Health Proposals Differ By Principles, Strategy

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Contributing Writer

WASHINGTON — Lawmakers are brimming with ideas about what to do for the 47 million uninsured, but it is not clear whether any single proposal has enough support to overcome political obstacles. Just months into the start of this session of Congress, several bipartisan bills have been introduced and sweeping reforms have been proposed, including some that would expand health coverage to most— if not all— Americans. Lawmakers are also proposing incremental approaches that would build on ongoing state efforts.

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

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

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

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

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

“The parts of the country where we spend the most on health care are not the parts where people end up with the highest quality health care.”

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

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

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

Some are rooted in the belief that the health care system cannot be fixed until everyone is brought into it. “As long as coverage is incomplete, efforts to achieve cost control with respect to the insured population will generate social and health consequences that none of us would find tolerable,” said Henry Aaron, Ph.D., an economist and senior fellow at the Brookings Institution in Washington, D.C.

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

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

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

“We are not—let’s be honest here—on the verge of a paradigm, insurers interested in whether we cover patients, whereas there would be pain, scarring, bruising or other side effects, and finally, if facial expressions would still be possible after treatment. The survey is part of a joint Allergan- NHWRC campaign to educate women on injectable treatments; fuller results will be released later this summer. The survey was about cost, whether results would look natural, duration of treatment and length of procedure, insurance coverage, whether there would be pain, scarring, bruising or other side effects, and finally, if facial expressions would still be possible after treatment. The survey is part of a joint Allergan-NHWRC campaign to educate women on injectable treatments; fuller results will be released later this summer.

Another survey from the National Women’s Health and Research Center (NWHRC) and Allergan Inc. found that 41% of physicians bought IVIG at prices below the Medicare reimbursement amount, which means they were able to marginally profit on the therapy. But that means that 44% of hospitals and 41% of physicians paid more for IVIG than Medicare reimbursed, said Marcia Boyle, president of the National Deficiency Foundation, in an interview. Further, the Inspector General found that a majority of physicians and hospitals were underpaid by Medicare relative to IVIG price for the first half-quarters of the year. Medicare acknowledged that the markup was fragile, but as prices increase and that physicians in hospitals would face the same crisis this year that they did last.

Debridement Restrictions Lifted

The American Academy of Family Physicians said that it has succeeded in its drive to remove restrictive language from a Medicare carrier’s draft local coverage determination on wound care. The re- striction would have affected physicians in Texas, Delaware, Maryland, and Virginia. Last December, AAFP questioned the guidelines, said Dr. J. Boyle, president of the Immune Deficiency Foundation, in an interview. He said that physicians in hospitals would face the same crisis this year that they did last.

Juries Side With MDs

Juries in malpractice cases sympathize more with physicians and less with their patients, according to a new survey of studies involving malpractice cases from 1989 to 2006. Philip Peters, of the University of Missouri–Columbia School of Law, found that plaintiffs rarely win weak cases, although they have more success in cases viewed as a “toss-up” and better outcomes in cases with strong evidence of medical negligence. Mr. Peters, whose study appeared in the May edition of the Michigan Law Review, said that several factors sys- temically favor medical defendants in the courtroom—among them, the doctors’ superior resources, physicians’ social standing, social norms against “profiting” by injury, and the jury’s will- ingness to give a benefit of the doubt when evidence conflicts.

—Alicia Ault