bedsores, and post-operative infections.

The real secret to this is making a way for consumers to talk to their providers and ask all the right questions, Curtis said.

Health Care Review director of corporate communications Bob Johannessen said the new law is a step in the process.

"It's like when you go to purchase a car. You don't get all of your information from a Web site. You don't get all of your information from Consumer Reports, and you don't get all of your information from your next-door neighbor," he said. "But all of those are sources where you will get information and you take that information and you combine it, and then you as a consumer have more information at hand to make a good decision."

The cost to create the site is estimated at $2.4 million, according to the Legislative Fiscal Office. The law calls for the initial phase of the Web site to be created by April 30, 2009.

The law was designed to give consumers access to provider-specific costs, quality and outcome data on healthcare facilities, providers and health plans. The Web site is also supposed to provide consumers with information about patterns and trends in the use, availability and charges for procedures.

The legislation also creates the Health Data Panel. The members will be drawn from healthcare purchases, hospitals and other service providers, consumer- and patient-advocacy groups, quality

improvement and health information technology groups, physicians and anyone else the DHH secretary deems necessary.

The Jindal Administration has thrown its support behind other measures to improve healthcare quality and patient outcomes, including the adoption of electronic health records.

An oft-cited study shows that medical errors kill more than 100,000 U.S. residents a year.

Jindal, U.S. Health Secretary Michael Leavitt and other supporters of the technology say electronic medical records could completely transform the healthcare system. The technology's benefits include higher efficiency, cost effectiveness and improved care quality for more patients.

Louisiana was one of a dozen states chosen to participate in a $150 million Medicare pilot program that will help physicians pay for adopting electronic medical records. The program will pay physicians up to $58,000 apiece and physicians practices up to $290,000 over five years.

The physicians will get higher Medicare reimbursements for installing the electronic health record systems, using the technology to report quality measures and to meet quality of care standards.

Leavitt has said the project will take place in two phases. During the first, the Centers for Medicare & Medicaid will work with Louisiana and three other communities to develop recruitment strategies tailored to each community. The actual recruiting of physician practices will begin this fall.

The second phase, with the remaining eight communities, will take place in 2009.

http://acadiana.medicalnewsinc.com/news.php?viewStory=1139

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