Feds Lag Behind States In Covering Uninsured

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SAN DIEGO — The pressure is building to expand health insurance coverage, and the states are taking the lead, Jack Ginsburg said at the annual meeting of the American College of Physicians.

The issue of covering the uninsured is likely to heat up during the 2008 presidential election season, but little is expected at the federal level until after the race is decided, said Mr. Ginsburg, director of health policy analysis and research at the ACP.

"Where the action is really taking place is at the state level," he said.

There are comprehensive plans aimed at covering the uninsured in Maine, Massachusetts, and Vermont. In Maine, the state offers its residents discounts on premiums and deductibles on a sliding scale. In Massachusetts, the strategy for expanding coverage focuses on individual coverage mandates and income-based subsidies. And in Vermont, the state offers subsidies for the uninsured and employers pay an annual assessment for uninsured workers.

Other states, including Connecticut, Illinois, Pennsylvania, and Tennessee, are offering expanded coverage for children. In Connecticut, families with an income of more than 300% of the federal poverty level can buy into the State Children's Health Insurance Program (SCHIP). More states are considering plans for universal health coverage for children.

In Montana, Rhode Island, Tennessee, and Utah, lawmakers have opted for incremental coverage that relies on public-private partnerships, including combinations of approaches such as limits on insurance premiums, purchasing pools, premium assistance, and tax credits.

Lawmakers in several other states are considering proposals to expand health insurance coverage. In California, Gov. Arnold Schwarzenegger (R) has proposed an individual insurance mandate, an expansion of Medicaid and SCHIP, and the creation of purchasing pools.

There are several legislative proposals circulating at the federal level, starting with the Bush administration plan, which involves tax deductions of $7,500 for individuals and $15,000 for families to offset the cost of purchasing health insurance. The president's plan also relies on health savings accounts, taxing employers' health plan contributions as income, and association health plans.

On the Democratic side, the most detailed plan so far has come from former Sen. John Edwards (D-N.C.), who favors mandatory coverage for all through an expansion of Medicaid and SCHIP, sliding-scale tax credits, and other initiatives. Two other candidates, Sen. Hillary Clinton (D-N.Y.) and Sen. Barack Obama (D-Ill.), have stated a goal of universal coverage but have released few details, Mr. Ginsburg said.

Among the GOP candidates, most have said that they support "market-driven" approaches, he said. ■

PQRI Reporting May Require Reason for Excluding Measure

Physicians who choose to participate in Medicare's pay for reporting program do not have to satisfy quality indicators to receive a bonus. But in some cases, they will need to cite why they did not follow evidence-based guidelines.

Under the Physician Quality Reporting Initiative (PQRI), which began July 1, reporting for certain measures includes adding a coding modifier explaining why a service was not performed. For example, the service may not have been provided because it was not medically indicated or the patient declined.

PQRI, a voluntary program that allows physicians to earn a bonus payment of up to 1.5% of total allowed Medicare charges for reporting on certain quality measures, will run from July 1 through the end of the year. CMS officials have selected 74 quality measures and physicians are expected to report on between one and three measures, depending on how many apply to their patient populations.

When reporting on measures, physicians must include a CPT-II code or G-code. Some measures may also require that physicians add a modifier to the CPT II code if the service was not provided. These modifiers are not used when reporting G codes. The CPT-II modifiers include performance measure exclusion modifiers and a performance measure reporting modifier. For example:

- ► Modifier -1P is used to show that the service was not indicated or is contraindicated for medical reasons.
- ► Modifier -2P is used to indicate that the service was not provided for patient reasons, such as the patient declining or religious objections.
- ► Modifier -3P is used to indicate that the service was not provided for systems reasons such as insurance coverage limitations or a lack of resources to provide the service.
- ► Modifier -8P is a performance measure reporting modifier and indicates that the action was not performed and the reason has not been specified.

Specific instructions on when to use a modifier in the 2007 PQRI Specifications Document, which is available online at www.cms.hhs.gov/pqri.

—Mary Ellen Schneider

POLICY & PRACTICE

Penn. Publishes Surgery Data

The Pennsylvania Health Care Cost Containment Council has published data on 17,331 coronary artery bypass grafts (CABGs) and/or valve surgeries performed in the state in 2005. The data include in-hospital and 30-day mortality rates, 7- and 30-day readmission rates, and hospital- and surgeon-specific post-surgical lengths of stay. Inpatient mortality for CABG dropped from 1.98% in 2004 to 1.9% in 2005, but 7- and 30-day readmission rates increased slightly. The in-hospital death rate for those without infections was 2.4%, compared with 13.5% for those with infection. Overall mortality was 1.9% for CABG without valve; 3% for valve without CABG; and 7.5% for valve with CABG. Charges averaged $330,000 for those cases; on average, Medicare reimbursed about $57,000, and private insurers reimbursed about $65,000. The report also found that the amount paid by commercial payers and Medicare to each individual facility varied wildly, from a low of about $18,000 to a high of $106,000. Every hospital and surgeon in the state was given an opportunity to comment on the report. The Hospital of the University of Pennsylvania, for instance, noted that the majority of the 13 patients who died at its facility after a combined valve-CABG procedure were "at exceptionally high risk for perioperative death." The report and associated comments can be found at www.ph4c.org.

Guidant Defib Suits Move Ahead

A U.S. District Court Judge in Minneapolis has ruled that a number of suits brought against Guidant Corp. can proceed. Guidant, now part of Boston Scientific Corp., was sued by 1,660 plaintiffs who allege that the company did not properly warn physicians and patients that its Model 1861 defibrillator had a design flaw. The model was recalled in 2005, but the suit contends that the company knew about the flaw in 2002. Boston Scientific has argued that the complaints should not be allowed to go forward because none of the plaintiffs were injured. However, Judge Donovan Frank said that the company should not be able to shirk liability just because the people alleging harm had their devices explanted. The first case is due to go to trial in late July. "We are fully prepared to take the bellwether cases to trial and remain confident that when juries look into the individual facts, they will side with us," said Boston Scientific spokesman Paul Donovan in an interview.

Avandia-Related Suits Start

GlaxoSmithKline is facing more headaches with its diabetes drug Avandia (rosiglitazone). A Texas man's relatives filed suit in the U.S. District Court for Eastern Texas in late June and claimed that the company failed to warn of cardiac risks. The 60-year-old, who was taking Avandamet (a combination of rosiglitazone and metformin), died on May 21, the day a meta-analysis showing increased heart risks by Dr. Steven Nissen of the Cleveland Clinic was published in the New England Journal of Medicine. And, Kaplan Fox & Kilsheimer, a New York–based law firm, has filed a class-action lawsuit against the drug maker on behalf of anyone who purchased shares between Oct. 27, 2005, and May 21, 2007. The suit alleges that although GSK submitted partial data to the Food and Drug Administration in September 2005 and August 2006, it did not adequately disclose to the public that it had conducted a meta-analysis that showed an increased risk of heart attacks. When the results of Dr. Nissen's analysis were published on May 21, GSK's share price dropped $4.53, or 7.8%, according to the law firm.

New FDA Risk Panel

Following an Institute of Medicine recommendation, the Food and Drug Administration has created a new advisory committee that will be charged with helping the agency better communicate the risks and benefits of pharmaceuticals and other products it regulates. In 2006, the IOM's report, The Future of Drug Safety: Promoting and Protecting the Health of the Public, urged Congress to establish a new advisory panel that would weigh in on the FDA's communications about safety and efficacy to health care providers and the public. The agency found an administrative process that let it establish the committee without congressional action. The FDA is now seeking 15 members to serve on the Risk Communication Advisory Committee, including experts on risk communication, social marketing, health literacy, journalism, bioethics, and cultural competency.

DTC Ads Still Fall Short

Direct-to-consumer (DTC) advertisements emphasize individual drugs over conditions, don't do enough to emphasize risk, and minimize the importance of underlying health issues, according to a panel that reviewed such advertisements for the Pharmaceutical Research and Manufacturers of America. The review was undertaken to determine if consumer-directed marketing is meeting PhRMA's voluntary guiding principles, adopted in 2005 to address "many of the concerns publicly expressed about DTC advertising." The four volunteer panelists—a pharmacist, a nurse, and two family physicians—also urged drug makers to include more information in their ads about assistance programs that provide low-cost or free medications. In a separate report, PhRMA said that comments it received from consumers on DTC ads indicated that many were confused about the ads' contents and thought they did not present a balance of risks and benefits. The organization received 458 comments from July to December 2006, mostly from consumers; 10% were from health professionals. The comments go to PhRMA's Office of Accountability, which forwards them for responses from individual drug makers.

—Alicia Ault