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HEALTH CARE REFORM UPDATE

Update #333

August 27, 2003

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THE PHARMACY CORNER

Jeanne Scott includes quotes, jokes, stories and other bits of entertaining information throughout her newsletter. To make it easier to find or skip this additional material, we have highlighted it in blue.

Quotes of the Week

“What we’ve got now under the current health-care system in the U.S. is a giant food fight between doctors, hospitals, patients and insurance companies as to who gets stuck with the bill.”

—Steffie Woolhandler, associate medical professor at Harvard Medical School, and co-author of a report calling for a USA single-payer health insurance system. [See, Report #1, below]

“This important bill will help people who have lost not only their jobs but also their access to affordable health care.”

—Democratic Senatecritter Max Baucus, ranking member of the Senate Finance Committee, on his "hope" to see legislation to help the uninsured find coverages they can afford. [See, Report #3, below]

“It’s a huge effort and is going to take a long time.”

—Leading health care Senate critter and long-time reform advocate John Breaux (D-La.), on his plan that would require all US residents to buy and have health insurance. [See, Report #5, below]

“We think as a matter of fundamental fairness that one group of Americans should not be moved into another class of benefits when they become poor because their illnesses have exhausted all of their resources.”

—National Governor’s Association Chair Gov. Paul Patton (D-Ky.), speaking in support of a provision in the House version of the "new and improved" Medicare bill that would bail states out from the prescription drug costs for dual-eligible Medicare and Medicaid recipients. [See, Report #6, below]

“I don’t think too many of us felt like we were going to get comprehensive revision of the

Medicaid program in this session of Congress, so you ask for everything and then you back off to the attainable."

—NGA Chair Gov. Paul Patton, suggesting the governors are asking for the mountain hoping for a mole hill. [Report #6, below]

"This is an important step toward making sure that Medicare beneficiaries get the drugs they need at a fair, appropriate cost."

—The ever popular CM2 Administrator Tom Scully, announcing that Medicare would stop paying the extra costs currently earned by physicians dispensing prescription drugs directly to their patients. [See, Report #8, below]

"Often there are a number of competing drugs to treat the same condition," said Senator Hillary Rodham Clinton, Democrat of New York, a leader of bipartisan efforts on the issue. "But which is more effective? Oftentimes we just do not know."

—Senatecritter Hillary Rodham Clinton, on proposals to establish a system to rate the "cost effectiveness" and efficacy of drugs purchased or paid for through government programs. [See, Report #11, below]

"There are many expensive products on the market that are no better than aspirin. We need to be able to demonstrate that and provide senior citizens and all Americans with that information so they can choose the most cost-effective, medically effective pharmaceutical for their particular needs."

—GOP Housecritter Nancy Johnson, chair of the Ways and Means Subcommittee on Health, suggesting that it isn't just the Democrats that want to rate drugs. [Report #11, below]

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1. USA HEALTH CARE ADMINISTRATIVE OVERHEAD: THREE TIMES CANADA'S SINGLE-PAYER —AND YOUR POINT IS?

The New England Journal of Medicine appears to be on another of its "almost" socialized medicine kicks. It has joined JAMA, the Journal of the American Medical Association, in reporting the alleged "advantages" if the USA were to adopt a Canadian-style single-payer system. In my May 2003 column in the HFMA Journal, I noted the resurrection of two words I thought I might never hear again: single payer. But since then the call for "single payer" has been echoing stronger than ever, with at least three of the announced Democratic presidential candidates issuing a clarion calls for single payer —Dennis Kucinich, Carol Moseley Braun, and perhaps to a more moderate extent, Dick Gephardt. So what's wrong with the single payer concept?

According to the NEJM, the administrative costs of health care in the United States are more than three times higher than those in Canada: $1,059 per person in the United States versus $307 in Canada. The lead author, professor Steffi Woolhandler of Harvard Medical School, has written similar articles over the years, all with the conclusion that the United States should embrace government-monopoly health insurance like they have in Canada. In the USA, providers must deal with a myriad of payers often confronted by Talmudic rules and restrictions which require legions of business managers, lawyers and others to decipher. In Canada, it is

the patient who has to deal with the “insurer” —one government-run insurer per province.

The argument for single-payer supporters is that the reduction in administrative overhead would mean additional monies available for actual health care. Everybody would get more, more efficiently, for less. Unfortunately, Canada’s experience shows that this is not the case. According to a study by a pair of British Columbia researchers, in 2002, the average Canadian patient waited almost four months from the time his general practitioner decided that surgery was necessary until a specialist provided the care. That span of time has been growing since 1993, when it was only nine weeks. Further, Canadians have little access, relative to other developed countries, to doctors and high-tech imaging machines. In a comparison of access to doctors, Canada ranked 17th of 20 countries. Canada also ranked of 17th of 22 countries in a comparison of access to CT scanners, 18th of 23 countries for access to MRI machines, and 13th of 14 countries for access to lithotriptors. See: John R. Graham and Nadeem Esmail, policy analysts at the Fraser Institute in Vancouver.

Just Between You and Me: This lack of access comes at a high price. Despite the alleged “savings” from its single-payer system and these dramatic as compared to the USA, limits on high tech services, Canada spends more on health care than all multipayer industrialized countries outside the USA —countries such as Germany, Switzerland, and Japan. Perhaps because getting into a hospital and Canada may require a long waiting period, Canadians don’t seem very anxious to get out. The average length of stay for a hospitalization in Canada is almost twice that of the USA, contributing to making Canada’s per capita health expenditures second only to the USA among industrialized nations. It seems a little “administrative overhead” may be a key to cost savings. With some of the longest waiting times in the world, and age-adjusted health expenditures higher than all other industrialized nations with universal health-care systems, the Canadian model is clearly not the rousing success it is purported to be.

Imagine an Auto Industry with a Single Government Producer: Low administrative costs, caused simply by government monopoly, do not necessarily cause a better health-care system. Consider the automobile industry: Wouldn’t it be cheaper if we got rid of all the salesmen, advertising, marketing, and models that differ in trivial matters such as color and chrome? If we all got our cars from the government-run factory, wouldn’t we have a fairer and cheaper automobile “system”? They tried it in the Soviet Union and East Germany. The results were Ladas and Trabants.

Closing Comments: Without competition among insurers, Canadian providers have little incentive to act in the interests of consumers. Hospitals do not feel the need to provide more surgeries to reduce waiting lists or provide higher quality care, because they are secure in the knowledge that patients cannot go anywhere else. Provincial insurers are not concerned with long queues for health services or a lack of access to doctors or technology, because those who pay insurance fees will never stop paying, nor will they go elsewhere. It would be a serious mistake for Americans to fall into this trap and opt for a Canadian-style, single-payer system — considering only the money saved on administration, and not the needless suffering and money lost unaccountably through lack of competition. Increased competition in health care results in better outcomes and higher quality of care for patients. A small increase in administration costs in Canada, through the introduction of competition, would be a good thing.

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Legal Quote of the Week

"I don't know if I want a lawyer to tell me what I cannot do. I hire him to tell me how to do what I want to do."

—J.P. Morgan, American Financier

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2. SENATE FINANCE COMMITTEE SETS ITS FALL AGENDA
MEDICARE 'REFORM" AND Rx HEAD THE LIST; THE UNINSURED ???

The Senate Finance Committee's ranking Senatecritter, Max Baucus (D-Mont.), says the committee's fall agenda will be heavy with Medicare and other health care legislation. Baucus says that committee members have begun to hammer out the final Medicare reform bill, adding that he expects negotiations on the compromise legislation to "take up the better part" of September. Senatecritter Baucus alls expresses his "Democratic optimism" and says he expects the Committee to move forward with legislation to provide the uninsured with health coverage and that he hopes to see it signed into law in the upcoming months.

Republican Finance Committee Chaircritter Charles Grassley is not so optimistic, indicating that without a compromise between the House and Senate over the privatization provisions in the two competing versions of a "new and improved" Medicare, there would be no legislation this year. As for the uninsured, Senatecritter Grassley has promised hearings after the summer recess, but little else.

Just Between You and Me: Finance Chairman Grassley is an honorable man, but I wouldn't hold out hope for a compromise between Senate Democrats and House Republicans over the Medicare privatization issue. Senatecritter Ted Kennedy has made it eminently clear that nothing that smacks of isolating traditional Medicare and promoting multi-level privately-run competition can survive a Senate filibuster. Gee whiz, the 2004 elections are still 14+ months off and we are already having so much fun!

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Jeanne's Lawyer Joke of the Week
(with special thanks to our long time reader, Patrick Gallagher in New Jersey)

Several cannibals were hired by a large Washington DC law firm. "You are all part of our team now," the business manager told them during orientation. "You will get the usual benefits and you can go to the cafeteria for something to eat, but please don't eat the other employees."

The cannibals promised to leave the other employees alone. Four weeks later their boss remarked, "You're all working very hard, and I am satisfied with your work performance. However, one of our Administrative Assistants has disappeared. Do any of you know what happened to her?"

The cannibals all shook their heads no. After the boss left, the head cannibal turned to the others and said, “Which one of you idiots ate the Administrative Assistant?” A hand was raised hesitantly, and the leader continued…“You fool! For four weeks we’ve been eating the law firm’s partners and no one noticed a thing, but noooooo, you had to go and eat an Administrative Assistant!”

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3. MEDICAL SAVINGS ACCOUNTS: AD NAUSEUM

Despite the fact that the marketplace has virtually ignored them, and most health economists think they will only exacerbate the problems of health care financing, the House’s version of the “new and improved” Medicare reform bill (HR 1), once again would create tax-sheltered medical savings accounts (MSAs), now renamed “health savings accounts” in hopes perhaps that no one would notice that they are really the same old failed plans from the 90’s. The bill would allow the creation of two types of savings accounts that people enrolled in private health plans could use to accrue money tax-free to pay for some medical expenses, including medical treatment, medications and long-term care services or coverage. Individuals with deductibles of at least $1,000 and families with deductibles of at least $2,000 could use Health Savings Accounts, and individuals with $500 deductibles and families with $1,000 deductibles could use Health Savings Security Accounts. This proposal would effectively amount to a yet another tax cut for wealthier Americans to the tune of $174 billion. Consumer and labor groups oppose creation of the accounts, but approximately two dozen conservative House members have said they would vote against the final bill if the provision is not included.

Just Between You and Me: The problem with health (read: “medical”) savings accounts is that they work only for the healthier and wealthier among us. If the healthy are allowed to effectively pull their money out of the health “insurance” pool that is set aside for the assurance and protection of all, then the very concept of “insurance” upon which the system is built is destroyed. Advocates of MSAs can never get around the fact that upwards of 90% of every health care dollar, in any one insurance underwriting year, is spent on less than 50% of the insured population. People get hit by cars; their kids fall out of trees and break a leg. Individuals who had never been sick a day in their lives suddenly come down with devastating illnesses. We have insurance to protect us from these imponderables. If people who remain healthy, buckle their seatbelts, eat wisely, don’t smoke and who happen to earn sufficient incomes to benefit from the tax-sheltering, take their money out of the insurance pool; the insurance pool can be quickly drained of its reserves. The fact is that 10% of our population, those suffering from chronic illnesses and debilitating injuries, use over 50% of the health care dollar every year. MSAs do absolutely nothing to reduce these expenditures. They don’t offer a cure for illness; they don’t help prevent accidents. In the real world, 10% of us will continue to consume 50% of the health dollar. Forty percent of us will spend another 40% of the dollar. The fortunate 50%, and maybe the very fortunate 5-10% with high incomes, can make off like bandits if we can stop contributing to all of those sick people. If we can take our money out —we come out way ahead in the game. And what’s wrong with that, you ask? Nothing I suppose, if you know that your kid will never suffer a debilitating injury or you won’t be diagnosed next week with a chronic illness.

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HIPAA FUN AND TRIBULATION

Travelers Bond, a division of Travelers Property Casualty Corp. this week announced that it has extended its fiduciary liability policies to provide a sublimit of coverage for civil fines and penalties assessed under the HIPAA.

Since HIPAA applies to self-insured health plans, it has implications for employers who provide and maintain these health plans for their employees. Violations of the Privacy Rule can result in civil penalties of up to $100 per violation, and up to as much as $25,000 per year.

Travelers is currently the only carrier to offer coverage for civil penalties under HIPAA.

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4. POORER SENIORS, INELIGIBLE FOR MEDICAID, WON'T GET MUCH FROM PENDING MEDICARE Rx PROPOSALS

Medicare beneficiaries who have incomes too low to allow them to purchase prescription drugs or private insurance but who have too much income or assets to qualify for public assistance would receive very little benefit from the Medicare prescription drug measures passed by the House and Senate, according to a new Commonwealth Fund study. The study, conducted by researchers at the Pennsylvania State University and the University of Maryland, examined two hypothetical Medicare beneficiary couples in 2006, when the Medicare prescription drug benefits would begin under the House and Senate bills, HR1 and S1, which are currently being reconciled in conference committee. Both hypothetical couples have yearly total out-of-pocket drug costs of $3,459; one couple has an annual income of 130% of the federal poverty level, making them eligible for full premium subsidies and partial cost-sharing subsidies under both bills, while the other couple has an annual income of 160% of the federal poverty level, making them ineligible for premium or cost-sharing subsidies under the bills. According to the study, the couple with an annual income of 130% of the federal poverty level, or $17,017, would see their out-of-pocket drug costs reduced from 20.3% of annual income to 4.1% under the House bill or 3.4% under the Senate bill. However, the couple with an annual income of 160% of the federal poverty level, or $20,944, would only see their out-of-pocket drug costs reduced from 16.5% of annual income to 11.6% under the House bill or 15.3% under the Senate bill.

Sticker Shock Between You and Me: One of the repeating complaints our summer-recessing Congressional critters are hearing back in their home districts, is the "sticker shock" from seniors promised relief from rising drug costs, but just now starting to do the math and figuring out that they really are not getting very much in either version of the bill.

The Senior Expectation: Based on 2000 election "promises" seniors expected co-pays of $10-15 with little or no annual premium.

The Senior Reality: Co-Pays of 25-33%, Premiums of $600+/year. Why?

Soaring Costs: CBO estimates of the cost have risen, with an estimate of total senior spending on Rx reaching $1.3 trillion by 2011. President Bush and Congressional Republicans have set aside "only" $400 billion.

The Broken Promise: Seniors feel they were promised more than can be delivered and this is leading to a political tension point that could "explode" during the 2004 election cycle.

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And then they tell of the story of old lawyer Rosenkoetter, who as he lay dying summoned his daughter, also a lawyer to his side. He handed her a bible.

“Do you want me to read to you, papa?” asked the daughter.

Rosenkoetter shook his head weakly and said, “No, I want you to find the loopholes.”

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5. MANDATORY HEALTH INSURANCE: CAN’T LEAVE HOME WITHOUT IT!

Moderate Democratic Senatecritter John Breaux has given more details on his proposal to mandate health coverage for all U.S. residents. Breaux, the former co-chair of Congress special committee on the “Reform of Medicare” first introduced his plan last January. Under the Breaux plan everyone in the United States would be required to have health insurance, similar to current state laws that require drivers to carry auto insurance. Breaux’s proposal would encourage businesses currently offering employee health benefits to continue doing so, but it would not require all businesses to offer coverage. The proposal also calls for states to establish purchasing pools to ensure that people without employer-sponsored coverage could buy insurance at group rates. In addition, the government would offer tax credits to help people with low to moderate incomes purchase insurance. Under the plan, the government would fully subsidize health plan premiums for people with annual incomes lower than 150% of the federal poverty level, or about $27,000 for a family of four, and would partially subsidize premiums for those with incomes up to 250% of the poverty level, or about $45,000 for a family of four. Breaux said he will attempt to convene a bipartisan group in Congress to draft a specific proposal.

Editorial Comment: If the run up in the number of uninsured due to job cuts and lay-offs continues, something like this may become a viable alternative. Until then, don’t hold your breath.

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Why did God create rats just before lawyers?

—For practice

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6. STATES AWASH IN RED INK: EVEN DEMOCRATIC GOVERNORS HOPE THE HOUSE Rx BILL PASSES

The nation's 50 governors have come out strongly in support for a provision in the House Medicare bill, HR1, that would require the federal government to cover the cost of providing prescription drug benefits to people who are eligible for both Medicare and Medicaid. Speaking at the National Governors Association summer meetings, NGA Chair Gov. Paul Patton (D-Ky.) said shifting the cost of prescription drug coverage for the Medicaid-eligible population to the federal government is the "highest priority of governors at this juncture of congressional issues." The governors said that the Senate bill, S1, under which costs for providing drug benefits to dual eligibles would continue to be shared by states and the federal government, could create the possibility of different benefits in different states.

About 6.2 million people are enrolled in both Medicaid and Medicare, and another four million people are considered dually eligible but have not yet signed up for both programs. Dual-eligibles make up 19% of all Medicaid beneficiaries, and states spend $7 billion per year to provide prescription drug coverage to such people. An NGA analysis of state health care spending found that states would spend about another $100 billion over 10 years if the federal government does not begin covering the cost of dual eligibles. Governors said that with Medicaid costs already a strain on state budgets, requiring them to cover the cost of dual eligibles could force them to cut other state programs.

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Mike Weintraub, a lawyer and partner with Shel Silverberg, drops dead suddenly one day. In his will, they find that he has named Shel executor of the will. The day comes to divide Sam's earthly possessions, over a million dollars' worth. In front of Sam's family, Shel read the will:

"Shel, if you're reading this, then I must be dead. You've were such a good friend for so long, how can I ignore you in this will? On the other hand, there are my beloved Sophie and my children to be looked after. Shel, I know you can make sure my family is taken care of properly. So Shel, give what you want to her and take the rest for yourself." Shel then looks at the survivors and tells them that, in accordance with Sam's instructions, Shel will give fifty thousand dollars to Sam's widow. The rest he is retaining for himself.

The family is beside itself. "This is impossible! Forty years of marriage and then *this*?! It can't be!" So the family sues. Their day in court arrives, and after testimony from both sides, the judge gives his verdict: "To Sheldon Silverberg, I award fifty thousand dollars of the contested money. The remainder shall go to Sophie Weintraub, widow of the deceased." Needless to say, the family is elated, but Shel is dumbfounded. "Your honor, how can you do this? The will made Mike's wishes quite clear: ' Give what you want to her and take the rest for yourself!' I wanted the lion's share! What gives?"

The judge answered back, "Mr. Silverberg, Mike Weintraub knew you his whole life, he was your law partner. He wanted to give you something in gratitude. He also wanted to see his family taken care of. So he drew up his will accordingly. But you misread his instructions. You see, Mike knew just what kind of a person you are, so with his family's interest in mind, he didn't say, ' give what you want to her and keep the rest for yourself.' No. What Mike said was, ' Give what YOU want to HER; and keep the rest for yourself.'"

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THE DOC BOX

7. OCTOBER 16, 2003 —MORE THAN JUST A HIPAA DEADLINE!

For all of you guys and gals worried about the HIPAA transaction mandates effective October 16, 2003 —here's another thing to keep you up at night. ALL MEDICARE TRANSACTIONS (with a few exceptions, see below) MUST BE ELECTRONIC as of that same date. On August 15, the Department of Health and Human Services published the Final Rule for Electronic Submission of Medicare Claims. This rule implements the statutory requirement found in the Administrative Simplification Compliance Act (ASCA). ASCA requires (with a few exceptions) all claims sent to the Medicare Program be submitted electronically starting October 16, 2003, concurrent with the HIPAA transaction standard mandate. ASCA was enacted by Congress to improve the administration of the Medicare program by increasing efficiencies gained through additional electronic claims submission. Although 86.1 percent of Medicare claims are currently being submitted electronically, CM2 reports that the volume of paper claims is still substantial, and moving from paper to electronic submissions has the potential for significant savings for the Medicare program.

The rule is available at:

http://a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/2003/pdf/03-20955.pdf

The regulation requires that all claims submitted to Medicare on October 16, 2003 and beyond be done so electronically except for certain circumstances including:

- The provider is a small provider
- Dental claims
- Claims where there is more than one payer primary to Medicare
- Roster billing for vaccinations
- Claims for Medicare demonstration projects

While these claims may be submitted electronically, they are not required to be done that way.

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"What do you get when you cross a lawyer with a pit bull?

..A nicer lawyer."

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8. Rx DISPENSING ONCOLOGISTS TAKE ONE FOR THE GIPPER, ER, MAKE THAT, FROM THE GIPPER'S HEIR

Medicare Drug Coverage Cuts: The Bush administration, to a chorus of groans and howls from several physician groups and their hastily organized patient supporters, unveiled four proposals to lower federal spending by between $4.1 billion and $27.6 billion over 10 years by reducing the amount Medicare reimburses doctors for administering cancer treatments and other medications. Currently, Medicare reimburses physicians 95% of certain drugs' "average wholesale price" reported by pharmaceutical companies. However, many physicians often purchase the treatments for lower prices and use the remaining money to cover the cost of other services. An audit of the Medicare drug pricing system in 2000 found $1.9 billion in such "overpayments" to physicians. CM2 officials proposed four options for reducing Medicare drug spending:

- Having Medicare pay between 80% and 90% of the average wholesale price in 2004 and then establishing "more reasonable payments" in the following years;
- Limiting Medicare payments to the same levels paid by private insurers;
- Setting "market-based" reimbursement rates prices as determined by the federal government; or
- Establishing a competitive bidding process for medicines that would require drug makers to report actual average sales prices.

Facing these cuts, physician groups led by oncologists have said that cutting reimbursements could threaten patient care. Many oncologists say the extra money obtained through higher reimbursements helps them cover costs for related services, including specialized nursing and patient counseling, for which they say Medicare reimbursement rates are too low. Hoping to head off a complete insurrection, CM2 officials vaguely promised to increase reimbursements for related expenses by $1.6 billion. The four proposals were published in the Federal Register on August 20 and CM2 officials will seek public comment until October 14. The House and Senate "new and improved" Medicare bills both have provisions that would change the way Medicare reimburses oncologists for administering cancer drugs.

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As the lawyer slowly came out of the anesthesia after surgery, he said, "Why are all the blinds drawn, doctor?"

"There's a big fire across the street," the doctor replied.

"We didn't want you to think the operation was a failure."

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SPECIAL REPORT

9. SPECIAL: AN UPDATE ON EMPLOYEE ATTITUDES TOWARD THEIR HEALTH INSURANCE —JOBS VERSUS BENEFITS

I have previously reported on the stance taken by unions representing Verizon employees in their contract negotiations and the position announced by the UAW in the current automobile industry contract dispute: cut jobs before making employees pay more for their health care! Does health care really rank that high among employee priorities? Now a recent poll indicates that many U.S. employees would prefer lower-pay jobs with health insurance benefits to higher-pay jobs with no coverage benefits. In the survey, researchers at Stony Brook University on Long Island conducted telephone interviews with 865 U.S. adults between July 22 and August 12. The survey found that 71% of respondents would select a job with a lower salary and health insurance benefits and that 24% would select a job with a higher salary and no health coverage.

The preference for a job with health insurance benefits over higher pay was not dependent on job description or the age, education or income of respondents, the survey found. According to the survey, 50% of respondents with employer-sponsored health insurance have concerns that their employers will reduce their coverage next year, and 29% have concerns that they will lose their coverage; 50% of respondents said that they could not afford to purchase health insurance on the private market. However, respondents were “generally satisfied” with their current health insurance and other benefits, the survey found.

The survey is available:

http://ws.cc.stonybrook.edu/surveys/HPAAug03.htm

Begging the Question: All of this begs the question, if employees think health benefits are so important, why isn’t this reflected in the political process? Health care continues to lag as an issue when it comes to how people say they will vote.

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A lawyer was well into a lengthy cross-examination of a witness, stopped and said:

“Your honor, a juror is asleep.”

The Judge ruled: “You put him to sleep; YOU wake him up.”

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PHARMACY CORNER

10. RETAIL "BOX" (BIG AND LITTLE) Rx VERSUS PBMs
LET THE COURTS DECIDE!

Two groups representing pharmacy owners plan to file antitrust suits against pharmacy benefit managers Medco Health Solutions and AdvancePCS. The groups, the Pharmacy Freedom Fund and the National Community Pharmacists Association, say the PBMs set artificially low payments to retail pharmacies; prevent them from competing with mail-order pharmacies by prohibiting the pharmacies from dispensing more than one-month supplies of medications; and fix prices paid to pharmacies for generic drugs. The groups are seeking class-action status for the case, which will be filed in U.S. District Court in Philadelphia. A spokesperson for Medco said the lawsuit is "completely without merit" and that the company would "defend itself vigorously" against it.

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"What do you get when you cross a lawyer with a demon from hell?

…Another lawyer."

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11. RATING PRESCRIPTION DRUGS:
EFFICACY, EFFECTIVENESS, COST, RELIABILITY

Over fierce resistance from the drug industry, Congress is moving to authorize research that systematically compares the effectiveness and cost of top-selling prescription drugs. Proponents say that if Medicare is to spend $400 billion on new drug benefits over the next 10 years, it should have objective, reliable information about which medicines are most effective. The House voted last month to provide $12 million to the Public Health Service to conduct research on the "comparative effectiveness" of prescription drugs. The money was in an appropriations bill for the 2004 fiscal year that will begin on October 1.

Researchers said they might address questions like these: How does Lipitor stack up against Zocor for lowering cholesterol? How does Prilosec compare with Protonix for ulcers and heartburn? How do the long-term effects of Vioxx and Celebrex compare with those of older drugs for arthritis, like Motrin and Naprosyn? But the Pharmaceutical Research and Manufacturers of America, the main lobby for brand-name drug companies, said they had many reasons for resisting the proposal. In a memorandum to members of Congress, the trade group said: "Cost-effectiveness analysis in the private sector can provide useful information. When employed by centralized decision makers, however, it often becomes just another term for health care rationing." With studies comparing various drugs, federal officials could make "simplistic, one-size-fits-all decisions about which patients should have access to new medicines," the industry said.

The Pharmaceutical Research and Manufacturers of America also made these arguments:

- The federal studies would almost surely influence private insurers. As a result, the government's cost-based decisions about medical access would be imposed on many patients in both public and private health plans.
- Cost-effectiveness studies show which drug works best, on average, for large numbers of patients, but the studies often overlook the value of specific medicines for individuals or subgroups, like racial minorities. Different people need "different medicines" because they respond differently.
- Federal studies could stymie "incremental innovation." The government often does not appreciate the value of the incremental benefits of a new drug over existing treatments, but a series of modest gains can produce a major improvement —a much safer, more effective medicine.
- Private insurers and health plans already evaluate and compare drugs all the time. The Department of Defense, which provides health care to more than eight million people, has a team of experts who continually assess the clinical effectiveness and cost-effectiveness of drugs.

Stay Tuned: Say folks, what do you expect? When the government pays, the government sets the rules. This is a clear indication that cost controls wouldn't be far behind.

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