Advocates, Democrats Vow To Override SCHIP Veto

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Soon after President Bush delivered on his promise to veto the bipartisan reauthorization of the State Children's Health Insurance Program (SCHIP) on Oct. 3, Democrats in the U.S. House vowed to round up the votes needed to override the veto.

Professional medical societies and advocacy groups said they would join in the battle. "If SCHIP is not reauthorized, millions of children will be denied basic health care needs. … We are asking Congress to override your veto," Dr. David C. Dale, president of the American College of Physicians, said in a letter to the White House.

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In a statement, Dr. Edward L. Langston, board chair of the American Medical Association, called the veto disappointing. "The number of uninsured kids has increased by nearly 1 million over the past year, and action must be taken to reverse this trend."

Families USA Executive Director Ron Pollack said that even if the House is not successful in overriding the veto, the SCHIP legislation will eventually be approved. "I think there will be increasing pressure on the White House to offer concessions to get this adopted," Mr. Pollack said in an interview, noting that every round of votes against SCHIP will prove increasingly embarrassing to Republican lawmakers.

Advocates have some time to make their case—SCHIP, which expired Sept. 30, is able to tap funds appropriated as part of a continuing resolution that was approved by Congress to keep the government running until Nov. 16.

The SCHIP program currently covers an estimated 6 million children; the package that was passed by the House and Senate (H.R. 976) and vetoed by the president would have added $35 billion in funding to the program, increasing the enrollment by as many as 4 million children. The new funding was to come from an increase in the excise tax on tobacco.

The package introduced several new elements, including dental benefits and mental health parity. States also would have been given the ability to seek a waiver to extend coverage to low-income pregnant women. And the Department of Health and Human Services was directed to develop a core set of measures to track quality in the Medicaid and SCHIP programs.

The president had signaled his intention to veto, saying that the initial package passed by the House would be a step toward government-run health care and would give coverage to higher-income children. Those children might drop private coverage to join SCHIP, Mr. Bush said.

The final package acknowledged that the program might be overreaching and directed the Government Accountability Office to study and share best practices in states that have successfully prevented children from higher-income families from dropping private coverage. That may have been the only point of convergence for the White House and Congress. ■

CMS Announces Higher Medicare Part B Premiums for 2008

The standard monthly Medicare Part B premium will rise to $96.40 next year, up 3.1% from the current $93.50, Kerry Weems, administrator of the Centers for Medicare and Medicaid Services announced in a teleconference with reporters.

That amount will be paid by individuals with an annual income of $82,000 or less, or couples with $160,000 or less a year—approximately 95% of all Medicare beneficiaries, according to the agency.

Next year, Part B premiums again will be tied to beneficiary income, as required by the Medicare Modernization Act. For example, for beneficiaries in the top bracket (annual income above $205,000, or above $410,000 for couples), the amount will increase to $238.40, up from this year's $161.40. The Part B deductible also will rise to $135 from the current $131.

The increases reflect higher fee-for-service costs—including for home health services and physician-administered drugs, and for the Medicare Advantage program—as well as the need to increase contingency reserves in the Part B trust fund, Mr. Weems said.

Dr. Edward Langston, chair of the American Medical Association Board of Trustees, expressed concern in a statement that government is cutting payment to doctors who care for the majority of Medicare patients who are in effect "helping subsidize overpayments to private insurance companies" that provide Medicare Advantage plans.

The AMA is urging Congress to eliminate overpayments to Medicare Advantage plans. CMS also announced increases in the Medicare Part A deductible and in the premium for those who must "buy in" for coverage. Beneficiaries who have less than 30 quarters of coverage would have to pay $432, up $13 from the current $419. The Part A deductible, payable at first hospital admission, will rise to $1,024, up $32 from the current $992, Mr. Weems said.

—Renée Matthews

POLICY & PRACTICE

Lawmakers OK Rx Rule Delay

Coming down to the wire on a new federal mandate requiring the use of tamper-resistant prescription pads for all Medicaid prescriptions, lawmakers in the House and the Senate passed legislation in late September that would delay the mandate's start until March 31, 2008. At press time, President Bush was expected to sign the legislation, National Community Pharmacists Association spokesman John Norton said. The delay was bundled with extensions on several programs due to expire Sept. 30, including an abstinence education initiative that the Bush administration supports, Mr. Norton said. The original mandate, passed as part of war funding legislation earlier this year, requires all Medicaid prescriptions to be written on tamper-resistant paper to be eligible for federal reimbursement. Even though many states have similar requirements, pharmacists' organizations have maintained that most physicians do not currently use these types of pads, nor are supplies readily available.

Insurance Premium Increase Slows

Employer-sponsored health insurance premiums rose on average 6.1% in 2007, reflecting a continuing slowdown in premium increases. The 2007 premium increase is the smallest hike since 1999, according to an employer survey by the Kaiser Family Foundation and the Health Research and Educational Trust. But experts say the slowdown is likely temporary and isn't providing relief to individuals or employers. In fact, the 6.1% increase is higher than the average increase in wages (3.7%) and in the overall inflation rate (2.6%). In 2007, the average premium for family coverage in the United States is $12,106, with workers paying about $3,281 for their share of the policy. The market continues to be dominated by preferred provider organizations, which insure about 57% of covered workers; consumer-driven plans account for only about 5%. For details, visit www.kff.org/insurance/7672.

N.J. Task Force Examines MD Gifts

The New Jersey Attorney General's Advisory Task Force on Physician Compensation, which met for the first time in September, is examining the potential impact of payments and gifts to physicians from the drug and device industry. The task force will also consider public disclosure of gifts, direct disclosure to patients, and limits on payments to physicians. Vermont, Maine, Minnesota, West Virginia, and the District of Columbia have passed laws requiring some form of reporting of payments made to physicians by drug and medical device companies. In response to the formation of the task force, the Pharmaceutical Research and Manufacturers of America issued a statement citing its 2002 Code on Interactions with Healthcare Professionals as an important safeguard. The code declares all forms of entertainment to be inappropriate gifts and says that any gifts given to physicians should support medical practice and be valued at less than $100.

Taxing Health Benefits

Proposals to cap the tax deductions employers and employees can take regarding health insurance could spell the end of employer-based health benefits, according to a new report from the Employee Benefit Research Institute. Currently, employers are allowed to deduct the cost of the health insurance coverage they provide to their workers with no limits and workers are not taxed on the value of the health coverage they receive. Capping these tax exclusions could cause young, healthy workers to seek insurance outside of their employers' offering, leaving employers with an older, sicker pool of patients, the EBRI report said. The organization also examined the potential effect of offering tax credits as a way to reduce the number of uninsured Americans. But even a sizable tax credit is unlikely to be enough to offset the high costs of health insurance, the report noted. The full report is available online at www.ebri.org.

One-Third of Americans Uninsured

According to a September report by Families USA, almost 35% of Americans had no health care coverage for at least part of 2006-2007, up from about 30% in 1999-2000. Of these, 19% were uninsured for the entire period and 19% were uninsured for longer than 1 year; more than half were uninsured for longer than 6 months. Of the 89.6 million individuals who lacked health care coverage, 71% were employed full time and another nearly 9% were working part time; only 17% were unemployed. The numbers in the report are substantially larger than those published by the U.S. Census Bureau (which cites 47 million uninsured in 2006, or 16%), because Census Bureau statistics include only those who were uninsured for a full year. The report is available at www.familiesusa.org.

Required Audits of Limited Value

The Centers for Medicare and Medicaid Services did not meet the audit requirement for private insurers participating in Medicare during 2001-2005, nor did it attempt to recover overpayments to the insurers that should have been channeled back to the beneficiaries and government, according to a report by the Government Accountability Office. The Balanced Budget Act of 1997 required CMS to conduct annual audits of at least one-third of the participating insurers. During 2001-2005, between 19% and 23% of organizations were audited, and only 14% were audited in 2006. In 2003, 49 of 220 participating plans were audited; a contractor identified errors for 41, which would have translated into $59 million for additional benefits or to offset costs for beneficiaries. CMS claimed that it does not have legal authority to pursue such financial recoveries, but the GAO asserted that CMS has the authority but did not exercise it.

—Leanne Sullivan