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Patients' Rights

SUPREMES: STATE SUITS AGAINST HEALTH PLANS VIOLATE ERISA

Enrollees in employer-sponsored health plans can't sue in state court for malpractice when the managed care organization that runs the plan refuses to pay for physician-recommended care.

That's what a unanimous Supreme Court held June 21 in two consolidated cases, *Aetna Health Inc. v. Davila* and *Cigna Healthcare of Texas Inc. v. Calad*. Writing for the Court, Justice Clarence Thomas said such state actions are preempted by a federal statute, the Employee Retirement Income Security Act of 1974, which governs many plans sponsored by employers.

The decision knocks out the suits that plaintiffs Juan Davila and Ruby Calad had brought against their MCOs under the Texas Healthcare Liability Act of 1997, the oldest of several state laws imposing malpractice-type liability on health plans. Davila sued over gastrointestinal bleeding caused by Naprosyn, a painkiller that Aetna insisted he try before it would pay for the more-expensive Vioxx Davila's physician recommended for his arthritis pain. Calad sued over hysterectomy-related complications that landed her back in the hospital, days after Cigna — against her physician's recommendation — had authorized only a one-day post-operative stay.

Davila and Calad remain free to sue in federal court under ERISA. But that statute allows them to sue only for the value of denied treatment — i.e. the price difference between Vioxx and

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LOWER PREMIUMS? MEDICARE PPOs? DON'T BET ON IT, ANALYSTS SAY

Medical cost trends are slowing, but don't expect a price-savvy, consolidated insurance industry to lower premiums to match.

That was among the predictions offered by a panel of financial and policy analysts who assembled in Washington June 24 for an annual forum on health-care markets sponsored by the nonpartisan research and policy group Center for Studying Health System Change (HSC).

Among the day's top themes: Insurers have a lot of clout, pharmaceutical manufacturers are still on shaky ground, and when it comes to government payments — nothing is forever.

• ***Medicare Advantage in 2006 will look a whole lot like the heyday of Medicare+Choice.*** With new payments for Medicare health maintenance organizations enacted in the 2003 Medicare Modernization Act, Medicare Advantage — Medicare's private-plan side — looks like a great bet to many companies, said Robert Laszewski, president of the Health Policy and Strategy Associates, Inc., consultancy.

For an HMO that does county-by-county analysis and chooses the right markets, the profit-making potential of MA is "extraordinary," despite the fact that many markets remain no-go zones, he said. It's possible to find a market that's "a real gem" even in some surprising states, such as Iowa.

A Medicare HMO is "the product the industry really wants," said Laszweski. But we won't see the PPOs that the White House, among others, has touted as a way to expand private plans nationwide, he

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Naprosyn, or the cost of a second hospital inpatient day — rather than the far larger consequential damages, such as pain and suffering, that they say resulted from their plans' negligence and that would have been available, along with punitive damages, under the Texas law.

Quoting from an earlier case, Thomas said ERISA represents "a careful balancing of the need for prompt and fair claims settlement procedures against the public interest encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA."

Thomas turned back Davila and Calad's arguments that their claims arose independently of ERISA. Under the terms of the Texas law, "a managed care entity could not be subject to liability" if it simply "denied coverage for any treatment not covered by the health care plan that it was administering," Thomas wrote. Thus, the plaintiffs were really suing "about denials of coverage promised under the terms of ERISA-regulated employee benefit plans." He noted that Davila and Calad "could have paid for the treatment themselves and then sought reimbursement," or sought injunctive relief under ERISA.

Unlike the Court, outside reaction to Davila was far from unanimous. For example, Ron Pollack, executive director of the consumers group Families USA, said the decision "takes HMOs off the hook from any liability when they deny needed health care. … Health plans will no longer be deterred from making improper decisions that could severely harm patients." On the other hand, Karen Ignagni, president of the trade group America's Health Insurance Plans, noted that federal regulations under ERISA already give consumers the right to appeal coverage denials outside of the courts. She said the ruling "represents a victory for consumers and employers who otherwise faced the prospect of higher health care costs without added benefit."

POLITICAL FORECAST: MUCH DEBATE, BUT NO ACTION THIS YEAR

The high court decision re-ignited political debate over federal patients' rights legislation. "A real patients' bill of rights has bipartisan support, and could become law tomorrow if the Bush administration were not standing in the way," said the presumptive Democratic presidential candidate, Sen. John Kerry (MA), according to the *Associated Press*. White House spokesperson Scott McClellan said that President Bush supports "meaningful legal remedies for patients who have been harmed by managed care companies' denial of medical care."

The issue could be tricky for the president because of his complicated history with the Texas law. After vetoing an earlier version of the legislation, then-Governor Bush allowed a second version to become law without his signature, expressing worries that it would increase costs and lawsuits. Bush then touted the law as an example of his leadership and a model for federal legislation during the 2000 presidential campaign, but in the *Davila* case his Justice Department joined the insurance industry in arguing that the Healthcare Liability Act conflicted with ERISA.

In 2001, after Bush became president, the Republican-controlled House, on a party-line vote, passed an administration-supported rights bill that would have allowed aggrieved consumers to sue health plans in state courts but under federal limitations on damages. By a wider, more bipartisan margin, the Democrat-controlled Senate passed a bill without the damages caps, and the houses never reconciled their difference.

In response to *Davila*, prominent backers of the more liberal Senate approach, such as Sen. John McCain (R-AZ) and Rep. John Dingell (D-MI), said they would renew the fight. However, given the short legislative calendar and polarized atmosphere of a presidential election year, there is little chance of action.

In a concurring opinion joined by Justice Stephen Breyer, Justice Ruth Bader Ginsburg said the court's ERISA jurisprudence left a "regulatory vaccum" in which "virtually all state remedies are preempted but very few federal substitutes are provided." One solution, she said, might be to interpret ERISA to allow consequential damages against an ERISA plan fiduciary, such as an MCO that administers a plan. Ginsburg said the Supreme Court could reinterpret ERISA this way without new congressional action, and she noted that the administration suggested this approach in its brief.

"Congress intended ERISA to replicate the core principles of trust remedy law, including the make-whole standard of relief. I anticipate that Congress, or this Court, will one day so confirm," Ginsburg wrote. Professor Sarah Rosenbaum, of George Washington University, told *M&H* on June 23 that Congress would have to make this change, since Ginsburg is unlikely to bring a majority of the Court to her interpretation.

Rosenbaum added, however, that there might be other situations in which ERISA-plan enrollees could still sue in state court even after *Davila*. "A health plan medical staff can be liable for medical negligence if they're really involved in the care of a patient," she said. In contrast, the issues decided by the Court were "really garden-variety coverage decisions," for instance whether "Vioxx is covered on the first pass, or do you have to start with Naprosyn."

At a certain point, when an MCO's medical staff gets directly enough involved in designing disease-management standards or overseeing a particular patient's care, "you're out of the realm of coverage and into straight-old 'med mal.'"

Not-For-Profit Sector

FINANCE CHIEF DRAFTS LAW FOR TAX-EXEMPT ORGANIZATIONS

Saying that too many tax-exempt charitable organizations have turned into "cesspools" due to "big money, tax free, and no oversight," Senate Finance Committee Chair Chuck Grassley (R-IA) is circulating draft legislation to tighten rules for the not-for-profit sector.

Among other provisions, the legislation would institute a five-year review of each organization's tax-exempt status; give states authority to pursue some federal tax-law violations; revise the Internal Revenue Service Form 990 that most tax-exempt organizations file annually, to enhance completeness and consistency of reporting; require top officials of not-for-profits to attest to the accuracy of their IRS filings, under penalty of perjury; tighten filing deadlines for Form 990; require enhanced reporting of affiliated exempt and non-exempt organizations; and require reporting of annual organization performance goals and measurements for meeting them.

Grassley hopes to introduce legislation along with Finance top-ranking Democrat Sen. Max Baucus (MT) in the fall, he said at a June 22 hearing. His draft bill can be viewed on the Finance Web site at http://finance.senate.gov/hearings/testimony/2004test/062204stfdis.pdf

Employer-Based Coverage

HEALTH COVERAGE PART OF GENERAL BENEFITS DECLINE

The percentage of full-time private-sector workers participating in employer-sponsored health coverage decreased from 80 percent in 1989-90 to 56 percent in 2003.

That's perhaps the most striking example of a general decline in the percentage of workers participating in many types of employer-provided benefits that's described in an May 26 article posted on the Bureau of Labor Statistics Web site.

Among all "civilian" workers — which includes state and local government as well as private-sector employees — participation in employer health coverage declined from 83 percent in 1989-90 to 68 percent in 1998-99. The article does not distinguish between nonparticipating workers who decline benefits and those who are not offered them.

"Perhaps the overriding trend in benefits over the past 25 years is towards more employee responsibility," says the paper. "Evidence of this phenomenon includes the availability of choices among medical care plans, the requirement that employees help fund the cost of their medical care plans, and the requirement that employees contribute to their retirement plans and make investment decisions."

The article notes that, while participation rates have declined, "the proportion of employer compensation dollars spent on benefits (as opposed to wages) has remained relatively stable at about 28 percent of compensation costs throughout the decade. This may suggest that the benefits that are currently provided are more costly than they have been in the past."

COVERAGE UNDERMINED BY CHANGING JOB MIX

In the June newsletter of the Employee Benefit Research Institute, senior research associate Paul Fronstin says that one reason for the declining trend in health benefits is the relative loss of manufacturing jobs, which are more likely than other types of employment to carry health insurance.

"In 2002, 64.2 percent of the nonelderly population was covered by employment-based health benefits, compared with 70.1 percent in 1987," Fronstin says.

Between 1987 and 2002, the percentage of workers age 18 to 64 employed in manufacturing decreased from 24 percent to 18.8 percent, according to Fronstin. In contrast, service sector employment increased from 17.7 to 26.4 percent. In 1987, 78.9 percent of manufacturing workers were covered by health insurance, 30 percentage points or more higher than all other categories except the public sector, where 74.4 of workers were covered.

The gap in health coverage between manufacturing and other types of jobs is actually narrowing, says Fronstin: **By 2002, only 70 percent of manufacturing workers had health benefits, while rates in other sectors stayed relatively constant or, in the case of the personal services sector, even increased, from 48 percent to 52 percent. Nevertheless, "workers in the service sector are still much less likely to have employment-based health benefits than workers in the manufacturing sector.**

"As a result, it can be concluded that the movement of jobs from the manufacturing sector to the service sector has partly contributed to the decline in employment-based health benefits," Fronstin says, pointing out that family members as well as workers are affected: In 2002, more than 78 percent of the nonelderly population whose family head worked in manufacturing had employer-based coverage, compared with 82.2 percent in the public sector and 58 percent in the service-sector.

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Fronstin concludes: "As long as the erosion of employment-based health benefits is due partly to structural changes in the economy, and with health insurance cost increases predicted to continue in the future, current trends in coverage can be expected to continue and even accelerate."

Information Technology

FEDS, MEDPAC, QIOs PROMISE NEW FOCUS ON INFO TECH

Where the nation's discussion of health care is going at present isn't all that clear. But one thing is certain: Examining the potential role of clinically oriented information technology in holding down costs and improving quality will be a top agenda item for the federal government.

For example, President Bush's "vision is to develop a nationwide [health information technology] infrastructure that ensures appropriate information is available at the time and place of care," which will improve care, reduce medical errors, and "may even reduce health-care costs," newly appointed National Health Information Technology Coordinator David Brailer, MD, said at a June 17 House Ways and Means Health Subcommittee hearing.

But analysts point to the tough challenges ahead and the danger of too-high expectations.

Said American Health Quality Association Executive Vice President David Schulke, in testimony submitted to Ways and Means: "Adoption of information technology will not by itself have a major impact on the quality of health care most Americans receive."

Schulke — whose group represents the state Quality Improvement Organizations that serve as the state-based quality infrastructure for Medicare and some other insurers — cited a report Brailer wrote last year for the California HealthCare Foundation in which the new federal health IT czar concluded that assistance with reengineering physician practices to make the most of IT is crucial. **Quoting Brailer, Schulke said that "unless substantial support is given, physicians will not be able to configure their systems, train for their use, integrate them into their workflow, and support the transition for their staff. In other words, if left alone, most physicians will fail at [computerized-patient-record] implementation."**

Beginning in 2005, QIOs in all 50 states, in conjunction with the American Medical Association and the American Academy of Family Physicians, will launch a focused initiative to promote adoption and effective use of IT, said Schulke.

That health-care IT can greatly improve quality and lower costs is a testable proposition that is also much on the minds of the Medicare Payment Advisory Commission these days and is a special concern of Chair Glenn Hackbarth, says Executive Director Mark Miller. In MedPAC's just-released June report, Commission staff make a first pass at outlining the field, defining terms, and assembling data on current levels of IT dissemination.

Determining the level of dissemination turned out to be "very difficult," says Miller; however, all indications are that dissemination is "low," he concludes. Furthermore, "to the extent that [clinical IT] is being taken up," doctors and hospitals "are taking up different things," potentially complicating initiatives that would weave the nation's health-care system together in a seamless electronic web. For the most part, physicians are adopting electronic health records, while hospitals utilize remote imaging and physician-ordering technology.

In an echo of Schulke's comments, the MedPAC analysis finds that the cost of IT doesn't lie in procuring and installing the technology. Instead, it's in the staff time and effort required to effect organizational changes in practice that are required for heavy and effective incorporation of health-care IT, says Miller.

In Congress

PANEL TAKES BIG HEALTH-CARE BITE, BUT WILL IT CHEW?

On the domestic front, health care remains among Americans' top worries. Unabated high numbers of uninsured people, burgeoning costs, and doubts about care quality are just some of the issues voters may look to Washington to ease. Accordingly, with Medicare behind them, the House Ways and Means Committee waded back into the to-do pile at a June 22 hearing and emerged pledging further consideration and even eventual action on … pretty much all of those problems.

In a session whose ostensible focus was whether not-for-profit hospitals hold up their end of the bargain to provide substantial amounts of charity care in return for state and federal tax exemptions, members and witnesses commented at length on pricing transparency to improve private-market health care, specialty hospitals, the design of consumer-directed health plans, the pros and cons of covering the uninsured, the possibly shaky future of full-service hospitals under current reimbursement systems, and more.

Nevertheless, it's not clear how much Washington can or will do to tinker further with private-sector health care, however deep the discontent. Despite recent rumblings about high hospital charges, for example, at a lengthy House Energy and Commerce Committee hearing on that matter June 24, Oversight Subcommittee Chair Jim Greenwood (R-PA) said he'd be highly reluctant to propose a legislative solution.

When it comes to tackling private-sector health-care problems such as mushrooming costs, there will be "a lot of talk, a lot of wringing of hands, and a lot of inaction," Urban Institute President Robert Reischauer predicted at a June 24

forum sponsored by the research and policy group Center for Studying Health System Change.

In the end, for the private sector, "all the changes will be evolutionary," said Robert Laszewski, president of the Health Policy and Strategy Associates consultancy and North American chair of the Global Medical Forum, said at the same meeting.

Naysayers aside, the Ways and Means Oversight Subcommittee waded into the issues June 22.

Full-committee Chair Bill Thomas (R-CA) has the most clout to actually move legislation, and his preferred future seems to look something like this: Create a well-functioning private market by, among other things, using the tax system to subsidize coverage for lower-income and high-medical-need individuals, paid for in part by a rollback of some current tax expenditures that subsidize health care in other ways.

Topping Thomas' hit list of current tax expenditures that could be trimmed or eliminated to expand coverage are the tax preference enjoyed by those who get health insurance through their employers and the tax exemption that helps support not-for-profit hospitals.

Thomas — who promised a "very long series of hearings" on not-for-profit organizations' tax status — laid the trade-off on the line. He asked a panel of hospital executives whether they'd give up their tax-preferred status in return for a government solution to eliminate uninsurance and thereby remove hospitals' bad-debt and charity-care burden, or whether they'd rather keep the preference and face much stricter oversight to guarantee that uninsured people have access to adequate charity care.

The executives' answer: For the most part, they prefer to keep the exemption.

Consumer-Directed Health Care

EASY TO SAY, NOT SO EASY TO AGREE ON

Many lawmakers and analysts agree that increasing patients' awareness of the cost and value of diagnostics and treatments may help drive costs down and quality up in the U.S. health-care system. But underneath the apparent agreement lie a host of specific disagreements about just what sorts of health-care payment arrangements actually would work to accomplish these goals, including such fundamental matters as what "price transparency" means and what roles insurers should play.

That's what a House Ways and Means subpanel found out at a June 22 hearing, where committee members sought answers for the mushrooming costs of care (see story, p 4)

For example, Harvard Business School professor Regina Herzlinger testified about her vision of a health-care market driven almost exclusively by individual consumers. Under her plan, consumers would buy insurance coverage of their choice in the individual market and patronize providers who would list prices — and could change them at will — and provide standardized quality information under supervision of a government agency similar to the Securities and Exchange Commission.

The role of insurers would decrease dramatically in Herzlinger's dream system, which has some strong congressional adherents, such as conservative up-and-comer Rep. Paul Ryan (R-WI). **Third-party payers — including private-sector insurers and, especially, managed-care plans — are the enemies of a reasonable health-care market for several reasons, in this view. Among other things, year-long negotiated contracts preclude quick price changes, and the negotiation process actually may cause providers to increase posted charges to "convince the insurers that they are receiving substantial discounts," Herzlinger told the panel.**

But Center for Studying Health System Change President Paul Ginsburg argued that insurers should still play a major role in more consumer-directed systems.

"In theory, empowered consumers armed with precise information about what care they need would compare information about each hospital's quality, amenities, and costs in relation to the benefit structure of their insurance," he said in written testimony. But "the reality … today is far from theory. … Hospitals charge on a fee-for-service basis that is highly detailed. … Patients all have different needs, so developing an estimate of what the charge would be for any patient is something that hospitals have not been willing to do."

This being the case, insurers have a big job — developing mechanisms that both give consumers accurate, understandable price and quality information and incentivize them to spend wisely, Ginsburg said. For example, rather than trying to publish the maze of individual service prices, Blue Cross of California uses a restaurant-guide approach, with hospitals categorized with between one and five dollar signs — $ to $$$$$ — depending on their average overall costs.

To the annoyance of full-committee Chair Bill Thomas (R-CA) and health subpanel Chair Nancy Johnson (R-CT), Ginsburg also said that the Holy Grail of consumer-directed care fans, price transparency — construed to mean divulging prices that health plans negotiated with hospitals — could be a two-edged sword, actually having the potential to raise prices in some places.

"Divulging negotiated prices could facilitate the workings of a cartel," he told the irate lawmakers.

"When managed-care plans negotiate prices with hospitals, both parties typically agree

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to keep prices secret," Ginsburg testified. "Each side is aware of the possibility that they can get a better deal if their counterpart can keep it secret from others in the marketplace." In many markets, the hospital side is much more consolidated than the health-plan side. And, in such markets, transparency could add to a concentrated hospital sector's already substantial pricing clout "because it facilitates taking into account how competitors will respond to prices and aids any collusion," he explained.

IN OTHER NEWS

• **Who Knows What Consulting Arrangements Lurk in the Hearts of Health Researchers?** Drug companies report about 100 consulting arrangements with National Institutes of Health scientists of which the NIH has no knowledge, House Energy and Commerce Oversight and Investigations Subcommittee chair Rep. James Greenwood (R-PA) said at a June 22 hearing.

Greenwood called the reports "especially disturbing" because, out of the "hundreds" of companies included on NIH's own lists of consulting arrangements, his panel — distrusting the NIH data — had sent inquiries only to the 20 companies that appeared most often. These companies reported a total of 264 arrangements, meaning the scientists had failed to report outside involvements almost 40 percent of the time.

If confirmed, "these unapproved, compensated activities would represent a very serious breach of NIH policies, federal ethics regulations, and, possibly, in a few cases, criminal laws," said full-committee Chair Joe Barton (R-TX). Barton's avowed campaign to reinvigorate Commerce's oversight role is not limited to NIH: On June 18, he asked 15 additional federal agencies, including the Department of Health and Human Services and the Food and Drug Administration, to report on outside compensated activities of their employees.

• **Bar On Anti-Reimportation FDA Spending Still In House Bill.** Under the fiscal year 2005 Agriculture Department spending bill approved by the House Appropriations Committee in a June 23 voice vote, the Food and Drug Administration could not spend money to enforce the statutory ban on importing prescription drugs from abroad. Similar "reimportation" language in last year's House bill did not survive a conference with the Senate.

• **Baucus Pushes Medicare Pay-For-Performance Bill.** In line with recent recommendations of the Medicare Payment Advisory Commission, top-ranking Senate Finance Committee Democrat Max Baucus (MT) is introducing a bill to establish performance-based payment for Medicare's private health plans and the end-stage renal disease program. Under the bill, top-quality Medicare Advantage plans and ESRD providers as well as providers that improve their performance year to year would get financial rewards, beginning in 2008.

In what is likely to be the most contentious provision, the program would redistribute current funding, rather than add new money for quality-based reimbursements. Under the budget-neutral plan, funds from a bonus pool created by withholding 2 percent of reimbursement for all providers in a group would be redistributed among the higher-performing and improving organizations.

A quality advisory board drawing its membership from stakeholder groups would assist the federal government in developing the quality-measurement system. MedPAC has said that ESRD care and integrated health plans are sectors for which quality-measurement mechanisms already are well developed and have stakeholder buy-in.

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Perspectives

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predicted. They are a complete non-starter for the industry. "Why would you want a PPO, with all the regional issues?"

Insurers are "talking much more aggressively" than in the recent past about entering MA, agreed Roberta Goodman, a long-time market analyst who is a principal with the consultancy Health Care Analytics LLC in Nashville, TN.

But she and others recommended caution about jumping on the bandwagon.

"The history is a period of boom followed by a period of bust" in federal payments, she said. "My personal bet is that a lot of what was given in the MMA" to MA plans and others "will ultimately be taken away."

The possibility of a Democrat winning the White House in November should give companies pause, said Alliance Capital Senior Vice President Norm Fidel. "Stability in Medicare policy lasts one congressional session," said Fidel, who noted that Senate Minority Leader Tom Daschle (SD) and other Democrats already speak of legislating big changes to the MMA.

But Urban Institute President Robert Reischauer said that insurers should be nervous no matter who gets elected. "We have a very large deficit, and sooner or later we're going to address it." Medicare, as always, will be looked to for solutions. When the day of budget reckoning comes, it will be more politically acceptable to cut back MA — which affects only 11 to 13 percent of the Medicare population — than the fee-for-service program, which serves over 80 percent of beneficiaries, Reischauer said.

Likely "the most vulnerable chunk of money" in the entire law is the $12 billion fund to encourage sign-up of regional PPOs in MA beginning in 2006, said Reischauer. It's easiest of all to cut spending for programs no one's participated in yet, he explained.

Laszewski, however, argued that, if Republicans remain in charge, they won't make big cuts to MA. "They have a big political stake" in seeing private plans succeed, he said.

• ***Want to sponsor a stand-alone prescription drug plan in Medicare? You're the only one.*** Private PDPs simply won't show up in 2006, and the federal fallback plan is likely the main vehicle through which beneficiaries will get drug-only coverage.

That's the feeling expressed by Fidel, who noted that "I still do not find much enthusiasm from [pharmacy benefit managers] or health plans to come out and underwrite" PDPs. The biggest problem: Potential underwriters can't weigh risks because they don't know which beneficiaries — with what level of health problems and drug utilization — will sign up for a PDP.

Some policymakers, including administration officials, have said that the robust participation by companies in the Medicare discount cards is good news, providing evidence of a comparable level of interest in PDPs come 2006.

Wrong, and wrong, said Laszewski.

The Medicare-approved discount cards are being offered by entities that already sponsor discount cards — and wanted the government's "Good Housekeeping seal of approval" for an existing product — along with Medicare supplemental insurers and MA plan sponsors, who want to be sure they hold onto their customers, Laszewski said. "Policywise, this means nothing for Part D."

The analysts disagreed about how the full drug benefit will affect Medicare's private plans.

Goodman said that the Part D benefit likely will make MA less attractive to beneficiaries, many of whom joined HMOs based on a decision to give up some provider choice in return for drug coverage. With drug coverage available in FFS Medicare, "at the margins," it will siphon subscribers away from MA, she predicted.

But others said that MA plans will be in a strong position to woo beneficiaries with their far superior drug benefits.

Plans believe "they'll be able to design a drug benefit that's much more attractive," perhaps even comparable to current employer-sponsored drug coverage, said Fidel.

Reischauer concurred, noting that MA plans can "internalize all the savings associated with appropriate drug usage," and therefore provide the standard Part D benefit more cheaply. With the savings, they'll be allowed to fill the so-called coverage doughnut hole — the gap between low-dollar and catastrophic coverage — that's likely to make the stand-alone benefit unattractive to many beneficiaries.

• ***Note to pharmaceutical companies: Polish your image.*** Analysts gave passage of legislation to allow reimporting prescription drugs from Canada and possibly other countries a 50-50 chance of success this congressional season. If reimportation from Canada is allowed, the practice won't change drug prices or the fortunes of pharmaceutical makers, they agreed.

The Canadian market is less than one-twentieth the size of the U.S. market and thus can have little impact on U.S. prices. Drug importation from European Union countries — as most current bills would authorize eventually — could have some impact on the U.S. market, however, said Fidel.

Laszewski — who thinks there's a better chance reimportation will be authorized than do some other analysts — said that the really big problem for pharmaceutical companies will come

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if a measure is enacted and pharmas decide to contest it in court.

With public annoyance at drug prices still running high, "the smartest thing" the industry could do now is restructure its retail prices to defuse anxiety and thus head off legislative action, Laszewski said. Since only uninsured people actually pay the high retail prices that lawmakers are complaining about, if companies cut those prices — which he argued must represent only a small part of their market — a good deal of the political pressure would go away, he suggested.

If reimportation is authorized, any bill is likely to raise legal restraint-of-trade issues, among others, making it probable that drug companies will sue. If they do, such a move would play straight into the hands of Democrats who are pushing reimportation measures as a backdoor way of moving to government-set prices, since it would stir up even fiercer public anger at the industry, he said.

• ***Medical costs are slowing; premiums, not so much.*** A variety of factors slowed medical cost trends last year, analysts agreed.

In a paper published June 9 on the *Health Affairs* Web site, for example, HSC President Paul Ginsburg found that total health-care spending per privately insured person rose 7.4 percent in 2003 — 2.1 percentage points less than the 2002 increase of 9.5 percent — based on data from the Milliman USA Health Cost Index.

Fidel said June 24 that he'd estimate the 2003 increase a little higher, at around 10.4 percent. Inclusion of spending by the uninsured and Medicaid patients — who are subject to many cost controls — lowers the Milliman numbers too much, he said. However, he concurred that 2003 saw deceleration of spending growth in all health-care sectors.

Analysts note several reasons why cost trends are down.

For one thing, the overall economy is a predictor of health-care spending, but only after significant lag time, said Ginsburg and Goodman. This means that some of the slower spending trend seen last year and in the early quarters of 2004 results from the recent slow growth in the general economy. Increased cost sharing for individuals, plus stricter prescription-drug formularies, also have pushed spending down, analysts said.

A one-time drop in drug costs from several high-use drugs going to over-the-counter status also contributed, said Goodman. The drop in hospital utilization represents a "reversion to the mean," she theorized.

Earlier in the decade, hospital use swelled as the strictest managed-care controls were lifted and some markets shifted contracting arrangements away from capitation. At that point, pent-up demand pushed utilization way up, but it's now returning to "more normal" levels, she said.

A slowed cost trend continues in the first quarter of 2004, panelists said.

For example, pharmaceutical sales are up by only 8 percent, when a 10 to 11 percent increase was expected, said Fidel. It's been "almost a decade" since pharmaceutical sales rose in the single digits.

Banc of America Securities Principal and Senior Analyst Gary Taylor said that 2004 spending increases continue to be low for hospitals and other sectors. He said he wouldn't go so far as to predict continued slowed spending growth next year, but for 2004, "I would say we'd be surprised at the end of the year at how sharply down" the trend goes.

So, with cost growth dropping, premium growth will follow, right? Not really, panelists said.

Most predict that slower cost growth will continue for a couple of years, but they're uncertain that's the case. Also among the uncertain, said analysts: insurers, who put the price sticker on coverage

Premium increases will abate a bit, but they won't drop nearly as sharply as cost growth, said Laszewski, a former insurance executive. In a market dominated by a small number of for-profit health plans, premium "rates are going to stay high because they can," he said.

When cost growth slowed in the mid-to-late 1990s, premium prices also slowed significantly, said Fidel. "We actually ended up with a price war in health insurance."

But any upcoming slowdown in premium growth will be "moderate," said Frank Sustersic, a senior analyst with Turner Investment Partners.

Consolidation is the reason, the panel agreed. The total number of health plans has nearly halved over the decade, and for-profit insurers now control 45 percent of the market, up from 25 percent in the mid-to-late 1990s, according to Fidel. The market is consolidated into fewer hands, and "these fewer hands are more focused on the bottom line," he said.

"I have never seen such discipline" on pricing as currently, said Laszewski. The consolidated industry is "extraordinarily sophisticated" on pricing — "*much* more sophisticated" than their negotiations adversary, employers.

PEOPLE

James Capretta leaves the top health-care spot at the White House Office of Management and Budget to become managing director of the lobbying firm Wexler and Walker Public Policy Associates.

American Hospital Association vice president for legislative affairs **Kris Morris** departs AHA to open a legislative affairs office for Boehringer Ingelheim Pharmaceuticals.