Americans paying for private health care have experienced a leveling-off in annual spending increases recently, but that does not necessarily bode well for the future, according to a new report from the Center for Studying Health System Change.

In “Tracking Health Care Costs: Declining Growth Trend Pauses,” published June 21 as a Web-exclusive article in the journal Health Affairs, authors Bradley Strunk, Paul Ginsburg and John Cookson found that cost per privately insured American grew 8.2 percent in 2004, a virtually identical increase from 2003.

But that plateau was counteracted by a mere 2.6-percent increase in overall economic growth in 2004, state the authors, who relied on the Towers Perrin 2005 Health Care Cost Survey and the National Business Group On Health/Watson Wyatt Worldwide Employer Survey of Trends in the Health Care Marketplace for study data.

“The trend in private health insurance premiums slowed in 2004 after a long period of acceleration,” according to the report. “Nevertheless, premium growth continues to outpace growth in the economy and workers’ incomes by a wide margin.”

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QIOs

AHQA Cries Foul On JAMA Study Debunking QIOs’ Effectiveness

▶ Medicare QIOs have no significant impact on quality of care, JAMA researchers say.

The American Healthcare Quality Association refuted a study on Medicare’s quality improvement organizations, published in the June 15 Journal of the American Medical Association, arguing that the researchers used outdated information and created a “misimpression” of QIOs’ current effects on patient-care quality.

Johns Hopkins Bloomberg School of Public Health researchers Claire Snyder and Gerard Anderson collected data from four QIOs enlisted to improve quality care in Maryland, Nevada, New York, Utah, Washington and the District of Columbia. “Do Quality Improvement Organizations Improve the Quality of Hospital Care for Medicare Beneficiaries?” is a followup study that uses previous baseline data collected from hospitals prior to their involvement with the QIO program in 1998.

In each state, Snyder and Anderson used 750 Medicare beneficiaries’ medical records to compare 15 quality indicators associated with five clinical areas in hospitals participating in the QIO program to non-participating hospitals. Followup data from 2000 to 2001 showed that participating hospitals had no changes in patient-care quality that significantly differed from quality changes in non-participating hospitals.

In fact, the only area that showed a statistically significant difference in changes was the pneumonia immunization indicator, which participating hospitals improved upon more than non-participating hospitals, the researchers said. “Our study found that quality is improving regardless of involvement by the quality improvement organizations,” Snyder said in a statement. The findings are troubling because Medicare spends more than $200 million each year on QIOs, the researchers noted.

AHQA Says Study Is Misleading, Outdated

The study’s targeted time-period was well before the program was substantially revised, AHQA executive VP David Schulke said in a June 14 statement. “In 2002, the QIO program was refocused to take advantage of advances in quality improvement methodology developed by the Institute for Healthcare Improvement and other expert sources,” he explained.

Furthermore, Schulke disputed the study’s methodology, claiming that assessing QIOs’ contributions during that time period is difficult. “Many hospitals in the study sample had been working with the QIO for only a short time, and some had not yet started working with the QIO at all,” he argued.

Schulke wants JAMA to publish QIO data from 2002 to 2005, available later this year, to correct any misinterpretations relating to QIOs’ effectiveness. He offered the Institute of Medicine’s preliminary data for the current QIO work cycle. “Hospitals working intensively with QIOs achieved greater improvement in nine out of 10 quality measures than did hospitals that received little or no QIO assistance,” he said.

During the current three-year work cycle, 26 California hospitals participating in the QIO program increased the proportion of surgical patients who received antibiotics within 60 minutes of a surgical incision from 73.8 percent to 84.3 percent, Schulke claimed. Sixteen Colorado hospitals increased antibiotics delivery within one hour of incision from 62 percent to 88 percent, and 19 New Mexico and 16 Maryland hospitals both increased by 20 percent. Forty-two Texas hospitals increased from 61 percent to 84 percent, he said.

Although the IOM’s preliminary data shows QIOs in a positive light, whether JAMA will publish another followup study on the more recent QIO work cycle remains to be seen. And with the hundreds of millions of dollars in QIO funding at stake, coupled with an already strained Medicare budget, an impartial and accurate study is imperative.
According to data collected in 2003, only 45 percent of seniors 65 and older were willing to trade provider choice to save money, HSC found. That’s compared to 70 percent of people age 18 to 34.

The study shows that Medicare Advantage plans will have a much harder time substantially growing their enrollment base than they might have thought, HSC researcher and study author Ha Tu tells M&H. The types of seniors that MA plans need to win over — those with FFS or supplemental plans — are especially unwilling to accept the narrower provider networks that MA plans will be offering, she says.

Surprisingly, the survey showed that seniors who are most unwilling to accept decreased provider choice in return for cheaper rates are those with supplemental coverage: almost two thirds of seniors with MediGap or retiree coverage are unwilling, and about four in ten were strongly unwilling.

That could be a shock for the many health plans that have assumed that MediGap purchasers would be particularly likely to switch over to MA plans.

Can PPOs Compete With ‘Unfettered Choice?’

Proponents of Medicare Advantage have argued that Medicare PPOs will win support from seniors for the same reasons that PPOs are outpacing HMOs in the commercial market. But that’s a flawed argument, Tu suggests. In the commercial market, PPOs are attractive because they offer more choice than HMOs, their chief competitors. But in the Medicare market, the new PPOs will be competing with traditional Medicare fee-for-service, which offers “unfettered choice” to beneficiaries, Tu says.

MA plans could find it difficult to compete with FFS’ unlimited choice of providers, Tu warns.

“Given widespread beneficiary concerns about restricted provider choice, it appears that Medicare Advantage plans will need to offer broad provider networks, along with richer benefit packages or lower out-of-pocket costs, to attract enough seniors from traditional Medicare to boost enrollment significantly,” the report says.

But the news isn’t so bad for MA, says Mohit Ghose of America’s Health Insurance Plans. Even if “only” 45 percent of seniors said they are willing to sacrifice some choice for saving costs, that’s in contrast to the fact that currently a mere 11 percent of seniors are in MA. That supposedly small 45 percent actually represents a strong growth potential over existing MA enrollment, Ghose points out.

“We have always maintained that choice of plan is the key,” Ghose says.

Seniors May Reevaluate Options In 2006

It could be that Medicare benes are at a pivotal turning point and that future surveys will yield different results, Tu says. The reason that working-age Americans are more willing to accept reduced choice to save money is that they have felt the sting of increased cost-sharing in recent years, as insurers have sought to show them the impact of rising health costs.

“But in Medicare fee-for-service, seniors tend to be shielded somewhat” from cost concerns, Tu says. If, however, seniors too feel the sting through increased Medicare premiums, which have begun rising by double digits in recent years, they too may see the merits of more affordable, smaller provider networks. Other factors are the decline of retiree benefits and the fact that seniors are
Medicaid
Governors Offer Plan To Rein In Medicaid Costs

Congressional Democrats criticize impact on most vulnerable Americans.

Medicaid would provide a smaller safety net under a reform plan crafted by the nation’s governors. Govs. Mark Warner (R-VA) and Mike Huckabee (D-AR) presented the National Governors Association’s Medicaid proposal to the Senate Finance Committee on June 15. The committee is responsible for trimming up to $10 billion from the Medicaid program over the next five years. The House Committee on Energy and Commerce also held a June 15 hearing on Medicaid reform at which the two governors presented NGA’s plan.

A bipartisan working group of 11 governors led by Warner and Huckabee developed the plan based on input from Medicaid directors and governors from more than 30 states. It calls for reducing drug costs through expanded use of generics; restricting asset transfers and encouraging reverse mortgages to pay for long-term care; increasing cost-sharing through deductibles, premiums or co-payments; giving states greater flexibility to limit benefits; and making waivers easier to obtain.

“The recommendations to make Medicaid more efficient and effective were not developed to generate any particular budget saving number,” Huckabee said. “Instead they were developed as effective policies that would maintain or even increase health outcomes while potentially saving money for both the states and the federal government.”

Because of growing caseloads and health-cost inflation, Medicaid is not sustainable in its current form, the governors said. The nation’s largest health-care program, Medicaid provides health and long-term care services to 53 million low-income pregnant women, children, individuals with disabilities and seniors. States currently devote 22 percent of their budgets to the program, a greater proportion than they spend on K-12 education.

The NGA working group views the release of the policy paper as the beginning rather than the end of the process and hopes to work with Congress on developing proposals, the governors noted.

“Given that this working group will continue, it will be able to not only provide you with more detail on our recommendations, but also comment on alternative approaches you wish to discuss,” Warner said.

Budget
Public Health Advocates Decry Committee’s HHS Budget Cuts

Incoming Medicare Rx program makes already tight budget that much tighter.

Amid warnings of flu pandemic and concerns over bioterrorism, House Republicans have proposed cuts to the nation’s public health budget.

The House Appropriations Committee on June 16 approved a fiscal year 2006 spending measure that gives the Department of Health & Human Services a discretionary spending package of $63 billion. That represents a $633 million decrease over the previous year’s budget.
The Labor-HHS-Education Appropriations bill passed by the committee reduces funding for the Health Resources Services Administration by $400 million, cuts training grants for health care professionals by 84 percent and eliminates grants to 47 geriatric education centers.

The committee also recommended an overall reduction in funding for the Centers for Disease Control and Prevention. Total funds allocated for the CDC were $6.1 billion, $295 million less than last year.

Public health advocates criticized the proposed cuts. “These actions are shortsighted and undermine the very programs that are vital to protecting the health of Americans,” says Dr. Georges Benjamin, executive director of the American Public Health Association.

But there were also a few bright spots in the spending plan from a public health perspective. The committee approved an additional $37 million to fight the spread of infectious disease, a boost of $56 million for terrorism preparedness and a $100 million increase to HRSA for community health centers. It also voted to restore funding for the Prevention Block Grant, though at $18.5 million less than last year.

The committee was faced with the challenge of finding almost $1 billion needed to pay the cost of implementing the new Medicare prescription drug program, which takes effect Jan. 1, 2006.

Rep. David Obey (D-WI), a ranking member of the committee, blamed Bush administration tax breaks for the funding cuts. However, the committee voted against his amendment to roll back tax breaks for millionaires in order to boost HHS spending.

Cloning Ban Rejected, ED Drug Limits Embraced

The House Appropriations Committee by a narrow margin rejected an amendment offered by Rep. David Weldon (R-FL) that essentially would have prohibited any organization that engages in human cloning from receiving National Institutes of Health funding.

A physician, Weldon is also the co-sponsor of the Human Cloning Prohibition Act of 2005, which would amend the federal criminal code to ban human cloning, participation in human cloning and the importation of human clones.

“Any attempt made to clone a human for any purpose is repugnant experimentation that the American people oppose,” he says.

The committee did approve an amendment proposed by Rep. John Doolittle (R-CA) to ban the Medicare, Medicaid and other public health programs from paying for erectile dysfunction drugs for sex offenders. Almost 800 convicted sex offenders in 14 states have received Medicaid-funded ED drugs.

“The American public is justifiably outraged to discover that they are subsidizing the erectile dysfunction medication of dangerous sex offenders,” Doolittle says. “This practice is a disgusting abuse of taxpayer dollars and must be stopped now.”

Pharmaceuticals

State AGs: We Beat Big Tobacco, We’ll Beat Big Pharma

AGs want lower prices for drugs, and they’ll go to court for it.

A group of state attorneys general is calling states to action in the fight to “fix” the U.S. pharmaceutical industry.

In the June 20 report “Addressing the Cost and Benefits of Prescription Drugs,” the National Association of Attorneys General say that the spiraling cost of prescription drugs must be addressed. Further, NAAG feels that to put enough pressure on drugmakers, it may take a cooperative effort between states — or even cooperative legal action — to bring the price of prescriptions down.

“The United States pays the highest prices for prescription drugs of any country in the world. As health care costs in this country continue to grow faster than the rate of inflation, drug prices have come under scrutiny,” says William Sorrell, Vermont attorney general and president of NAAG.

Drug Spending Keeps Climbing Each Year

The report authors found that prescription drug spending is the fastest-growing component of health care spending, “increasing at double-digit rates for each of the past eight years, while [spending on] physician and clinical services and hospital care experienced only 8 and 10 percent increases, respectively, over the same period,” the report states. In 2002, the nation spent $162.4 billion on prescription drugs — four times more than the amount spent in 1990.

And Americans who think the cost increases are the result of exhaustive research and development efforts by drugmakers should think again, the report argues. In 2003, the top 10 drug companies spent 14 percent of revenue on research and development, and 34 of revenue on marketing and administration.

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If annual economic growth cannot keep pace with increases in health care spending, it could lead to disaster for Americans already struggling to afford health insurance, says HSC director of public affairs Alwyn Cassil.

“We know health care costs are going to increase from year to year, but the number we care most about is the increase relative to [worker’s incomes], and the recent trend has been that health care costs increase more than wages increase, which leads to insurance being less affordable for more people each year,” Cassil explains.

Prescription Increases Fall Furthest

“Tracking Health Care Costs” monitored 2004 trends in several spending segments that produce underlying costs for patients. According to the report, Americans paying for private health care:

- spent 6.4-percent more on physician care in 2004, the same spending increase as in 2003.
- spent 6.2-percent more on inpatient hospital services, and 11.3-percent more on outpatient care, in 2004. Though inpatient increases were essentially the same in 2003 and 2004, “outpatient hospital care was by far the fastest-growing category of health care spending. Taken together, growth in spending on inpatient and outpatient hospital care accounted for 54 percent of the total increase in health care spending in 2004,” according to the report.
- spent 7.2-percent more on prescription drugs in 2004, a drop from the 8.9-percent increase in 2003 and less than half of 1999’s whopping 18.1-percent bump. The continuing drug-spending slowdown in 2004 was largely due to the reclassification of some widely used drugs, such as Claritin and Prilosec, to OTC status. “Other factors that may be contributing to continued slow growth in drug usage are higher copayments and new information about the negative side effects of hormone replacement therapy,” states the report.
- spent 2.9-percent more on hospital utilization services, up from a 1.7-percent increase in 2003. This may be chalked

Health Plans Propose Lowest Rate Increases In 5 Years

**Health trend should abate somewhat, but it’s still far beyond inflation.**

The cost of health coverage has been increasing faster than anyone can catch up with, but there’s a chance it’s at least slowing down a tad.

That’s according to new analysis released by benefits firm Hewitt Associates. Hewitt predicts that health plan rates will increase 12.4 percent nationally in 2006 — the lowest rate of increase in more than five years. In contrast, last year’s figure was a 13.7-percent increase. And because these are the rates health plans are offering before negotiations, it is expected that employers will be able to bargain them down further. Last year, after employers altered plan designs, the final rate of increase was 9 percent. Hewitt is predicting this year’s final rate will be below that, “perhaps in the 8 percent to 9 percent range.”

Last year was “a turning point” as employers picked benefit packages that relied on increased cost sharing and were able to aggressively negotiate plans down below a 10 percent increase, Hewitt says.

Copays are increasing for office visits, prescription drugs and ER visits, as employers shift more of the burden onto their workers’ backs. The moderation in costs shows that this strategy is working, at least to an extent.

It’s too early in the cycle to determine how much of the cost increase is attributable to drug costs, hospital costs or other issues, explains Paul Harris, senior health care strategist at Hewitt. Those figures should come out after the summer.

It’s also too soon to tell how large of a role health plan competition is playing. If employers successfully bargain health plans down at a more aggressive rate than they usually do over the summer, that would be a sign that growth-minded insurers are cutting their prices in order to steal business from their competitors.

**Although the rate of the cost increase is lower than in years past, it is still unsustainably high, the study says. “Companies are still facing double-digit increases and, therefore, continue to adjust their plan designs and share more of the cost with employees,” the study says.**

Most industry experts are calling for a downward trend on cost increases for the next couple of years, Harris tells *M&H*. But the trend will remain far greater than inflation, he says, and no one thinks it will drop down to inflationary levels in the forseeable future.
up “in part, to the recent economic recovery driving greater demand for hospital services,” according to the report.

**Plateau Could Foment Higher Future Premiums**

The study also found that employers increased beneficiary cost-sharing in 2004, upping the underlying cost of care for beneficiaries yet again in a move that perhaps precedes a bump in private health insurance premiums.

When coupled with the recent annual rates of increase in health care spending, employers’ more aggressive cost-sharing measures could lead everyone down the road to higher premiums, according to “Tracking Health Care Costs.”

“Underlying cost trends are the dominant long-term determinant of premium trends,” the report reads. “The stabilization of the cost trend at a relatively high rate may foreshadow a similar development for premiums in the near future.”

Premium increases often lag behind other health care spending indicators, so whether premiums will actually increase, and by how much, is yet undecided.

**HEALTH I.T. LEGISLATION, continued from page 1**

“More widespread use of proven health care IT such as electronic prescribing and electronic medical records would save lives and money,” Marisa Milton, HR Policy Association’s director of health care policy and associate general counsel, said in a June 16 statement.

To develop HIT standards and infrastructure, Frist and Clinton propose to codify the Office of the National Coordinator of Health Information Technology, develop standards that are mandatory for all federal government programs and voluntary for the private sector, and harmonize differing state health information privacy laws. The bill also authorizes $125 million per year for five years in competitive grants for implementing regional or local health information plans that use standardized HIT.

While coordinating all federal HIT efforts within ONCHIT is important, “it is also critical that Congress endorses consultation with private industry by establishing the Standards Working Group, thus ensuring that the national IT infrastructure achieves its intended results,” Medical Group Management Association president and CEO William Jessee said in a June 15 statement.

To encourage interoperable systems implementation, the legislation provides exemptions from Stark and anti-kickback laws for physicians and other providers. The narrow statutory safe harbor from Stark self-referral and anti-kickback laws, in addition to a safe harbor from federal antitrust laws, applies to standard compliant hardware, software and support services. The bill also allows health plans to share savings from HIT systems utilization and implementation with providers.

**Do Quality Measures And HIT Go Hand-In-Hand?**

“The prospect of using one method to track quality measures, while simultaneously holding physicians responsible for increased utilization, may produce a system that is inherently unfair,” Jessee said. That is why the third part of the Health TEQ bill directs the Secretaries of the Department of Health and Human Services, Department of Defense, Veterans Affairs and other federal agencies to adopt uniform health care quality measures.

The quality measures would be voluntary for the private sector, but encouraged through a value-based purchasing two-year pilot program under Medicare and various collaborative efforts.

“This legislation marries technology and quality to create a seamless, efficient health care system for the 21st century,” Clinton said. The bill requires the Secretaries to make comparative quality reports on federal health care programs, which would be available to consumers and providers.

HHS Secretary Michael Leavitt is already on board with the legislation. “Electronic health records and other information technology will transform our health care system, resulting in fewer mistakes, lower costs, better care and less hassle,” he said in a statement.

“Apples-to-apples” health care quality comparisons are possible for consumers with the use of HIT, Alliance of Community Health Plans president and CEO Jack Ebeler said in support of the bill. “The widespread adoption of information technology puts real-time health care data at physicians’ fingertips and facilitates collecting and reporting quality information that will create a new environment of transparency in health care,” he added.

Frist and Clinton’s bill is the seventh submitted to Congress on HIT, but already organizations are hungry for more. Congress will weed through the proposed legislation in the coming months, but at this point there’s no telling which bill will come out a winner.
PHARMACEUTICALS, continued from page 6

“In other words, for every dollar made in sales, the industry spent 34 cents on marketing and administration and 14 cents on developing new products,” says the report.

“Addressing the Cost” included a section summarizing the action that states have taken recently to curb their health care budgets.

“As the deadline for implementation of Medicare Part D approaches, state legislatures have responded by considering legislation that seeks to adjust existing state subsidy plans in 32 states and discount plans in 23 states,” the report reads.

Among the states’ actions to help reduce pharmaceutical costs:

- reimportation of drugs from Canada and other countries;
- disclosures or restrictions related to pharmaceutical marketing;
- pharmaceutical benefit manager regulation;
- preferred drug lists;
- price disclosures; and
- recycling or reuse of pharmaceuticals.

Suggestions Include Smart Shopping, Legal Action

The report offered several courses of action for state AGs wanting to put a dent in drug costs, among them “smart shopping,” which is the practice of using the “best possible evidence,” rather than drugmakers’ marketing materials, when considering the purchaseability of a drug.

NAAG also suggested legal action against the pharmaceutical industry, if that’s what it takes to bring prices down. As evidence that legal maneuvering can make a difference, the report cited the “legal and moral” victories state AGs won in the tobacco settlement and over Pfizer for its product Neurontin.

AGs should remember how they achieved these victories — through collaboration with other AGs and with policy makers — and apply that same philosophy to the struggle with the pharmaceutical industry, the report recommends.

“[Attorneys general] can continue this important work through ongoing legal action, which discourages those business models [that] routinely weigh the risk and benefit of litigation as part of the business strategy,” reads the report.

MEDICARE, continued from page 3

living longer, stretching their retirement nest eggs as they need to pay for longer-than-expected retirements.

“Seniors may start to make the trade-offs that workers have,” Tu says.

Indeed, the fact that the survey data was collected in 2003 is important, Ghose says. Over the last two years — and especially since the passage of the Medicare Modernization Act — both the government and health plans have launched extensive education campaigns to teach seniors about rising health costs and the values that managed care can offer, Ghose says.

Finally, seniors have grown accustomed to using the political process to hold onto or improve their benefits, Tu says, a strategy that working Americans can’t utilize. But in a time of tight budgets, the political well may dry up, leaving seniors more willing to accept managed care plans that they once might have refused.