

theJeanneScottletter

HEALTH CARE REFORM UPDATE

Update #414
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Jeanne's speaking schedule is filling up and she is now booking into 2009 (topic: *what to expect from the 111th Congress and from President (... fill in the blank ...)*). Catch her at one of these important public events in 2008: Association of Healthcare Internal Auditors, Denver, September 8; Western Medicaid Pharmacy Administrators, San Antonio, September 14; California HFMA Managed Care Conference, Newport Beach, September 16; Michigan Patient Accounting Association, Lansing, September 18; Indiana HFMA, Bloomington, September 25; Michigan HFMA Fall Conference, Plymouth, September 27; Idaho HFMA, Coeur d'Alene, October 6; Iowa HFMA, Des Moines, October 24-25; Tennessee HFMA, Gatlinburg, October 28; Region 9 HFMA, New Orleans, December 4; and Illinois AAHAM, Bloomington, December 5. In addition, Jeanne is in demand for many private conferences, board retreats, sales meetings and political consulting.

HIGHLIGHTS IN THIS ISSUE

HEADLINE NEWS

1. The Number of Uninsured is DOWN, at Least as of the End of 2007
2. But the Cost of Covering the Uninsured is UP, over \$122 BILLION a year
3. Workers With Insurance Still Can't pay Their Bills
4. CM² Braggadocio: Falling Down in the Area of Fraud and Abuse

HIPAA: NOW AND FOREVER

5. Wordsmithing and Coburn: The Result No Federal Support for Healthcare I.T.
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7. "Corrective Action Orders" Fill the Bill, Says the OCR

ELECTION 2008

8. Just What are the Differences Between Obama and McCain?

THE PHARMACY CORNER

9. Medicare Part D: the Donut Hole and Its Impact

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Quotes of the Week

"The U.S. stands out for being the only country ... that reports significant fractions of the population not getting needed care."

-- Commonwealth Fund President Karen Davis, on a new report outlining the growing problem of medical debt as it weighs upon the average American family. [See, Report #3, below]

"We attributed these review discrepancies to the ... contractor's reliance on clinical inference rather than additional medical records available from health care providers, CMS' inconsistent policies regarding proof-of-delivery documentation, physicians' lack of understanding of documentation requirements and CMS's lack of procedures for obtaining information on high-risk DME items from beneficiaries."

-- DHHS Inspector General Daniel Levinson, in a report, heavily criticizing CM² over its "claimed" success in auditing Medicare DME fraud and abuse. [See, Report #4, below]

"I highly urge that the appropriations hearing be held in order to determine the cause of this alleged misreporting."

-- Housecritter Ileana Ros-Lehtinen (R-Fla.) in a letter asking House Oversight and Government Reform Committee Chair Henry Waxman (D-Calif.) to hold hearings on the question as to why CM² claimed far greater success than actually achieved. [Report #4, below]

"We keep wordsmithing and wordsmithing. Health I.T. is so significant and so important that everyone wants their fingerprints on it, and that is delaying the legislation."

-- Senatecritter Mike Enzi, speaking on delays that have tied up a bill that would give new impetus and most importantly funding to building an electronic health record." [See, Report #5, below]

"We have found that [corrective action orders are] the most effective way to obtain industry compliance with the privacy rule."

-- Susan McAndrew, deputy director of health information privacy at DHHS' Office of Civil Rights, says that her office has resolved 6,800 HIPAA complaints through corrective action orders. [See, Report #7, below]

"The Medicare drug benefit has produced tangible relief for millions of people, despite the unusual coverage gap that was created to make the benefit fit within budget constraints. But if a new president and Congress consider changes to the drug benefit, it will be important to keep in mind that the coverage gap has consequences for some patients with serious health conditions."

-- Kaiser Family Foundation President and CEO Drew Altman, commenting on a new study outlining the impact of the Medicare prescription drug benefit program on American seniors.[See, Report #8, below]

HEADLINE NEWS

(1)

U.S. CENSUS BUREAU RELEASES NEW FIGURES ON THE UNINSURED

"[Income, Poverty, and Health Insurance Coverage in the United States: 2007](#)," U.S. Census Bureau: The Census Bureau on Tuesday released findings from the Current Population Survey that show both **the percentage and number of U.S. residents without health insurance decreased in 2007**. The percentage of U.S. residents without health insurance was 15.3% in 2007, down from 15.8% in 2006, and the number of uninsured was 45.7 million in 2007, down from 47 million in 2006. **The percentage of people covered by private health insurance fell from 67.9% in 2006 to 67.5% in 2007, while the share of people covered by public programs such as Medicaid rose from 27% to 27.8%**. ("Income, Poverty, and Health Insurance Coverage in the United States: 2007," August 2008).

Just Between You and Me: *While the numbers were surprising, raising a suggestion in some quarters, that they have been deliberately manipulated to "lessen" the potential impact of a health care "crisis" on November's presidential election, they do not tell the real picture of health insurance in America as of September, 2008. Several major factors have been left out of the 2007 report: (1) the impact of President Bush's late in 2007 veto of an expansion of the State Children's Health Insurance Program (a veto with John McCain's announced support); (2) the impact of 2008 changes in CM² policy and requirements limiting states in expanding S-CHIP and Medicaid in an effort to cover even more children; (3) growing concern among several of the states that Medicaid will have to be curtailed as part of shrinking state budgets and the slowing economy; and (4) increasing numbers of lay-offs and growing national unemployment numbers during the first 8 months of 2008, none of which are included in the Census Bureau's 2007 report.*

Also not surveyed or included, the rising number of UNDERINSURED Americans, forced to opt into high deductible health plans. These people are nominally INSURED, but unable to pay the bill when a sudden illness or accident happens. Recent studies from the Kaiser Family Foundation, Consumers Reports and Families USA, have stressed the growing problem of "underinsurance" and its impact on American families.

Jeanne's Legal Quote of the Week

"Lawyers sometimes tell the truth. They'll do anything to win a case."

-- Attributed to Jeremy Bentham (1748-1832)

(2)

THE UNINSURED: COST TO THEM, COST TO US/U.S., AND COSTS YET UNKNOWN

Uninsured U.S. residents will spend about \$30 billion out-of-pocket on health care this year, while other parties -- mainly the government -- will spend about \$56 billion on uncompensated care for the uninsured, according to a study published online Monday in the journal *Health Affairs*. The report, by Jack Hadley of George Mason University and colleagues, found that government programs -- including Medicare, Medicaid and state and local programs -- pay about 75%, or \$42.9 billion, of the amount uninsured individuals are unable to pay for services received. Some physicians and hospitals also donate time or forgo profit to care for low-income residents, and in some cases private donations cover the costs. **While difficult to assess, some estimates of this uncompensated care raise the total cost of the uninsured -- and indirect tax, being**

paid by all of us in one way or another – to nearly \$123 BILLION annually.

The report defined uncompensated care as the difference between the amount the uninsured paid and how much health care providers would have received if the patients had been privately insured. The report found that the total additional cost to the health system of covering all uninsured U.S. residents in 2008 would be \$122.6 billion, driven by the fact that insured people tend to use more health care services than the uninsured. **Health care spending accounted for 16.3% of gross domestic product in 2007, or about \$2.2 trillion**, and this portion could almost double in 10 years, according to federal data.

Free access to the study, prepared for the Kaiser Family Foundation's Commission on Medicaid and the Uninsured, is available

<http://content.healthaffairs.org/cgi/content/full/hlthaff.27.5.w399/DC1>.

Just Between You and Me: *Over \$120 BILLION in indirect costs associated with the uninsured and even that enormous number, in my opinion, does not tell the true story of the uninsured and underinsured in America. As President Bush said a year ago, in vetoing the S-CHIP expansion, "Every American has access to health care; all they have to do is going to the hospital emergency room!" Yeah right, but who pays for it, Mr. President? Every American is forced to pay this bill – an indirect, but very real tax on each of us, insured or not. It's time to quit fooling around and get serious about health care for every American.*

Jeanne's Lawyer Joke of the Week

Three health lawyers and three hospital accountants got on the train in New York to go to a convention in DC. The three accountants bought a ticket each, but the three lawyers bought only one ticket between them. The accountants commented on the illegality of their action but the lawyers said, "Trust us -- we're lawyers."

When the conductor entered the end of the car to collect the tickets, the three lawyers got up and all went into the bathroom together. When the conductor knocked on the bathroom door, a hand shot out with the one ticket, which the conductor duly canceled.

On returning to their seats the three accountants expressed admiration for such a clever trick.

"Well," they said modestly, "we ARE lawyers."

After the convention they all entered Union Station for the return trip home to New York. This time the accountants bought one ticket between them, while the lawyers did not buy any tickets at all. The accountants were amazed and said so. "Trust us," the three said. "We're lawyers."

When the conductor arrived, the three accountants quickly jumped up and went into the bathroom. As soon as the door closed, the three lawyers got up and headed for the adjoining bathroom. As the last lawyer went by the accountant's bathroom, he knocked on the door. A hand shot out with the ticket, which the lawyer quickly grabbed before entering the other bathroom.

(3)

FORTY PERCENT OF WORKING ADULTS ARE HAVING TROUBLE PAYING FOR THEIR HEALTH CARE

More than 40% of working age adults in the U.S. had difficulty paying medical bills or accumulated medical debt last year, compared with about 33% in 2005, according to a new Commonwealth Fund study. For the study, researchers analyzed data from the Commonwealth Fund Biennial Health Insurance Survey, conducted in 2001, 2003, 2005 and 2007. The survey found that about two-thirds of U.S. adults between ages 19 and 64 were uninsured, underinsured, reported a problem with a medical bill or did not get care due to high costs in 2007.

The study also found:

- 39% of U.S. residents with growing medical bills used their savings;

- 30% incurred credit card debt;
- 29% said medical bills left them unable to pay for basic necessities such as food, heat or rent; 28% of working age adults had no insurance at some time during the previous year, up from 24% in 2001;
- 61% of people with difficulty paying medical bills or debt were insured at the time they received the treatment;
- 14% of adults in 2007 were insured but without adequate insurance, compared with 9% in 2003; and among people with annual incomes below \$20,000, 53% spent more than 10% of their income on health care, compared with 26% of this group in 2005.

The study also found that half of U.S. adults with incomes less than \$20,000 were uninsured at some time last year, compared with 41% of those with annual incomes between \$20,000 and \$40,000 and 18% of those with incomes between \$40,000 and \$60,000.

The study is available

http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=700872.

A Commonwealth Fund issue brief on medical debt also is available

http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=700868.

What's the quickest way to a lawyer's heart?
... Through the ribcage.

(4)

CM² MISLED CONGRESS ABOUT ITS MEDICARE DME FRAUD DETECTION SUCCESSES AND A BIPARTISAN CONGRESS IS REALLY PISSED

DHHS Inspector General Daniel Levinson on Monday released a federal audit that found that **Medicare officials underestimated the amount of incorrect payments for durable medical equipment in 2006** and that the miscalculation was caused by the agency's failure to have auditors follow CM²'s policy for checking claims. The DHHS audit reviewed a sample of 363 Medicare DME claims to determine whether auditing contractor AdvanceMed had found all improper payments. CM² had estimated a payment error rate of 7.5%, or about \$700 million in improper payments. The DHHS audit found an "error rate" of nearly 29% for the sample of DME claims. The report cited 20 payment errors identified by the Medicare audit and 73 errors the contractor had not identified.

The report faults Medicare officials for allowing AdvanceMed to conduct the review without fully documenting claims from suppliers. According to the audit, more incorrect payments would have been identified if Medicare had told the contractor to follow the agency's written policy. Levinson in a cover letter for the report wrote,

Levinson also wrote that Medicare auditors should check a wider range of records related to claims, including physician records and other medical documents verifying the necessity of equipment. He also recommended requiring contractors to contact beneficiaries who allegedly receive devices considered to be at high risk for improper payments, such as motorized wheelchairs, and check to see if the devices were received and if they were medically necessary.

CM² CFO Timothy Hill said the agency implemented a requirement last year that more documentation be provided for wheelchairs. A top Medicare official said there was no written policy requiring auditors to use medical records to count error rates in 2006. AdvanceMed spokesperson Chuck Taylor said the firm was prohibited by its contract from commenting on the issue without Medicare approval.

The report is available <http://www.oig.hhs.gov/oas/reports/region1/10700508.htm>.

CM² Braggadocio and Angry Congresscritters: Senatecripper Chuck Grassley (R-Iowa), ranking member of the Senate Finance Committee, said, *"I want to know what happened, who's responsible, who will be held accountable and what [DHHS Secretary Mike Leavitt] will do about it."* He added, *"If people cooked the books, manipulated the methodology or told the contractor to ignore the rules, those individuals need to take the heat."*

Housecripper Ileana Ros-Lehtinen (R-Fla.) said the House Committee on Oversight and Government Reform would hold hearings on the issue this fall. Housecripper Mario Diaz-Balart (R-Miami) said, *"If this is true, this is an outrageous and unforgivable stunt. Cracking down on fraud should be a top priority for Medicare, not fixing numbers to make an agency look better."* He added, *"I expect hearings and I expect answers -- truthful answers -- from Medicare about this report."*

Just Between You and Me: In an editorial, the Miami Herald said what many Congresscritters, and just plain Americans are feeling: *"The amount of fraud and corruption in Medicare is simply mind-boggling" and "exceeded only by a staggering lack of oversight by Congress and by Medicare's own failure to protect the program against open thievery... If the DHHS Inspector General's claims of Medicare "cooking the books" ... proves true, heads should roll at [CMS]."* The Wall Street Journal in its editorial tried to pin the blame on "government-run" health care: *"We're speechless. Mr. Stark and his ilk consistently claim that Medicare is a model for government-run "universal" health care because it spends less on overhead than the private sector. True, Medicare's administrative costs are just 3% of total spending, while the private sector hits 11% to 14%. But insurance companies spend money to screen their claims for fraud. Medicare automatically pays more than 95% of the bills it receives. This lack of scrutiny reduces overhead, but it makes the program highly vulnerable to abuse."* One problem in the WSJ's hubris, it failed to note that the then GOP-controlled Congress cut funding for Medicare auditing in 2003 and the early successes of the 1996 HIPAA anti-fraud provisions have been greatly undermined. And even so, it has been a GOP-run CM² that has failed to keep up with the early promise of health care fraud and abuse reform, not Pete Stark and his "ilk."

What do you say when you see a lawyer about to be hit by a truck?

"_____."

HIPAA, NOW AND FOREVER: HEALTH CARE I.T. STUFF

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KENNEDY-ENZI BIPARTISAN ELECTRONIC HEALTH RECORD BILL DELAYED UNTIL AFTER POLITICAL CONVENTIONS

Additional action on a bill ([S 1693](#)) that would create a national electronic health records system has been delayed until after the political conventions. The bill jointly sponsored by Senate Health, Education, Labor and Pensions Committee ranking Senatecripper Mike Enzi (R-Wyo.) and committee Chaircripper Ted Kennedy **would greatly expand the government's role in building an electronic health care record, most importantly through federal funding of the effort to the tune of \$100 million or more.** Enzi and Kennedy had hoped to advance the measure to the floor by unanimous consent before the Congressional recess but Oklahoma GOP Senatecripper Tom Coburn put a hold on the bill and has effectively tied the matter up. Coburn objects to the authorization of more than \$100 million annually toward grant and loan initiatives to encourage adoption of health information technology. **He recommended revisions to the bill that would force hospitals, at their expense, to provide physicians with health I.T. equipment at a discount or at no cost.**

Just Between You and Me: *The U.S. needs a national health information network that respects patient confidentiality but that also lets hospitals share records across states quickly, seamlessly and accurately. A national legal framework to create such a network is required, but current legal barriers to such a network's formation include a patchwork of state and federal patient-privacy laws, flaws in federal physician anti-kickback and anti-self-referral statutes, prohibitions against practicing medicine across state lines, and concerns about medical malpractice in an electronic health care environment. Lawmakers rave about the need for affordable health care, but too little is done in the area of eHealth and instead of taking the initiative and forcing the issue top down, they are implicitly hoping for a bottom-up solution while taking partisan stances in the periodic debates over medical-malpractice liability. Establishing a national health I.T. network is one area where the federal government could act and needs to act, but will Congress and the next administration have the vision and political courage to make a bold move that could save countless lives and reduce health care costs? The nation needs revolution, not evolution, in health care informatics.*

What's the best thing to get for a lawyer who has been hospitalized?

... Dr. Kevorkian!

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MEDICAL PRIVACY LANGUAGE REVISED

House Energy and Commerce Committee Chaircritter John Dingell (D-Mich.) and ranking membercritter Joe Barton (R-Texas) have released a revised version of a bill ([HR 6357](#)) that aims to promote nationwide adoption of an electronic health record system. The lawmakers substantially changed the information-sharing and privacy provisions of an earlier proposal following concerns from stakeholders in the health care, high-tech and consumer advocacy arenas. **Under the revised bill, patients would give their consent only once to health care companies that want to access health care records without identifying information for DHHS-approved purposes, such as hospital audits or fraud and abuse allegations.** The bill previously would have required patient consent each time the records were accessed. According to the revised bill, the patient consent provision would be implemented two years after the bill is enacted, and DHHS would be required to develop "reasonable and workable" rules to implement the provision.

The original version of the bill also would have required health care providers to notify patients of any unauthorized acquisition, access or disclosure of their health care information. **The revised version states that a "good faith" disclosure, such as a mislabeled letter with a wrong address, would not be considered a breach.**

Other revised provisions in the bill would:

- Prohibit the sale of patients' records without consent unless it is necessary for treatment or to receive payment for treatment;
- Change existing federal privacy laws to allow for the provision of a no-cost digital copy of an individual's medical record;
- Strengthen language to ban direct and indirect payments to providers who advertise health care products to patients without permission; and
- Require the DHHS Office of Civil Rights to launch a formal investigation of complaints and allow the office to impose fines for violations deemed "willful neglect."

Why don't lawyer's worry about the wages of sin?

They charge "professional fees", not "wages".

(7)

HIPAA COMPLAINTS: LESS THAN 2% HAVE BEEN ACTED UPON

A DHHS office has resolved more than half of complaints about possible violations of the medical privacy rule issued after the passage of the Health Insurance Portability and Accountability Act without investigation. Since the rule took effect in 2003, 38,000 U.S. residents have filed complaints with the DHHS Office for Civil Rights, and the office has resolved 56% of those complaints without investigation, the review found. **The review also found that OCR has referred only 437 complaints, less than 2% of the total, to federal prosecutors.**

Just Between You and Me: *One of the main problems with enforcement of the rule is that health care providers do not have to report internal violations. This is a tremendous loophole. Enforcement is left to the health care community to sort of self-police itself, and to the Office of Civil Rights, which has done virtually nothing.*

DO YOU KNOW WHAT'S REALLY BAD ABOUT HELL?

Having so many lawyers around!

ELECTION 2008

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BARACK vs JOHN: VIVA L'DIFFERENCE!

In the face of escalating costs, uneven quality of care, and the growth of the uninsured population, there is broad agreement that the U.S. health care system requires reform. However, Democrats and Republicans remain sharply divided over how to reform it, as evidenced by the health care plans offered by the parties' presidential candidates. The ambitious reform agendas of Senatecritters John McCain and Barack Obama would take the U.S. health care system in very different directions.

John McCain: McCain's plan embraces market forces and promotes individually purchased insurance. **Its centerpiece is a change in the tax treatment of health insurance.** Currently, workers do not pay taxes on health insurance premiums paid by their employers. The McCain plan would eliminate this tax exclusion and use the revenue generated -- projected to be \$3.6 trillion over 10 years -- to pay for refundable tax credits for Americans obtaining private insurance (\$2,500 for individuals, \$5,000 for families). Uninsured Americans could use their credits to help buy insurance coverage on the individual market, and workers with employer-sponsored insurance could use theirs to offset the cost of paying taxes on their employers' premium contributions or to purchase coverage on their own. The McCain campaign emphasizes key advantages of this approach. **First, the current tax exclusion disproportionately benefits higher-income Americans, since its value depends on a worker's tax bracket. Providing an equal credit to all Americans is a fairer allocation of federal revenues, and since the credit is refundable, even those who do not pay taxes would qualify for federal payments. Second, the tax exclusion benefits only persons with employer-sponsored insurance, whereas under the McCain plan everyone, including the unemployed and workers whose employers do not offer coverage, would receive a credit to purchase insurance regardless of where they obtained it.**

In terms of cost control, the McCain plan offers several initiatives aimed at spurring competition and changing the status quo in health insurance and medical practice. **It would deregulate the private insurance market** to allow insurers to sell policies across state lines; residents of states that extensively regulate insurance (for example, by mandating covered benefits) would be able to shop nationwide for less comprehensive, less costly health insurance policies than those available in their home states. **McCain's plan also calls for changing the way Medicare pays**

for medical services -- moving away from fee-for-service reimbursement and toward bundled payment for episodes of care and payments based on outcomes. The hope is that Medicare payment reform would drive broader changes in the health care system.

In addition, replacing the invisible, unlimited tax exclusion with a visible, limited tax credit could slow health care spending. Making employer premium payments taxable income would make insurance costs more transparent to workers, many of whom are unaware how much their employers are paying for their insurance. **And since Americans would receive a fixed credit, the expectation is that they would seek out lower-cost, less comprehensive insurance plans,** fostering competition among insurers. Other cost-control provisions include speeding up generic-drug development, encouraging prevention, improving care for chronic diseases, and adopting medical malpractice reform.

Problems with the McCain Plan: How the McCain plan would affect costs and coverage is uncertain. Nobody knows how effective repealing the tax exclusion would be in controlling costs, but if it turns out not to be a magic bullet, the plan lacks other mechanisms for reliably slowing spending. Prevention, better care for chronic conditions, and enhanced competition represent aspirations rather than concrete policies for controlling costs. **In addition, most uninsured Americans would probably remain uninsured under the McCain plan.** Given the high price of health insurance, even with the new tax credits, many lower-income people would still not be able to afford coverage. And if the credits are not indexed to the rate of growth in health care spending, that affordability gap would grow over time. Not mentioned much by McCain is the fact that Americans, who would continue to have employer-funded health insurance, would now be paying taxes on that value. Indeed, even with the proposed credits, many if not most Americans could afford only high-deductible insurance policies, increasing the problem of "underinsurance" and the impact of serious illness or accident. **The McCain plan could consequently trigger a move from comprehensive insurance toward thinner coverage policies that shift costs onto sicker patients.** Moreover, some employers, particularly smaller businesses, might stop offering insurance if the tax benefits of employer-sponsored insurance were eliminated. As a result, some currently insured workers could lose coverage.

Perhaps the most serious problem with McCain's plan is its reliance on the individual insurance market. **Individual insurance policies are administratively expensive, typically involve medical underwriting so that sick persons and those with preexisting conditions are charged higher premiums (premiums also increase with age) or are denied coverage altogether, and generally offer less comprehensive benefits than employer-sponsored insurance.** The McCain campaign has proposed a "guaranteed access plan," whereby the federal government would work with states to create insurance alternatives for those unable to afford coverage on the individual market. The plan builds on the experiences of the 34 states that operate high-risk pools for residents who are deemed to be medically uninsurable. Yet such a program is unlikely to remedy problems inherent in the individual market. State high-risk pools ironically suffer from the same problems (high costs, limited benefits, preexisting-condition exclusions) that plague the insurance markets from which they are supposed to offer refuge. **Furthermore, the McCain plan for interstate insurance markets could weaken regulatory protections in some states.** Fraudulent insurance is already a very significant problem and crossing state lines would virtually assure a lack of consistent enforcement without a major federal investment in policing the plans being offered.

Barack Obama: In contrast to John McCain's emphasis on markets and deregulation, **Barack Obama's reform plan relies on an employer mandate, new public and private insurance programs, and insurance-market regulation.** The core of the Obama plan is a requirement that employers either offer their workers insurance or pay a tax to help finance coverage for the uninsured (some small businesses would be exempt, and others would be subsidized). The Obama plan would also create two new options for obtaining health insurance: a new government health plan (similar to Medicare) and a national health insurance exchange (a purchasing pool analogous to the Massachusetts Connector) that would offer a choice of private insurance

options. Both would be open to persons without access to group health insurance or other public insurance, as well as to small businesses that wanted to purchase coverage for their workers. Income-related subsidies would be provided to help lower-income persons afford coverage. And private insurers could not deny coverage because of preexisting conditions or charge substantially higher premiums to sick enrollees: **the Obama plan would end medical underwriting according to health status.**

The Obama campaign emphasizes that its plan offers a choice of insurance options.

Rather than deciding whether public or private insurance is a better model, the plan would allow people to choose between them. In addition, the new national health plan and **insurance exchange would provide insurance pooling and purchasing power that, along with insurance-market regulation, would effectively address the problems that Americans without group coverage encounter when trying to purchase affordable insurance on the individual market.** The Obama campaign says that the insurance exchange, by providing broader pooling and cutting marketing expenses, can reduce administrative expenses in private insurance and promote competition. The plan also calls for a new system of reinsurance, whereby the federal government would reimburse employers for a portion of the costs they incur for employees with high-cost, catastrophic medical cases — theoretically enabling businesses to reduce insurance premiums and particularly benefiting smaller businesses whose risk pools are too small to spread the costs of expensive cases.

Other cost-control measures include accelerated adoption of electronic medical records, promoting disease management and better coordination of long-term care, paying providers on the basis of performance and outcomes, strengthening prevention, permitting the federal government to negotiate prescription-drug prices for Medicare patients, cutting excessive payments to private health plans contracting with Medicare (the 12-19% in “bonus” payments currently being paid to private Medicare Advantage plans), and establishing an institute for comparative-effectiveness research to generate information about effective treatments.

Problems with the Obama Plan: The Obama plan's precise impact on coverage is impossible to gauge. If the payroll tax is set low, many businesses would choose to pay it rather than offer coverage, and enrollment in a new national health plan could be substantial. **The capacity of the Obama plan to expand insurance coverage depends on the scope of subsidies, premium prices, and the effectiveness of automatic enrollment or other participation-boosting policies, but details of those policies are not clear.** Since the plan lacks an individual mandate for adults (coverage is mandated for children), it would not cover all the uninsured and therefore would provide universal access to insurance rather than universal coverage. However, most Americans without insurance would gain coverage through the new public and private insurance options, and **Obama has not ruled out adopting an individual mandate in the future if the plan does not produce universal coverage.**

Although the Obama plan would substantially expand access to insurance, **it lacks reliable cost-control mechanisms and a viable financing source.** Reinsurance would shift private-sector costs for catastrophic cases to the government but would not reduce total health care expenditures. The plan also assumes that substantial savings will be achieved by increasing the use of electronic medical records, improving the management of chronic conditions, and strengthening prevention, but none of these worthwhile measures is likely to control costs in the short run. The new national health plan could control costs, but its effectiveness in slowing spending would depend on its enrollment and the political willingness to restrain provider payments.

The Obama campaign says it would finance the \$50 billion to \$65 billion in new federal spending for its health plan by allowing tax cuts adopted in 2001 and 2003 for families making over \$250,000 to expire. However, **the Congressional Budget Office (CBO) already assumes in its projections that these tax cuts will end after 2010, so their expiration will not generate new revenues to satisfy congressional budget rules. And if savings from prevention, disease**

management, and electronic medical records are not realized -- or if the CBO does not validate them as an acceptable financing source -- then the Obama plan would need substantial additional revenues to fund expanded coverage.

Summary: The McCain and Obama health plans are best viewed as sketches rather than finished portraits, with many important details yet to be revealed. Still, the 2008 presidential election clearly offers voters dramatically different alternatives. The candidates' opposing visions of health care reform reflect fundamentally different assumptions about the virtues and vices of markets and government. With the debate over how to reform U.S. health care far from settled, whoever wins the presidency can expect fierce opposition to any attempt at comprehensive reform. And that opposition may come in many instances from within the candidate's own party.

**Why don't lawyers play hide-and-seek?
Nobody will look for them.**

THE PHARMACY CORNER

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MEDICARE PRESCRIPTION DRUG "DOUGHNUT HOLE" SMACKED OVER 3 MILLION BENEFICIARIES UP BOTH SIDES OF THEIR HEAD IN 2007

In 2007, about 3.4 million Medicare beneficiaries reached the so-called "doughnut hole," or gap in Medicare prescription drug coverage, during which time they were responsible for their medication costs, according to a Kaiser Family Foundation study. In 2007, the coverage gap occurred when total drug spending for an individual reaches \$2,400 for a single year and continues until total out-of-pocket spending reaches \$3,850 in that year. Researchers from the Kaiser Family Foundation, Georgetown University and NORC at the University of Chicago analyzed pharmacy claims data provided by IMS Health. The analysis excludes beneficiaries who receive low-income subsidies because they do not face a gap in coverage under their Medicare drug plan.

According to the study, **one out of four Medicare beneficiaries enrolled in the Part D drug benefit, or 26%, who filled any prescriptions in 2007 reached the coverage gap,** 22% of which stayed in the gap for the remainder of the year. **Only 4% ultimately received catastrophic coverage.** Applying this estimate to the entire population of beneficiaries enrolled in the drug benefit, the analysis suggests that about 3.4 million beneficiaries (14% of all drug benefit enrollees) reached the coverage gap and faced the full cost of their prescriptions in 2007.

Beneficiaries who take medications for serious chronic conditions were much more likely to reach the coverage gap. For example, 64% of beneficiaries taking medications for Alzheimer's disease, 51% of those taking oral anti-diabetic medications and 45% of patients on antidepressants reached the coverage gap in 2007. Across eight classes of drugs examined -- used to treat a variety of relatively common chronic conditions -- **about 15% of the beneficiaries who reached the coverage gap in 2007 stopped taking their medications,** according to the study. The report also found that 5% of those reaching the gap switched to a different drug, most often a generic, while 1% reduced the number of medications of a certain class they were taking. The study found that 10% of drug benefit enrollees taking oral anti-diabetic drugs who reached the coverage gap stopped taking their medications. Among drug benefit enrollees taking a drug for osteoporosis who reached the gap, 18% stopped taking medications. And, 20% of those taking Proton Pump Inhibitors (for ulcers and acid reflux) who ended up in the gap discontinued their medications. According to the study, **beneficiaries who reached the coverage gap but did not receive catastrophic coverage on average spent \$196 monthly while in the doughnut hole, compared with \$104 monthly prior to reaching the coverage gap.** In addition, beneficiaries who reached the coverage gap paid the full cost of their medications for just over four months on average and received catastrophic coverage for less than one month on average.

The study is available <http://www.kff.org/medicare/7811.cfm>.

What do you get when you cross a blonde and a lawyer?
Hey! There's some things even a blonde won't do.

Looking for a speaker for your next meeting or conference? One who is informative and entertaining at the same time? Jeanne Scott, one of Washington DC's leading health care policy analysts and lobbyists, is a veteran of more than 600 such presentations and brings the latest in "inside-the-beltway" analysis and insight, touched with her humor and anecdotes, all for probably a lot less than you might expect. For dates, fees and other information, contact Jeanne at her numbers below, or see: <http://www.health-politics.com/speak.html>

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