

FDA Funding Will Also Get Boost

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budget documents note that the HHS proposal lays the "groundwork" for health reform, but the plan is a stark contrast to last year's proposal, which included a \$635 billion "reserve fund" dedicated to health reform over the next decade. With the prospect for passing comprehensive health reform legislation waning, there was a much smaller emphasis on health reform in the current budget proposal.

Ms. Sebelius said that although the current budget proposal tries to increase coverage and curb costs, it would do little to affect the overall trajectory of health care costs if not accompanied by health care reform legislation. The FY 2011 budget aims to invest in wellness, health information technology, and comparative effectiveness research, but it won't significantly alter the rise in health care costs, fill coverage gap, or provide security to those with coverage, she said.

Overall, the Obama administration is seeking \$911 billion in funding for HHS in FY 2011, an increase of \$51 billion over the current fiscal year. The bulk of HHS's funding is tied up in mandatory obligations including Medicare and Medicaid, so the budget includes just \$81 billion in discretionary program spending, an increase of \$2.3 billion over last year.

The Obama administration's budget request assumes that Congress will step in to correct the Medicare physician payment formula, known as the sustainable growth rate. Currently, physicians are scheduled to face a 21% across-the-board cut to their Medicare payments on March 1, unless

Congress passes legislation to avert the cut. The budget proposal assumes no growth in Medicare physician payment over the next 10 years, at a cost of \$371 billion, Ms. Sebelius said.

The budget request also calls for a \$290 million investment in community health centers, bringing their funding to \$2.5 billion. The increase should allow the health centers to continue to serve the new patients they began caring for when the centers got an infusion of funding under the American Recovery and Reinvestment Act (stimulus bill) last year. HHS estimates that community health centers will be able to serve more than 20 million patients in FY 2011.

The budget request also calls for nearly \$1 billion, an increase of about \$33 million, to help shore up the health care workforce. The money will help to expand loan repayment programs for physicians, nurses, and dentists who agree to practice in medically underserved areas.

The Obama administration also proposes to spend \$4 billion to fund the Food and Drug Administration, with \$1.4 billion going toward medical product safety, including drugs, devices, vaccines, and the blood supply. The funding represents an increase of \$101 million in FY 2011. The new money would go toward import safety, high-risk products, and partnerships for patient safety. About \$40 million of that new funding is slated to go toward the generic drugs program, including new investments in postmarket drug safety and the establishment of a medical device registry. ■

Hospitalization Climbs When Outpatient Copayments Rise

BY JANE ANDERSON

When Medicare managed care plans raise outpatient copayments, outpatient visits decline, but hospitalizations increase and inpatient stays get longer, especially among chronically ill beneficiaries and those living in areas of poverty, a study showed.

Increasing cost sharing for ambulatory care among elderly patients may have adverse health consequences and could increase total spending on health care, the researchers concluded (*N. Engl. J. Med.* 2010;362:320-8).

"In response to increases in ambulatory copayments, the elderly cut back on outpatient visits but are more likely to need expensive hospital care," said lead author Dr. Amal Trivedi of Brown University, Providence, R.I.

"Therefore, increasing such copayments among the elderly may be an ill-advised cost-containment strategy," he said in an interview.

Dr. Trivedi and his colleagues compared the use of outpatient and inpatient care between Medicare enrollees in plans that had increased copayments for ambulatory care in a given year and enrollees in

matched plans that had not. Nearly 900,000 Medicare beneficiaries were included in the study of 2001-2006 data.

The mean copayment increases were from about \$7 to \$14 for outpatient primary care and about \$12 to \$22 for outpatient specialty care, while the control plans kept copayments at about \$8 for primary care and \$11 for specialty care.

In the year after a plan increased copayments, it would have almost 20 fewer outpatient visits per 100 enrollees but more than two additional hospital admissions per 100 enrollees, adding about 13 additional inpatient days, compared with plans not increasing copayments.

The effect of increased copayments was significantly greater among enrollees in areas with lower average income and education. "We didn't explicitly measure health status, but the increased need for acute hospital care among these enrollees is concerning," Dr. Trivedi said.

The effect of copayment increases also was magnified among Medicare managed care enrollees with hypertension or diabetes and those with histories of acute myocardial infarction.

The authors reported having no conflicts of interest. ■

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VITAL SIGNS

PhRMA Topped Health Sector Lobbying in Third Quarter (in millions)



Source: U.S. Senate Office of Public Records, 2009 data