

# Medicine & Health

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## Medicare

### CONFEREES AGREE ON DRUG CARDS, CRITICAL ACCESS HOSPITALS & MORE

Medicare conferees met Sept. 9 and approved a series of agreements reached by staff over the August recess, notably a framework for temporary Medicare-endorsed drug discount cards.

The cards, designed to offer seniors immediate help while a full-scale drug benefit gets up and running, would go into effect within six months after the president signed Medicare prescription drug legislation, and would disappear when the full benefit was implemented, now slated for 2006.

In a single unanimous voice vote, the conferees also ratified a funding boost for critical access hospitals, a guarantee of medication management services for beneficiaries with multiple chronic illnesses, and coverage of screening tests for cardiovascular disease and diabetes, among other items.

Conference Committee chair Rep. Bill Thomas (R-CA), while warning that nothing is final until everything is final, said the staff agreements covered "hundreds" of pages of legislation. But they also covered generally noncontroversial items, and the conferees must now move on to decidedly more controversial topics. Next up, said Thomas: provider payments, and coverage for low-income Medicare beneficiaries and the "dual eligibles," i.e., those eligible for both Medicare and Medicaid.

Still ahead as well are the most controversial items, like the role of private plans in Medicare and whether they will compete

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*Copy Health Policy class*  
In *Medicine & Health Perspectives* this week...

### INSURERS GEAR UP TO FIGHT NATIONAL HEALTH INSURANCE

Look for the term "consumer-directed health plan" to morph into "consumer-choice health plan" in the near future.

The language shift, recommended to the Health Insurance Association of America by Republican pollster Bill McInturff based on recent survey evidence, could be part of a new push by insurers to encourage widespread adoption of high-deductible, individually owned, tax-preferred, cash-based portable health-coverage vehicles before it's too late.

What does "too late" mean? To insurers as well as to many Republicans it means this: Get consumers effectively involved in stemming monster year-to-year health-care spending increases, or end up with a single-payer national health program.

"I believe that we're on the verge of socializing health care," Rep. Jim DeMint (R-SC) said at a Sept. 9 HIAA forum where McInturff's results were released. "If we don't restructure soon, we're going to have one payer for everybody." On recent visits to doctors and hospitals, DeMint found that many are "very close to throwing in the towel and asking the government to do it," he said.

Nevertheless, "solutions are sprouting up all around us," said DeMint. The Bush administration and congressional Republicans are doing as much as they can to ease the way by expanding eligibility for the various health-care cash accounts that have been created over the past several years and liberalizing

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directly with the fee-for-service version of the program as envisioned under the "premium support" provisions of the House bill. Senate Finance chair Charles Grassley (R-KS), vice chair of the conference, called this issue an "uncharted wilderness" about which negotiators were still educating themselves.

Moreover, one Republican aide said at a Sept. 8 reporters' breakfast that some of the supposedly agreed-upon regulatory and contracting provisions in the Medicare bill may need to be revisited. Thus, predictions by staffers from both parties that the Medicare debate may stretch on to Thanksgiving, or even Christmas, seem very plausible, particularly given a Democratic aide's complaint that minority conferees were being shut out of meetings. "It's difficult to see how Democrats are going to vote for the bill if they haven't had input into the process," that aide said, although another Democratic staffer and a GOP aide said Republicans simply needed to negotiate a common position on premium support among themselves.

At the conferees' meeting, Senate Finance Committee senior Democrat Max Baucus (MT) warned Republicans to include Democrats in deliberations or face not getting the 60 votes needed to prevail against a Senate filibuster. "I underline the necessity" of working together in a bipartisan manner, said Baucus, who worked closely with Grassley to push Medicare legislation through the Senate. "If at some point, I feel that this is not happening, I am going to have to reconsider my position on this legislation. I'd rather have a good bill passed, but no bill is often better than a bad bill."

Responding to a similar point from Sen. Jay Rockefeller (D-WV), Thomas said House and Senate Medicare conferees had met as a group only once, but he suggested that, if Democrats kept accusing Republicans of excluding them, then Republicans would have nothing to lose by doing exactly that.

Conferees as diverse ideologically as Rockefeller (D-WV) and Rep. Michael Bilirakis (R-FL) found union over worries that a new Medicare drug benefit might prompt employers to drop retiree coverage they now provide. This represents "the one concern that I have found more than any other" among constituents, "said Bilirakis, who warned that "frankly we're going to have another catastrophic" if the issue is not satisfactorily addressed.

Bilirakis was referring to Congress' passage of drug and catastrophic health coverage for Medicare beneficiaries in 1988, which Congress quickly repealed because of perceived anger from seniors who thought they would lose existing retiree coverage. The Florida Republican said he and House Commerce chair Billy Tauzin

(R-LA) had talked with Thomas about using tax breaks to avoid employers dropping coverage, but "I don't know how good an idea something like that is."

### **LOW-INCOME SENIORS WOULD GET \$600, ONLY PAY COINSURANCE**

All beneficiaries would be eligible for Medicare-endorsed discount drug cards, except those with Medicaid drug coverage. Card sponsors — including pharmacy benefit managers, wholesalers, retail pharmacies, insurers, and Medicare+Choice plans — could charge up to a \$30 annual fee.

Seniors would have a choice of at least two Medicare-endorsed drug discount cards. They could hold only one such card at a time — although they could also hold discount cards not endorsed by Medicare — and could change cards once between now and 2006.

The Health and Human Services Secretary would have the discretion to limit the number of cards that Medicare endorsed, a potentially important feature since administration officials and congressional drug-card backers argue that the aggregated buying power of seniors would enable sponsors of Medicare-endorsed cards to deliver bigger benefits than offered by currently available discount cards. Administration officials predict that seniors would see discounts of at least 15 to 25 percent using the Medicare-endorsed cards.

Individuals with incomes below 135 percent of the federal poverty level and no third-party drug coverage would get \$600 added to their drug cards, and the government would pay their annual fee. In addition, under an agreement worked out by Sen. Don Nickles (R-OK) and Rep. John Dingell (D-MI), those with incomes below the FPL would pay only 5 percent coinsurance for each prescription, while those with incomes below 135 percent of FPL would pay 10 percent coinsurance.

Some have speculated that the House and Senate might fail to agree on a comprehensive drug benefit, leading to a permanent drug card by default. If that happened, warned Baucus, conferees would have to revisit certain aspects of the drug cards dealing with "administrative costs, pharmacy access, consumer protections," and directing more savings towards beneficiaries.

Critical Access hospitals, rural facilities that are generally at least 35 miles drive from any other hospital, would get a payment increase to 101 percent of costs under the agreements approved Sept. 9. Conferees also okayed a provision authorizing \$35 million in "Rural Flexibility" grants, of which hospitals would get 95 percent.

*Drug Reimportation***FEDS MOVE TO SHUT DOWN REIMPORTATION BUSINESS**

After several Food and Drug Administration warning letters went unheeded, the Justice Department Sept. 11 sought a court order to shut down immediately and permanently an Oklahoma company, Rx Depot, that helps U.S. residents buy cheaper drugs from Canada.

Company President Carl Moore said he wouldn't close or sign a consent decree, the *Associated Press* reports. "Just because this is the federal government, this does not scare me. I look forward to my day in court."

The government argues that food and drug law makes it illegal for anyone but a drug manufacturer to import a U.S.-made drug from another country.

However, FDA has looked the other way when it comes to personal reimportation of small supplies bought by individuals over the Internet or on trips to Canada. This fact creates the loophole that Rx Depot and some similar businesses hope will support their case. The businesses argue that they themselves do not reimport drugs and thus aren't in violation of the law. Instead, say the companies, they simply assist individual consumers to complete paperwork required to fill their personal prescriptions at Canadian online pharmacies.

But as actual storefront operations to aid reimportation have sprung up around the country, the agency has signaled that it will act against these entrepreneurs. FDA's arguments center on what it says are the safety and security risks of reimportation.

"Under current law, FDA does not have the resources or the legal authorities necessary to assure the safety of unapproved drugs imported into the United States," said FDA Commissioner Mark McClellan, MD, in a statement. "A long-distance international scheme that is deliberately out of compliance with U.S. and Canadian laws not only poses risks in itself; it also creates wide channels for criminals who only care about making a fast buck to exploit," the agency said.

Pharmaceutical manufacturers and U.S. pharmacists both argue that purchase of Canadian drugs exposes U.S. consumers to unacceptable risk, arguing that the imported drugs themselves may not meet U.S. standards and that the process also is risky on other grounds. Reimportation is widely said to be the top must-defeat item on the congressional agenda for big pharmaceutical makers.

For their part, community-based pharmacists make the same charge against reimportation as they do against the mail-order pharmacies that are favored by pharmacy benefit managers: When patients buy reimported drugs, they don't

have the opportunity for personal consultation with a pharmacist about how to use the medications, making the whole process of purchasing a prescription more chancy, pharmacists say.

At congressional hearings this year, however, FDA officials have testified that up to now they do not have documented cases of patient harm caused by medications reimported from Canada.

*Medicare+Choice***HEMORRHAGING FROM MEDICARE PLANS SLOWS**

About 40,000 people will lose their Medicare+Choice coverage next year, roughly a fifth of last year's total and the lowest number since the program's creation in the Balanced Budget Act of 1997.

That's according to the American Association of Health Plans' annual survey, which has been a reliable predictor in the past. Health plans had until Sept. 8 to tell the Centers for Medicare and Medicaid Services whether, and in which counties, they would participate in M+C in 2004.

Almost 200,000 seniors and disabled people lost their M+C coverage effective Jan. 1 of this year, and, in 2002, 536,000 people saw their plans pull out of their county or out of M+C entirely. Cumulatively, over the past 5 years just over 2.4 million M+C enrollees have lost coverage due to plan withdrawals.

M+C membership peaked at 6.3 million in 1999, representing 16 percent of the total Medicare population. Since then, enrollment has dropped to 4.6 million, roughly 11.5 percent of Medicare's 40 million beneficiaries.

In a Sept. 8 telebriefing, AAHP President Karen Ignagni warned that her organization's survey does not capture the number of M+C enrollees affected by benefit reductions and premium increases, "but we know that number is growing, and I think that trend will continue this year."

Ignagni declared that M+C plans are poised to expand if Congress puts more money into the program. She said three-fourths of enrollees affected by the current and prior rounds of plan withdrawals have come from counties where plans were limited to two percent reimbursement hikes in the face of 10-12 percent cost increases.

The House Medicare bill would add \$1.9 billion for M+C in 2004 and 2005, according to the Congressional Budget Office. The Senate bill would reduce funding for M+C by \$100 million over those two years, but both bills would provide plans with higher benchmarks after M+C became part of new competition-based programs starting in 2006.

*Cost of Coverage***EMPLOYERS AREN'T LEAPING TO NEW PLAN OPTIONS**

The average cost of employee health-care coverage soared another 13.9 percent between the springs of 2002 and 2003, the third year in a row for a double-digit increase. But while employers clearly are weary and seeking solutions, no new scheme has yet won much allegiance.

That's the finding of the Kaiser Family Foundation/Health and Educational Trust's annual employer health benefits survey, released Sept. 9.

Employers are trying to get a handle on costs, favoring both care-management strategies and ploys to increase workers' cost awareness. However, companies have little confidence "that current market strategies can reduce premium growth," according to the study.

Among key findings are the following:

- For the first time, a significant number of workers — 44 percent — face a separate deductible for hospital services.

- A "small but significant" group of employers with 5,000 or more workers — 17 percent — currently offer a high-deductible plan; another 16 percent say they'll add such an option next year.

- When employers were asked what approaches might help hold down costs in future years, no strategy got a ringing endorsement: 22 percent pegged disease management as "very effective"; 14 percent named consumer-driven health plans; 10 percent higher cost sharing; and six percent tighter managed-care networks.

- Demonstrating the discontent with current options, 62 percent of employers said they looked for new health-plan arrangements last year; 33 percent changed either the types of health-plans they offered or insurance carriers.

Other findings include these:

- Preferred provider organizations — the most popular option — remained the most expensive plans, averaging \$9,317 for family coverage. Health maintenance organizations averaged a family premium of \$8,514.

- In PPOs, the average deductible applied to services of non-preferred providers rose 20 percent, to \$561.

- Premiums remain lowest in the western states, but prices in the West rose faster — by 16.3 percent — than in any other region last year.

*Drug Safety***UNSAFE DRUGS — THEY'RE NOT JUST FOR FOREIGNERS ANYMORE**

Debate rages about how safe patients are if they buy U.S.-made drugs reimported from Canadian pharmacies (see story, p. 3). But evidence suggests that, at least in some places, state and federal officials may have an equally

hard time ensuring the safety of drugs purchased right here at home.

A series of alarming press reports over the past few years have documented egregious cases of counterfeiting, dilution, and contamination of drugs by segments of Florida's wholesale drug industry, for example. A legislative auditing agency and a state grand jury both issued reports earlier this year documenting multiple points of risk, and the state has since enacted legislation to beef up scrutiny and enforcement.

As of February, Florida had granted permits to 422 in-state drug wholesalers and 977 out-of-state dealers, according to the grand jury report. The wholesalers buy and sell drugs to each other and to end users like pharmacies and hospitals, in a process that the state legislature's auditing office says has thus far lacked all but the most rudimentary safeguards for screening wholesaler hopefuls, penalizing wrongdoers, and tracking products to prevent introduction of illicit drugs into the ultra-complex prescription supply chain.

The result, according to the grand jury: "An alarming percentage" of drugs in the wholesale market "have been illegally acquired." They have been stolen from shipments, pharmacies, clinics, and hospitals; "purchased on the black market from recipients and health care professionals who are defrauding insurance companies or Medicare with bogus prescriptions; or illegally imported from overseas."

Furthermore, "many" of Florida's licensed wholesalers "are unqualified, inexperienced, irresponsible and incompetent to properly handle, store, or deal in pharmaceuticals. Some even have criminal records."

What the jury labels as "corrupt secondary wholesalers" introduce tainted, expired, illegally imported, or falsely labeled drugs into the system. Once in the marketplace, the dangerous products move easily to unsuspecting end users, including patients who purchase their prescriptions at large chain pharmacies, "largely due to the failure of federal and state agencies to strictly enforce the law, as well as the complicity of wholesalers who turn a blind eye to the corrupt practices" of other wholesalers who are their suppliers, the jury charges.

There is plenty of incentive to join the trade, the jury finds. Potential profits "rival those found in narcotics trafficking," in part because many drugs involved are among the most expensive treatments for the most vulnerable patients, such as cancer and organ-transplant patients.

The counterfeiting problem is growing, Food and Drug Administration Commissioner Mark McClellan, MD, acknowledges in a *Wall Street Journal* interview Sept. 11. He notes "clear opportunities" for counterfeit drugs to enter mainstream distribution channels.

New technologies that make it easier to counterfeit labels and the high price of drugs that

fuels demand for cheaper alternatives both drive the heightened activity, says the paper. An FDA task force will make recommendations for countering the trend later this month, according to the *Journal*. Expected recommendations include packaging drugs dose-by-dose in blister packs rather than in bottles and incorporating two anticounterfeiting devices such as hidden watermarks into drug packages, says the paper.

The agency has quadrupled its counterfeiting investigations over the past few years, undertaking a high of 22 last year.

#### Costs

### HEALTHIER SENIORS LIVE LONGER FOR SAME PRICE

Healthier seniors live longer but don't rack up bigger cumulative medical bills, meaning increasing lifespans do not threaten the financial health of the Medicare program.

So says research published in the September 11 *New England Journal of Medicine* by James Lubitz and three other researchers from the Centers for Disease Control and Prevention's National Center for Health Statistics. The CDC team found, for example, that a 70-year old with no functional limitations could expect to live another 14.3 years and incur \$136,000 in medical expenditures, while a 70-year old who had difficulty performing at least one activity of daily living — such as bathing, eating, dressing, or walking — could expect to live another 11.6 years and incur \$145,000 in medical expenditures.

These results stem from the high cost of the last years of life, likely to be spent in a disabled — and often institutionalized — state. "For example, a person at age 70 could expect to live 34 percent of remaining life (4.5 years) with limitations in activities of daily living or in an institution but to incur 63 percent of medical expenditures (about \$88,200) in these health states," write Lubitz and his coauthors.

Therefore, total costs are determined less by total lifespan and more by disabled lifespan, and healthier seniors spend a significantly lower percentage of their years in a disabled state. Seventy-year olds with no functional limitations could expect to be active for 61 percent of their remaining lifespan, while persons of the same age with difficulty performing an activity of daily living could expect to be active for only 35 percent of theirs.

If the CDC team is right, "current Medicare projections, which implicitly assume that longer life costs more," are "substantially overstated," writes Harvard University Economist David Cutler in an editorial accompanying the Lubitz piece.

#### Appropriations

### \$1.5 BILLION ADD-ON FOR NIH FALLS SHORT

The Senate Sept. 10 approved fiscal year 2004 spending for the departments of Health and Human Services, Labor, and Education.

Passage came on a 94-0 vote that did not reflect the vigorous debate that occurred over many of the areas covered by the bill. Notably, a bid to add \$1.5 billion in "emergency spending" to the National Institutes of Health budget drew 52 votes, but failed to garner the 60 votes needed to overcome a budgetary point of order raised by Sen. Don Nickles (R-OK).

Sen. Tom Harkin, the senior Democrat on the Senate Appropriations Labor-HHS subcommittee, pointed out that the \$1 billion, 3.7 percent increase afforded NIH in the Senate bill would be the smallest increase for that agency since 1995. "The number of new and competing nonbiodefense research grants would actually drop from 9,902 in FY 2003 to 9,827 in FY 2004," said Harkin, who sponsored the emergency increase along with Labor-HHS panel chair Arlen Specter (R-PA) and Sens. Susan Collins (R-ME) and Dianne Feinstein (D-CA).

Nickles, the Senate Budget Committee chair, responded that the NIH budget has increased from \$7.5 billion in 1990 and \$13.6 billion in 1998 to almost \$28 billion under the unamended House bill. He accused Specter's panel of providing more funding to other agencies at NIH's expense, then trying to take advantage of NIH's broad support to violate the congressional budget resolution.

"If we are going to be declaring emergencies on appropriated accounts where there is nothing that wasn't intended, where there was nothing unanticipated, then we could just take the whole budget process and throw it out the window," said senior Budget Committee Democrat Kent Conrad (D-ND) in support of Nickles' position. Specter countered that "there is a very big difference between NIH and anybody else who wants to declare an emergency. Simply stated, NIH deals with life and death."

The House version of the Labor-HHS bill funds NIH at \$27.66 billion for FY 2004, a 2.5 percent increase.

#### IN OTHER NEWS

- **Medicare To Decide On Accepting Legacy Claims.** Medicare will decide by Sept. 25 whether to continue accepting electronic claims in their current formats once new rules designed to standardize electronic health care transactions become effective on Oct. 16, said Leslie Norwalk, Centers for Medicare and Medicaid Services acting deputy administrator, Sept. 11.

It is likely that Medicare will, in fact, continue to accept so-called legacy claims. Norwalk said fewer than 11 percent of current electronic Medicare submissions comply with the Transactions and Code Set regulations issued under the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996.

In July 24 guidance, CMS' Office of HIPAA Standards — which is separate from Medicare and responsible for enforcing the Transactions and Code Set requirements — said covered entities that had made a good faith effort to comply with the rules could delay compliance and rely on contingency plans, in order to maintain operations and cash flow with their trading partners, without fear of penalty. For health plans, good faith compliance efforts would require outreach to, and testing with, the plans' provider networks, criteria Norwalk said she was confident Medicare would meet.

Noting evidence that many providers, particularly small and rural ones, would not be prepared on time to submit HIPAA-compliant claims, Norwalk urged other health plans to develop contingency plans — which might mean accepting legacy claims like Medicare but might take other forms as well — and to pursue the testing and outreach necessary to avoid sanction. The alternatives, she said, were consumers not getting health care and providers not getting paid, or reverting to submitting paper claims.

"While Y2K was, 'Oh the sky is falling, Oh the sky is falling, Oh the sky didn't fall,' this is a very different scenario," warned Norwalk, who also expressed concern about reports that some state Medicaid agencies are not HIPAA-ready.

**• Road To Medicare Bill Must Go Through Defined-Contribution Diehards.** Look for conservative Republicans to withhold approval from Medicare prescription-drug legislation if it doesn't do more than either the current House and Senate proposals to help shift the entire health-care system toward a defined-contribution, rather than a defined-benefit, approach. So said Rep. **Jim DeMint** (R-SC), a three-term member of Congress who next year will seek the South Carolina Senate seat being vacated by retiring Sen. Ernest Hollings (D), at a Sept. 9 forum sponsored by the Health Insurance Association of America.

Salvation for the health-care system lies in a shift to individually owned, portable, high-deductible coverage that puts consumers directly at risk for much of their health spending, said DeMint. But the shift won't come if the big gorilla — Medicare — takes a different route, he said. Hence, his commitment to ensuring that any Medicare overhaul includes at least strong provisions for some kind of cash health savings accounts — that can be funded with actual Medicare dollars, not just patient contributions — and provisions for private insurers and providers to

compete directly for Medicare patients' business.

"If we set up Medicare for defined contribution, we can move in this direction," said DeMint.

According to DeMint and some audience members, the current drug proposals don't create nearly enough market competition.

For one thing, the plan for insurers to compete to provide coverage in multistate regions actually will lead to virtually no competition, despite administration and congressional protestations to the contrary, said one insurance-industry attendee. Of the nation's insurers, virtually all, including all Blues and Blues-related plans, would be unable to offer coverage extending to an entire multistate "region," as envisioned in the proposals. Unless the region idea is scrapped, only Aetna and UnitedHealth Group could participate, the audience member said.

DeMint wasn't sanguine about seeing a Medicare bill he'll vote for. "I have not heard much good out of the conference [committee]," he said. "I don't think anything Ted Kennedy would sign, I would sign."

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# Medicine & Health Perspectives

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rules for their use, he said.

But government officials can do only so much without demonstrated constituent will, and insurance companies must get more involved, DeMint said. Some in the industry may worry that, if consumers use their own dollars to choose their own providers, insurers' role could disappear. But **"I believe insurance companies are going to make much more money as they manage these cash accounts,"** DeMint said.

**• Job one, describe it right.** Consumer-directed — or consumer-choice — health plans will be a solution only if they control costs without triggering backlash, McInturff warned. Nevertheless, he said, there's good reason to avoid hampering efforts from the start by choosing language that pushes the wrong buttons.

As soon as he heard the terms "consumer-directed" and "consumer-driven," he sensed trouble ahead, said McInturff. "Directed" and "driven" subliminally suggest that somebody who's not the consumer is likely to do the directing and the driving. The word "choice," on the other hand, like the word "cure," is "always positive in health care." So the coinage "consumer choice health plan" is preferred, the pollster said.

It would be unwise to underestimate the power of language to shape debate or McInturff's clout in the phrase game. In the early 1990s, he helped shift the key term in the debate over Clinton administration coverage proposals from "national health insurance" to "government-run health care." Survey respondents gave "national health insurance" 57 fat points on McInturff's polling "thermometer" — which measures the extent to which a word gives listeners warm, fuzzy feelings. "Government-run health care" registered a chilly 41, a 16-point difference that served insurers well in those battles, he reminded his HIAA audience.

**• Some things you just can't spin.** Even if the name game is won by consumer-choice forces, however, if new-style plans don't end up pleasing the celebrated man in the street, the big game still will be lost, McInturff said. **"You can't spin people's actual life experience. These plans have to work."**

Careful naming can soften initial resistance. But everything — everything — depends on plans operating in a way that works for consumers and is relatively pleasant for them, said McInturff.

He recounted an experience while surveying opinion on school choice, which he said offered a lesson that advocates must take to heart. After he explained to a focus group

several models for the education system, one of which would offer parents a choice of sending their children to one of a wide range of schools, a woman asked, "But where will the bus stop be?" in the school-choice model. At that moment, "I said, Well, so much for school choice," McInturff said.

Adopted thus far by a relatively few employers, most of whom offer the plans as one of several options workers may choose, consumer-directed plans — which come in numerous varieties — have a slim track record.

Employers are looking for early-adopting companies to show "that these plans make even a two to three percent difference in costs," said Paul Dennett, vice president for policy at the large-employer group American Benefits Council. "Right now, there's not a lot of solid evidence." To convince employers that workers will see the plan as a benefit rather than a takeaway — and to convince unions to redo collective-bargaining agreements to accommodate the plans — such evidence is needed as soon as possible, Dennett said.

The national managed-care company First Health, for example, saw "a lot of interest in [health reimbursement accounts], but it kind of faded, I think because there is not enough good data," said Vice President Susan Fleming.

Many early adopters are offering the plans as one among several options, and report 10 to 15 percent cost savings. But, "if it's a catastrophic option, then you always save 10 to 15 percent," said Jerry Ripperger of Principal Financial Group. To use — and test — a plan to full advantage, "you've got to make it the most generous plan in your program so you can influence the high users," whose costs are the chief drivers of high spending.

In a wide-ranging analysis of public opinion, McInturff found most people "only vaguely familiar" with even the oldest consumer-directed health strategies, such as medical savings accounts. The lack of familiarity extends to senior human resource executives in "America's largest companies," he said. But there could be good news for advocates in the fact that the public mind is a blank slate. "We're at the beginning of the process," and therefore "have flexibility to change the language" to encourage Americans to think of the plans in a positive light, focusing on the choice they offer consumers.

Additional good news for advocates is that many employers who are familiar with the plans already portray them to workers as a boon — a true benefit — that would free employees from the managed-care restrictions that have triggered intense backlash. That

employers speak of consumer-choice models as a benefit rather than only as a money-saving strategy puts the fledgling plans ahead of where health maintenance organizations were in terms of consumer acceptance back in the early 1990s, when employers first turned to them in large numbers, according to McInturff.

• **A quick shift of the system?** Polling results showed both negative and positive views on consumer-directed coverage, but McInturff said that highly favorable results from one employer and one employee group suggest that a quick shift to consumer-directed dominance may "happen sooner than we think."

Small employers are growing desperate for a form of coverage that will simultaneously content employees and hold down costs. And some of employers' chief qualms can be quelled by explaining the facts, he said.

For example, the specter of having to put a full \$1,000 in upfront money into each of, say, 20 employees' HRAs at the beginning of the year sent some employers in focus groups reeling. "Oh, my God," small businesses "don't have that kind of cash flow," said one. In fact, however, employers fill the accounts in much more manageable monthly installments, McInturff said. Small businesses "will move very quickly" to offer plans once they know the details, he predicted.

But if employers build it, will employees come?

One group of workers will, according to McInturff. His surveys show that a quarter of people say they currently pay \$200 or more a month in premiums and face a \$400 deductible or larger. Among this group 59 percent said they would likely switch to a consumer-directed plan. "If in fact that many folks are paying that kind of money, it should be fairly easy to migrate them" into new options.

• **Hold your horses, Wild Bill.** Some forum analysts were skeptical that a kaleidoscopic shift of the coverage picture to consumer-directed plans is in the offing.

For starters, "consumers are very ignorant for the most part about their health plans," said Paul Ginsburg, president of the nonpartisan research and analysis group Center for Studying Health System Change (HSC), which is conducting multi-year studies of 12 U.S. health-care markets. HSC consumer data has shown that many people have the grossest possible misconceptions about even their own current health coverage, with people in restrictive HMOs telling surveyors that they are enrolled in traditional indemnity plans and vice versa.

For example, one of McInturff's key responses — the finding that consumers were especially excited that consumer-directed plans would allow them choice of providers —

seems based on a fundamental misunderstanding that could make it a shaky foundation for government or business policy, said Ginsburg. Most workers today are in preferred provider organizations, which offer virtually unlimited choice of providers already. Since people already have choice, why are they so excited about the prospect of getting choice in a consumer-directed plan? he asked.

Perhaps the most formidable foe insurers face is physicians. Based on his survey work, primary-care physicians "don't want to see these empowered consumers" that a health-care marketplace would require, said McInturff.

Advocates envision a system where consumers wisely use their own dollars to purchase care from providers based on knowledge of price and quality. But the physicians he surveyed "were really berserk on the issue of being quality rated," an ominous sign since "we've already seen how doctors submarined HMOs," said McInturff.

Ginsburg said that those who are predicting that a new and revolutionary coverage option is the next big thing may be mistaken. Some hybrid of managed care with coverage that features greater consumer cost sharing is more likely to dominate in the near future, and the consumer-directed care movement may be "just a different way of doing" what is happening already, he said. Cost sharing such as that which consumer-direction advocates recommend, after all, has turned out to be "the key tool" that managed care uses to achieve its cost-trimming results.

## PEOPLE

**John Murray**, most recently on the communications and strategic-planning staff of the Pharmaceutical Research and Manufacturers of America, has joined the Pharmaceutical Care Management Association as vice president of strategic initiatives.

Recently retired Congressional Budget Office analyst **Judy Wagner** is a scholar-in-residence at the Institute of Medicine. A specialist in pharmaceutical and health-technology issues, she earlier served at the federal Office of Technology Assessment.

**Katrinka Smith Sloan**, formerly senior vice president for member services at the American Association of Homes and Services for the Aging, is now chief operations officer for the group.

New at AAHSA is **Ann Gillespie**, senior vice president for organizational excellence. She's been executive director of the Continuing Care Accreditation Commission, previously sponsored by AAHSA.