Policy & Practice

Alefacept for Sale

Biogen Idec, which markets alefacept (Amevive), has announced plans to sell its global alefacept business franchise. The company plans to focus instead on other products in the oncology, immunology, and neurology fields. At press time, the company was in discussions with potential buyers. John Palmer, senior vice president of the immunology business unit at Biogen Idec, noted that the pending sale will not impact delivery of the drug. During this interim period, the product supply will remain available through normal distribution channels and the company will continue to provide customer service and medical support, according to a letter from Biogen Idec to doctors who prescribe the drug. In addition, ongoing clinical studies and associated activities will be continued, the letter said. "The dermatology community and psoriasis patients deserve the best support available and we are committed to finding a company that ensures ongoing support and development of Amevive," the letter said. Physicians with questions can call the company at 866-263-8483.

Salary Affects Specialty Choice

When it comes to choosing a specialty, U.S. medical graduates are more concerned with earning power than medical liability costs, according to a study published in the September issue of Obstetrics and Gynecology. Procedure-based and hospital-based specialties, generally associated with higher incomes, are the most likely to have residency positions filled by U.S. medical graduates, the researchers found, even when the specialty had higher professional liability costs. For example, U.S. medical students filled more than 90% of the residency positions in neurosurgery and orthopedic surgery, where liability insurance costs are high, but so are incomes. But the researchers noted that students also may be attracted to high-earning fields because of the technical challenges or the ability to have a more controllable lifestyle. The results are based on data from the 2004 National Resident Matching Program, the American Medical Association, the Medical Group Management Association, and a major Massachusetts liability insurer.

Part B Premiums on the Rise

Monthly Medicare Part B premiums will be $88.50 in 2006, an increase of $10.30 from the current $78.20 premium, the Centers for Medicare and Medicaid Services announced. The agency cited continued rapid growth in the intensity and utilization of Part B services as the primary reason for the premium increase. "This growth is seen in physician office visits, lab tests, minor procedures, and physician-administered drugs. It also includes rapid growth in hospital outpatient services," the agency said in a statement. Part of the premium increase is necessary to increase funds held, for accounting purposes, in the Part B trust fund. Though premiums are rising, most Medicare beneficiaries will see significantly lower out-of-pocket health care costs in 2006 because of the savings in drug costs from the new Medicare prescription drug benefit, the agency claimed. About 25% of beneficiaries can receive assistance that pays for their entire Part B premium, and about 33% can receive assistance for their Part D premium.

Health IT Standards

The National Committee for Quality Assurance (NCQA) is planning to make changes to its 2-year-old program that recognizes physicians for using clinical information and technology to improve patient care. The Physician Practice Connections (PPC) program was launched in 2004 with nine modules. The new version attempts to streamline those modules into eight standards as part of a single program. The eight elements include patient tracking and registry functions, care management, patient self-management support, electronic prescribing, tracking of laboratory and radiology tests, referral tracking, performance reporting and improvement, and interconnectivity. Currently 80 practices, representing nearly 700 physicians, are recognized under the NCQA program. For more information, visit www.ncqa.org/ppc. The revised standards will be published early next year.

Research Fraud Investigation

Key members of the House Energy and Commerce Committee are calling for an investigation into the alleged misuse of millions of dollars in government research funds at top U.S. universities. Committee chairman Rep. Joe Barton (R-Tex.) and Rep. Ed Whitfield (R-Ky.), chairman of the committee's oversight and investigations subcommittee, have asked the Department of Health and Human Services' Office of Inspector General to audit some of the largest research grants from the National Institutes of Health to compare the number of research activities projected to the NIH and the number actually performed. They cited recent settlements between NIH university grantees and the Department of Justice over allegations that federal grant funds were misused. "The alleged misuse of NIH grant funds raises serious public policy concerns of waste, effectiveness, and integrity of taxpayer-support research programs," the congressmen said in a letter to the inspector general.

—Mary Ellen Schneider

Premium Increases Could Hurt Medicaid Enrollment

BY MARY ELLEN SCHNEIDER
Senior Writer

NASHVILLE, TENN. — Proposals to increase cost sharing for Medicaid beneficiaries could reduce enrollment in the program, according to the preliminary results of a study presented at the annual conference of the National Academy for State Health Policy.

Genevieve Kenney, principal research associate at the Urban Institute, and her colleagues examined the impact of premium increases in the State Children's Health Insurance Program (SCHIP) as a way to inform policy changes under Medicaid.

More than 30 states have premiums for some children whose incomes are above the federal poverty level. No existing Medicaid program charges premiums for children below poverty, Ms. Kenney said.

However, proposals, such as one from the National Governors' Association, would permit states to charge up to $480 annually per child to low-income families.

The research, which was funded by the David and Lucile Packard Foundation, looked at enrollment and disenrollment patterns in three states that increased premiums in 2003—Kansas, Kentucky, and New Hampshire.

SCHIP officials in Kansas increased premiums from $10 to $30 per family in February 2003 for families between 151% and 175% of the federal poverty level. The state then decreased the premiums to $20 in July 2003. For families between 176% and 200% of poverty, the premium was increased from $15 to $45 and then decreased to $30.

The total caseload growth rate 6 months before the premium increase in Kansas was 14.6%. Six months after the increase the growth rate had fallen to –4.2%, Ms. Kenney reported. Although there was an initial drop in enrollment, the caseload picked up over time, and there has been healthy growth, she said.

The results were similar in New Hampshire, where SCHIP officials increased the premiums from $20 to $25 per child in January 2003 for families between 185% and 249% of poverty. For families between 250% and 300% of poverty, the premium was increased from $40 to $45.

But in Kentucky, which instituted a premium for the first time, the decline in caseload was more dramatic. Officials there initiated a $20 premium for families between 151% and 200% of poverty in December 2003. Six months before the change, the total caseload growth rate was –0.2%. Six months after the new premium was instituted, the growth rate fell to –17.4%. The premium increases there also had a stronger disenrollment effect than in the other two states.

These findings add to a growing body of evidence that increased premiums appear to reduce enrollment and increase disenrollment, Ms. Kenney said, though the impact is different among subgroups.

The largest effects occur when new premiums are imposed, especially on lower-income beneficiaries. The availability and cost of employer-sponsored insurance and other public premium policies, such as sanction policies for nonpayment of premiums, may also play a role, she said. ■