McCain: Carrot Rather Than Stick Approach

BY JOYCE FRIEDEN
Senior Editor

Senator John McCain (R-Ariz.) doesn't think there should be a mandate to have health insurance. "I think one of our goals should be that every American own their own home, but I'm not going to mandate that. … I feel the same way about health care. If it's affordable and available, then it seems to me it's a matter of choice amongst Americans," the Republican presidential hopeful said at a forum on health care policy sponsored by Families USA and the Federation of American Hospitals.

"The 47 million Americans that are without health insurance today, a very large portion of them are healthy young Americans who simply choose not to" sign up for it, he said at the forum, which was underwritten by the California Endowment and the Ewing Marion Kauffman Foundation. He added, however, that some people with chronic illnesses or preexisting conditions do have problems accessing insurance, "and we have to make special provisions for them."

Sen. McCain, who is serving his fourth term in Congress, said his priority as president would be to rein in health care costs. "I'm not going to force Americans to do it; I don't think that's the role of government," he said. "But if we can bring down costs, as I believe we can … I'm absolutely convinced more and more people will take advantage of [insurance]. The panacea isn't all just health care costs, but unless you address health care costs, you're never going to solve the other aspects of the health care crisis."

One way to control costs at the federal level is to not pay for medical errors involving Medicare patients, Sen. McCain said in an interview after the forum. "Right now we pay for every single procedure—the MRI, the CT scan, the transfusion, whatever it is. [Instead], we should be paying the provider and the doctor a certain set amount of money directly related to overall care and results. That way we remove the incentives now in place for overmedicating, overtaxing, and overindulging in unnecessary procedures. I also think it rewards good performance by the providers."

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Sen. McCain proposes a refundable tax credit of $2,500 per individual and $5,000 per family to help the uninsured buy health insurance. To pay for the credits—which would cost an estimated $3.5 trillion over 10 years—he proposes abolishing the tax deduction employees take when they pay premiums on their employer-sponsored health plans. He would leave intact the deduction employers take on their portion of the premiums as an incentive for employers to continue offering coverage.

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SEN. McCAIN

The "refundable tax credit for employees [allows] them to go out and make choices," Sen. McCain said. "When it's their money and their decision, I think they make much wiser decisions than when it's provided by somebody else." Low-income Americans who pay no taxes will receive a check for the amount of the credit, he noted.

When a reporter pointed out that the average cost for family health insurance is more than $12,000 per year—far higher than the amount of the proposed family tax credit—Sen. McCain said the credit still would be beneficial. "If someone has a gold-plated health insurance policy, they'll start to pay taxes [on those premiums] and it may make them make different decisions about the extent and coverage of their health insurance plan," he said. Additionally, "For low-income people who have no health insurance today, at least now they've got $2,500, or $5,000 in the case of a family, to go out and at least start beginning to have [it]."

Sen. McCain admitted the tax credit plan "is not a perfect solution, and if not for the price tag involved, I'd make it even higher. But according to the Congressional Budget Office, by shifting the employee tax aspect of it, you save $3.5 trillion over a 10-year period, and I think that would have some beneficial effect at reducing the overall health care cost burden that we're laying on future generations."

Sen. McCain said he does not support outlawing the "cherry-picking" that some health plans do to make certain they insure mostly healthy people. Outlawing cherry-picking "would be mandating what the free enterprise system does." Instead, he favored broadening the high-risk pools that states use to provide coverage for some of their uninsured residents. "I would rather go that route than mandate that health insurance companies under any condition would have to accept a certain level of patients. … One reason is that we have seen in the past that [insurance companies] have a great ability to game the system."

The senator said in an interview that he favors reforms to the malpractice system. "I would like to see that any medical provider or doctor who stayed within medical guidelines would then not be sued." Sen. McCain also noted that although he is against abortion, "I think stem cell research holds great promise in addressing some of these terrible afflictions that face our nation and the world, such as Alzheimer's and Parkinson's." ■

SCHIP Wins Extension Until 2009

BY ALICIA AULT
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After months of debate and two presidential vetoes, Congress has successfully voted to extend the State Children's Health Insurance Program to April 2009.

President Bush signed the legislation on Dec. 29. The SCHIP extension is included in a bill that also addressed Medicare physician reimbursement, payments for Part B drugs, lab tests used by diabetics, and long-term care hospitals.

Authorization for SCHIP expired Sept. 30. The program continued to operate through two continuing resolutions that kept the entire federal government funded until mid-December while lawmakers and the President wrangled over a 5-year reauthorization.

The showdown ended when the Senate and House both agreed to a stripped-down version of the Democrats' wish list. Congress voted to allocate enough funds to keep SCHIP enrollment at 2007 levels—about 6 million children and adults—through March 31, 2009. Democrats had sought to cover 10 million children.

And the bill provided enough funding to keep programs afloat in a handful of states that were facing budgetary shortfalls.

Democrats and child advocates were relieved the program was extended temporarily, but many expressed concern about SCHIP's future.

"Today we passed a package that puts a band-aid on Medicare and buys just a little more time for families currently relying on SCHIP to keep their children healthy," Rep. Charles B. Rangel (D-N.Y.) said in a statement. "My concern with this legislation is not what's in it, but what's not in it."

House Speaker Nancy Pelosi issued a statement noting the bill "does not make headway in reducing the number of uninsured."

Some Republicans weren't happy, either. Sen. Charles Grassley (R-Iowa) said although the original bill was passed unanimously in the Senate, he knew it fell short of what many in Congress were hoping for. "I do hope we can do more when we come back next year," he said in a statement.

The SCHIP package that was passed did not—as Democrats had preferred—reverse a directive issued by the Centers for Medicare and Medicaid Services last August. States were notified that if they were raising eligibility for children whose family incomes were equal to or above 250% of the federal poverty level, they would have to meet stringent new requirements. Primarily, states would have to prove that 95% of eligible children—those at 250% of poverty—were enrolled. The goal: to ensure that these families are not opting for SCHIP instead of private insurance.

States must meet that target by August 2008. In a briefing, Acting CMS Administrator Kerry Weems said at least two states, Vermont and Massachusetts, will soon meet the goal. Currently, there is no enforcement plan, he said.

In a conference call with reporters, Robert Greenstein, executive director of the Center on Budget and Policy Priorities, a liberal-leaning think tank in Washington, said that the directive could have a huge impact on enrollment. Fourteen states already cover children above 250% of poverty, and 10 more had plans to expand eligibility above that level.

Thus, the SCHIP bill "was not a maintenance of the current situation but backwards progress," he said. ■

Use Specific Codes to Boost Your Chance of Getting Paid

BY MITCHEL L. ZOLER
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PHILADELPHIA — When submitting diagnostic codes, always use the most specific code possible.

If very specific codes are not used, or if they are submitted with one or more less specific codes, payers will often reimburse based on the more general code and ignore anything else, Dr. Gregory L. Barkley said at the annual meeting of the American Epilepsy Society.

Providers should also add a fifth digit to the code when appropriate. The number 1 at the end of a code indicates the condition is intractable—both resistant to cure and so severe, the patient cannot live a normal life, said Dr. Barkley, director of the Comprehensive Epilepsy Center at Henry Ford Hospital in Detroit. For example, an ICD-9 code 345.91 means unspecified, intractable epilepsy. The counterpart code 345.90 is unspecified but not intractable epilepsy.

It's also important to specify what services were provided on each day of care. Several days of treatment should not be presented together. Instead, each day should be dealt with individually, with the charges calculated for each day and the coding clearly showing how the charges were determined. And every facet of care must be itemized for every day it was provided. For example, speaking with a patient can qualify as a hearing assessment. If that is relevant to the case, put this interaction into the claim and the patient's chart, Dr. Barkley advised.

For 2008, new codes include the 359 series for myotonia, including 359.21 for myotonic muscular dystrophy, 359.22 for myotonia congenital, 359.23 for myotonic chondrodystrophy, 359.24 for drug-induced myotonia, and 359.25 for other, specified myotonic disorder.

Also new is the 389 hearing loss series, including 389.05 for conductive hearing loss, unilateral; 389.17 for sensory hearing loss, unilateral; and 389.21 for mixed hearing loss, unspecified. Related is 388.45 for acquired auditory processing disorder.

There are new 787 codes for dysphagia, like 787.20 for dysphagia, unspecified; and 787.23 for dysphagia, pharyngoesophageal phase.

Deleted codes are 359.3, periodic paralysis; 389.14, central hearing loss; and 389.7, deaf, nonspeaking, not elsewhere classifiable. ■